

**Florida Guidelines
For
Substance Abuse
Family Intervention Specialists
(FIS)**



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**Department of Children and Families
Substance Abuse Program Office**

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Florida Guidelines Substance Abuse Family Intervention Specialists

Family Intervention Specialists (FIS) are staff positions of contracted substance abuse providers who perform linkage to the child welfare system to engage and support substance involved child welfare families in appropriate substance abuse treatment and recovery with a goal of improving both substance abuse treatment and child welfare outcomes.

THE FIS INITIATIVE

The FIS Initiative was funded to support the following joint system goals for Florida's Child Welfare/Community-Based Care (CW/CBC) and Substance Abuse Programs:

1. Protect and ensure the safety of children
2. Prevent and remediate the consequences of substance abuse on families involved in protective supervision, or at risk of being involved in protective supervision, by reducing alcohol and drug abuse
3. Plan for permanency and reunify healthy, intact families
4. Support families in recovery

The FIS Initiative is based on the hypothesis that:

- if caregiver substance abuse is identified, and
- if the caregiver is engaged in successful treatment resulting in abstinence and recovery, and
- if the caregiver's progress in achieving the substance abuse treatment plan is coordinated with child protective investigation and/or the permanency plans, then
- prognosis is improved for the family to stay together or be reunified, and for reducing the probability of future child abuse/neglect in that family.

The Florida Legislature funded 35 FIS in state Fiscal Year 2000-2001 and an additional 35 FIS in state Fiscal Year 2002-2003 to support this initiative. Since then, some circuits contracted additional discretionary local funding for FIS. By January 2009, 85 FIS are contracted to 18 substance abuse treatment providers through out the state providing services in all but five counties in Florida.

FIS perform critical support for the General Appropriations Act performance outcome measure to:

"Increase the number and percent of individuals (adults) in protective supervision who have case plans requiring substance abuse treatment who are receiving treatment."

FIS are funded to improve identification of substance abuse treatment need and to support retention and success in substance abuse treatment for CW/CBC cases. They are substance abuse professionals who are employees of contracted substance abuse providers. They work with, and most are co-located with, CW/CBC protective investigation or protective supervision staff.

Mental Health FIS: Over time, several circuit Substance Abuse and Mental Health (SAMH) Program Offices identified funding to support FIS focusing on individuals having a primary mental health problem. This is a critical need statewide, yet no new funds have been made available to expand the current substance abuse FIS capacity for this population. Department of Children and Families' (DCF) circuit SAMH Program Offices are encouraged to explore opportunities to fund mental health FIS.

Co-Occurring (Substance Abusing/Mentally Ill): Many of the individuals and family members referred to substance abuse FIS are dually diagnosed. Consequently, substance abuse FIS should systematically and aggressively screen for co-occurring mental health problems using the FIS screen or another comparable screen approved by the FIS treatment provider. FIS shall link these individuals with services which address their mental health treatment needs and include concurrent mental health services received by the individual in FIS case management and coordination.

Compliance with these guidelines is required for FIS funded through Florida's FIS legislative appropriation and for any additional FIS specifically contracted for by the circuit in the Substance Abuse and Mental Health contract's FIS Exhibit. These guidelines are specific to justification and implementation of the program model presented to the Florida Legislature which resulted in the line-item FIS appropriations. They also are appropriate for use by the circuit or treatment provider for any local FIS initiatives.

MINIMUM FIS QUALIFICATIONS

FIS function as substance abuse treatment system experts and representatives to child welfare. At minimum, a FIS should have a bachelor's degree in a social or behavioral science and one year of experience working with substance-involved individuals/families. Preference in selecting FIS should be given to individuals who hold a clinical or counseling license or certification, who are certified addictions professionals, and who have both substance abuse and child abuse/neglect knowledge and experience. If an individual hired as a FIS prior to state Fiscal Year 2004-2005 and is functioning effectively in this capacity, yet

does not have a college degree, the individual may continue to function as a FIS. The minimum qualifications apply to new hires by the FIS provider.

REGULATIONS – FLORIDA ADMINISTRATIVE CODE

FIS services must be performed in compliance with the Substance Abuse Licensure Rule 65D-30, F.A.C. All services shall be provided under the supervision of a qualified professional as defined by Rule 65D-30, F.A.C. FIS services should be provided consistent with these guidelines and with provisions delineated in the Substance Abuse and Mental Health Model Contract's FIS Exhibit. Provider sites supervising FIS must be licensed for Intervention: General Intervention and Intervention: Case Management and shall adhere to the minimum requirements for intervention programs delineated in Rule 65D-30, F.A.C. Intervention includes activities and strategies that are used to forestall or impede the development or progression of substance abuse problems.

Statewide FIS services are funded at approximately \$5 million with a mix of fund sources: Targeted Assistance for Needy Families (TANF); Substance Abuse Prevention and Treatment Block Grant (SAPTBG); Tobacco Settlement funds; and General Revenue. Expenditures must additionally comply with applicable regulations for those fund sources.

Adult Services Funding Source: Although current FIS funding is appropriated in the adult substance abuse category, there was no intent to limit FIS services for parents/caregivers under 18 years of age. In fact, this caregiver population may be among those most critical to target, even though it represents only a small percent of the total.

SERVICES THAT FIS PROVIDE

FIS provide adult substance abuse outreach, screening, intervention, and case management. FIS do not function as the primary treatment counselor. Their role is to serve as a consultant to, and coordinator with, child welfare and a motivator/supporter for families. FIS responsibilities are to:

- ✓ Take referrals;
- ✓ Provide initial screening;
- ✓ Provide the linkage for further assessment/treatment as indicated;
- ✓ Provide case management;
- ✓ Motivate and support the family and assist in removing barriers to successful substance abuse treatment outcomes;
- ✓ Track and report on the progress of individuals referred;
- ✓ Provide information and recommendations for development and case management of the joint family service plan; and

- ✓ Work with the child welfare case worker to ensure compatibility between the substance abuse treatment goals and child welfare's plans and interventions for the family.

Services are provided, at a minimum, Monday through Friday with flexible hours to meet the needs of the families they support. If feasible, some of the direct family support services will be provided in the family's home.

DEPARTMENT OF CHILDREN AND FAMILIES (DCF) CIRCUITS AND REGIONS

The circuit SAMH Program Offices and regional CW/CBC Program Offices are responsible for ensuring that local policies and operating procedures are developed regarding coordination and integration of Substance Abuse and CW/CBC services. How coordination and integration will occur should be delineated in the Substance Abuse, Mental Health, and Child Welfare Policy Working Agreements. These agreements should further specifically describe how FIS will function in the circuit.

Circuit SAMH Program Offices allocate FIS funding and incorporate any specific provisions they require through substance abuse provider contracts. Service units for FIS in contracts include the following cost centers: Outreach, screening, intervention, case management, and incidental expenses. Training dollars are built into the unit cost in contracts for FIS. Circuits also should delineate any specific requirements they prefer related to the use and management of FIS incidental funds. FIS licensure and contract/program monitoring is a responsibility of the circuit SAMH Program Office.

FIS OPERATING PROCEDURES AND COLLABORATION

FIS assist CW/CBC staff in jointly developing and maintaining local procedures that explicitly define the processes for referral, content of a referral package, follow-up and on-going case management. FIS also mutually support Substance Abuse and CW/CBC staff in the sharing of information regarding mutual clients for the purpose of coordinating the provision of optimal services, and develop operational procedures to address confidentiality issues between their respective program areas.

Additionally, it is vital that the FIS work closely with the Substance Abuse Women's Intervention Specialist (WIS) in circuits where a WIS exists. WIS focus on substance abusing pregnant/post partum women and perform functions similar to the FIS, but not specific to families involved in child welfare. A FIS provider, who also is a WIS provider, may want to have the WIS perform FIS functions for pregnant women to reduce the FIS caseload.

FIS maintain a directory of substance abuse treatment resources with contact information and eligibility criteria for referral.

Family Team Conferencing (FTC) is a preferred practice model for joint case planning and management for families involved in child protection services. FIS providers should seek out FTC training opportunities and participate as a member of the FTC team when this option is available through CW/CBC service partners. It is expected that the CBC staff will provide the lead role on the team and that a FIS will represent substance abuse treatment on the team.

CO-LOCATION WITH CHILD WELFARE

When feasible, FIS are co-located with child protective investigators and/or community-based care staff. If not directly co-located, FIS services are located in a place where they are readily accessible and available to child welfare personnel. The FIS shall make every effort to make sure that the protective investigators and other caseworkers and supervisors know who they are, what they do, and how to reach them.

ELIGIBILITY FOR FIS SERVICES

Eligible Families: Eligible FIS referrals are parents/caregivers, significant others, household residents and their children referred by child welfare, protective investigations, or a dependency court. Referred family members are those for whom substance abuse is suspected as a contributing factor to the abuse/neglect situation. Referrals may be made during the initial child abuse/neglect investigation or at any point during child protective supervision or out-of-home care.

Priority Families: Priority will be given to parents/caregivers in cases where a child is at risk for immediate removal or has been removed from the family, with a goal of reunification. The Substance Abuse Prevention and Treatment Block Grant regulations also require that priority be given to pregnant women and injection drug users in need of treatment.

Strategic Use of FIS Capacity/Waiting Lists: Ideally, sufficient FIS capacity would be available to handle all eligible substance-involved families in child welfare. However, FIS capacity is significantly less than the number of eligible families. Consequently, each circuit should identify, in consultation with the local child welfare program, how it will prioritize FIS services to maximize the use of this resource in support of the desired outcomes. For example, at the circuit's option, FIS may be strategically directed geographically. Some circuits may want to limit FIS referrals exclusively to child protective investigations. Others may want to

use some of their capacity exclusively for dependency drug court cases or to handle caseloads of a specific community-based care organization. Some may choose to discontinue FIS involvement for families with a parent/caregiver placed in a long-term residential program when case management and child welfare linkage can be provided through the residential program.

Referrals for Adolescents/Teens: When families are referred, FIS should screen any adolescents/teens in these families who are suspected of substance abuse/use and, if indicated by the screen, link them with a resource which will provide an in-depth assessment to identify treatment needs. If the FIS is involved with a family having a parent/caregiver who will receive substance abuse treatment, they should provide case management support for all family members requiring substance abuse treatment, including adolescents/teens. Nonetheless, given limited FIS capacity, FIS should NOT case manage non-parenting adolescents/teens (exception is pregnant teens) in need of treatment in the absence of having already selected the family for the FIS caseload based on parent/caregiver substance abuse eligibility. It is appropriate and desirable for FIS to provide substance abuse screening and treatment linkage for child welfare referrals of adolescents/teens in the absence of parental/caregiver referrals for substance abuse screening. This policy is driven by limited capacity and the need to maintain FIS strategic focus on parents/caregivers to reduce alcohol and drug related child abuse/neglect.

Priority on Protective Investigations: FIS were originally conceived to provide outreach for parent/caregiver referrals in child protective investigation cases. This focus is to ensure early identification of substance abuse problems, expedite entry into treatment, and to support continued participation and retention in treatment. This early contact and support optimizes the opportunity to reduce the number of families having to experience out-of-home child placements, or reduces the amount of time that the family is not together, by providing immediate substance abuse treatment intervention and support. Front-end involvement maximizes the dependency court judges' access to professional substance abuse treatment provider recommendations about these families. It further optimizes the potential use of therapeutic jurisprudence to motivate the parent/caregiver to commit to clinical interventions designed to support recovery.

Since child welfare law and regulations require that permanency planning must be completed within 12 months, the potential for successful outcomes with the family are improved when substance abuse treatment needs are identified and addressed as early as possible in the child abuse/neglect investigation and protective supervision process. If the circuit chooses to redirect FIS focus for referrals away from child abuse/neglect investigations, it should ensure that alternative substance abuse treatment resources are available to provide substance abuse screening and treatment linkages for protective investigations referrals.

FIS CASELOADS

FIS have a caseload of up to 35 families. The FIS provider should evaluate each FIS caseload individually at periodic intervals to ensure that the workload is manageable and that the FIS has sufficient time to provide necessary support for the families assigned. Examples of some workload factors to consider are: conducting a large volume of screenings weekly; having large numbers of new cases that require high intensity workload; having large numbers of FIS families engaged in residential treatment requiring less FIS time involvement; and travel time for in-home services or court appearances.

Given limited capacity, the FIS provider should plan for the inevitable day when the FIS caseload will reach maximum capacity and a waiting list for these services will occur. The FIS provider should identify alternative resources within the treatment program for screening, linking and admitting FIS eligible clients within the substance abuse treatment program when FIS are operating at maximum capacity.

REFERRALS TO THE FIS

A referral can be made when the dependency court or a child welfare case worker suspects that parent(s)/caregiver(s) alcohol and/or drug use/abuse may be contributing factors in a situation where a child's safety or well-being is at risk.

In the event that a person or family is in need of screening or referral, the CW/CBC worker should inform the family member that a recommendation will be made to the FIS for a substance abuse screening and obtain the appropriate release of information. The case should then be discussed with the FIS and the CW/CBC worker should provide the FIS with a referral packet.

The provider agency and the FIS are responsible for determining what constitutes a complete referral package and conveying these requirements to the referral agents. This will likely include copies of any relevant assessments, contact information, and recommendations or background information that may be of use to the FIS in conducting the substance abuse screening,.

The FIS will attempt contact with the client within three (3) working days of receipt of the complete referral package. A phone contact or face-to-face visit is acceptable for the initial contact when the FIS will set an appointment to conduct a screening.

SCREENING

The FIS will conduct a face-to-face screening within ten (10) working days from the date of the receipt of the referral package. If the FIS is unable to

accomplish this screen within 10 days because the client is unavailable, attempts to schedule and complete the screen and justification for why it was not accomplished shall be documented in the client record.

Screening for alcohol and other drug abuse should be a standard element of every protective service risk assessment. The screen should incorporate a standardized or recognized substance abuse risk assessment administered in person with the referred individual(s), as well as collateral contact information and/or drug testing, as appropriate. The detail and length of the screening is a matter of professional judgment combined with requirements of the substance abuse provider accepting the referral.

FIS are required to use the DCF "FIS Screen for Mental Health, Substance Abuse and Co-Occurring Instrument" (attached), or a comparable screening instrument approved by the department. The FIS provider may choose to use additional circuit screening tools at its option.

The screening should be comprehensive and include demographic data and a good picture of the individual's substance involvement: history of present and past use, attitudes regarding use, risk and protective factors, and barriers to treatment. It should address the extent to which judgment, behavior, and the home environment are affected by substance use/abuse. It should conclude with a preliminary recommendation about the type of treatment program and level of care that would best meet the individual's treatment needs, and recommendations for the need for further assessment. The person conducting the screening shall provide rationale for any actions taken.

Required documentation for intervention shall include a record of whether the person is:

1. Not in need of services
2. Appropriate for services
3. Not appropriate for services at the screening site, or
4. Appropriate for referral elsewhere

If appropriate, a toxicology chemical dependency screening may be completed to identify the nature and extent of the substance use and to determine the most appropriate substance abuse treatment referral source. Clients shall give a written consent for a toxicology drug screen release of information (Rule 65D-30, F.A.C.).

A request for an alcohol or drug screen is an appropriate way to verify abstinence. However, the results of this screen alone are not considered sufficient reason for treatment referral in the absence of more detailed information. The FIS provider may, or may not, assign the FIS responsibility for coordination of collection, custody, and verification of results.

USE OF SALIVA/RAPID TESTS

FIS may find it helpful to use saliva/rapid testing in both their screening and case management roles, with client consent. The uses of drug and/or alcohol detection methods that rely on the collection of oral fluids are considered Point-of-Contact tests. These tests have the advantages of being small, easy to transport, relatively inexpensive, and they are much less invasive than urine screens. In the case of the rapid testing kits, results are available within minutes.

A disadvantage of these tests is that potentially unknown factors may affect reliability. Point-of-Contact tests may be good indicators of substance use and should be used with caution only by persons trained to use and interpret their results. Positive results in a Point-of-Contact test should not be taken at face value. Results should be confirmed by a lab or by a standard urine screen (with confirmation) as soon as possible.

CASE RECORDS

Case records must be consistent with requirements of Chapter 65D-30, F.A.C. The following are required for clients' case records that are receiving intervention:

- Name and address of client and referral source
- Screening information
- Informed consent for services, or notation of refusal
- Informed consent for alcohol/drug screens, when conducted
- Informed consent for release of information
- Client placement information
- Intervention plan for persons continuing in intervention for more than 30 days
- Summary notes
- Record of attendance and contact, with exception of case management
- Record of disciplinary problems
- Record of ancillary services
- Reports to and from criminal or juvenile justice systems, when provided
- Copies of service-related correspondence, generated or received
- Copies of transfer summary, if transferred
- Discharge plan

MAKING REFERRALS

FIS make referrals to community treatment providers or resource agencies that are best suited to providing the appropriate services to the client or family,

considering the client's needs, available community resources, and financial situation.

Following screening and placement into FIS services, referrals and appointments for substance abuse treatment are scheduled within 48 hours (Rule 65D-30, F.A.C.) and all referrals and appointments are scheduled so that the client can be seen within seven (7) working days if possible. If the FIS is unable to accomplish this within these time frames, attempts to schedule the appointment and justification for why it was not accomplished is documented in the client record.

FIS thoroughly document all referrals in the case record including reasons for the referral, appointment times, referral contact information, appropriate releases of information to provide and obtain information, phone calls to make or verify appointments, and visits as necessary.

The primary referral will be to substance abuse treatment providers for more in-depth evaluation and treatment placement, if needed. Others may include referrals for mental health screenings, assessments or treatment, referrals for medical or physical problems, other social or assistance services, legal, educational, housing, vocational, or employment services.

Upon completion of the client referral, the FIS provides a summary to the referral agent/child welfare case worker and may use secure electronic transmissions. The FIS must use appropriate safeguards to prevent use or disclosure of protected substance abuse and health information.

FIS are responsible for developing and maintaining an up-to-date directory of treatment, prevention, and other community resources that includes contact information, eligibility criteria, and referral procedures.

INTERVENTION/SERVICE PLAN

FIS establish and maintain collaborative relationships between the CW/CBC case worker and the substance abuse provider to ensure joint case planning integrating the goals of the CW/CBC case plan and the client's substance abuse treatment process.

FIS develop a substance abuse intervention/service plan as required by Rule 65D-30, F.A.C. and provide a copy of the intervention plan to the child welfare case worker.

The Intervention/Service Plan is developed for the client within 45 days after the screen is completed and placement is made for FIS services, if the FIS will continue to provide intervention/case management for the family. This plan includes goals and objectives that are clearly designed to prevent, halt,

or reduce the severity and intensity of factors associated with the progression of substance abuse and its effects on the family, and to encourage abstinence.

FIS review and update the substance abuse intervention plan minimally every 60 days (Rule 65D-30, F.A.C.). Preferred practice for coordination with child welfare staff is that this be accomplished monthly. FIS update the intervention plan anytime there is a major change of status regarding the client's participation in substance abuse treatment. Copies of these updates are provided to the child welfare case worker for incorporation into the child welfare case plan. The intervention/service plan should be signed and dated by the staff developing the plan, as well as the client.

CASE MANAGEMENT

FIS perform ongoing case management related to the substance abuse portion of the child welfare/child protection plan. This role continues throughout the duration of the client's participation in substance abuse treatment services. FIS will make ***at least monthly face-to-face contact with the client. If this is not possible, justification shall be documented in the client record.*** This may include participation in formal staffing or an informal contact. FIS shall have flexible weekday and weekend hours, as needed, rather than being limited to traditional Monday through Friday hours of 8:00 a.m. to 5:00 p.m. Service demand and client needs should reveal the times of availability most needed.

Case management activities shall include (Rule 65D-30, F.A.C.):

- On-going assessment and monitoring of the client's condition and progress
- Linking and brokering for services as dictated by the client's needs
- Follow-up on all referrals for other services
- Advocacy on behalf of clients
- Facilitating client's participation in treatment by removing barriers

PROGRESS REPORTING AND STAFFING

FIS track the progress of the client and attempt to ensure that appointments are made and kept. Progress reports are obtained from referral resources on a regular basis, including attendance at support group meetings if these are part of the plan. If a client misses appointments, or absconds from treatment, the FIS and CW/CBC staff is notified. Regular, or at least periodic contact with the client, or treatment staff, is maintained.

Regular progress reports are provided to the CW/CBC staff making the original referral to the FIS, or the CW/CBC currently responsible for

protective supervision for the family (no less than monthly) throughout the duration of substance abuse treatment/aftercare. The reports indicate treatment progress and alert the child welfare staff to any barriers or other concerns. A written report is made when there is a major change of status regarding the client's participation, as well as at the close of the case.

Summary notes are completed weekly for those weeks when client contacts are made. They will state the client's progress or lack of progress in meeting the conditions of the plan and document services provided (Rule 65D-30, F.A.C.). Each summary note is signed and dated by staff delivering the service.

Contact is maintained with the child welfare case worker, the substance abuse treatment provider, the client, and any other providers to monitor client progress and sustain open communication. This may include participation in formal staffings or informal contact. The contact and outcome of the contact is documented and entered into the client record. The staffing reports and contacts do not take the place of the monthly reports to the CW/CBC caseworker.

FIS participate in staffing of the family's progress as requested by the child welfare case worker or the substance abuse provider and may facilitate a staffing of the family's progress when there is a major change of status regarding the client's participation in substance abuse treatment. Although it is desirable that the staffing be face-to-face, interested parties may participate through telephone conferencing. FIS ensure that they know the status of the child welfare case plan.

DEPENDENCY COURT LIAISON

FIS may provide liaison services to the dependency court and inter-agency communication regarding the status and progress of clients in the FIS caseload who are in substance abuse treatment. In accordance with 42CFR2.61, FIS may assist child welfare staff in making recommendations to the court regarding family reunification.

FIS may appear in court under any of the following circumstances:

- Clinical case staffing of the client indicates the need for the FIS.
- The court issues a subpoena to the FIS.
- The department or a child welfare agency provides a request to the FIS in writing, requesting client court representation.

If the court requests a written status report, FIS will provide it. Client/family requests for a FIS to appear on their behalf will be taken into consideration.

Procedures for how the FIS relate to the dependency court or drug court are locally determined.

LENGTH OF SERVICE AND DISCHARGE

Decisions about when to close a case or keep it open is made by the FIS in consultation with the CW/CBC caseworker and/or the court, as well as within the framework defined by the FIS service provider.

The client may be discharged from FIS services upon any of the following:

- Substance abuse treatment is completed
- The case is closed by the child welfare agency
- The client refuses to participate in the program
- The client is incarcerated or moves to another geographic area

“Termination of parental rights” is not a reason for eliminating FIS services. Many parents/caregivers who lose parental rights go on to birth additional children, frequently have new substance-exposed newborns, or become parents/caregivers through newly formed families or live-in relationships. It is critical that these individuals – especially women of child-bearing age who can become pregnant - are supported in their motivation to remain in substance abuse treatment and to aim for successful recovery, even in situations where the opportunity is lost to retain custody of the children in the original family.

A client is considered to have successfully completed FIS services when he/she:

- attains goals and objectives in his substance abuse intervention/service plan, including formal substance abuse treatment;
- continues to demonstrate a willingness to maintain an active program of abstinence/sobriety; and
- demonstrates a commitment to comply with the conditions of his intervention/service plan.

Originally, the FIS model anticipated that FIS would continue to provide support for the client up to 90 days following discharge from formal substance abuse treatment. This strategy provided maximum support for ensuring successful outcomes related to both child protection and substance abuse recovery. However, due to limited FIS capacity and high caseloads, the policy of continuing support after completion of formal substance abuse treatment was reevaluated. Although the desire for longer-term support has not been abandoned entirely, it is no longer required or even believed to be necessary for all families. Continued involvement beyond discharge is still desirable for some families. The FIS provider should evaluate the family’s situation on an individual case basis to determine whether continued FIS involvement is critical after discharge from formal treatment. Examples of family situations which may warrant consideration

for extended FIS involvement are: there is a substance-exposed newborn under 2 yrs of age; the parents/caregivers have limited natural supports; there is a single parent with several children being returned to the home from out-of-home care; or a parent/caregiver expresses a strong desire for continued FIS support. Clinical considerations shall guide the decision.

A written discharge summary is completed for both clients who finish treatment services, and those who leave prior to treatment completion. The discharge summary plan shall include a summary of the client's involvement in services, the reasons for discharge, and a plan for the provision of other services needed by the client following discharge, including aftercare. The discharge summary is signed and dated by a primary counselor.

FIS ensure that reunification plans address substance abuse relapse prevention and intervention, and include strategies for community support for families after the substance abuse treatment case is closed.

DATA REPORTING REQUIREMENTS

Data are maintained by the provider and submitted to the state Substance Abuse Program Office. Effective October 2005, FIS began reporting with a specific FIS Staff ID in the Substance Abuse and Mental Health client data warehouse. This FIS staff ID provides the ability to produce computer data runs to identify the services provided by each FIS and the clients involved with each FIS at the county, circuit, and service provider levels. (Note: The code space for recording Staff ID on the data forms was previously referenced as Rater ID and is also used by other data sets assigned through the Florida Mental Health Institute certification process. In the FIS data set, the word "Staff ID" should be used in lieu of "Rater ID".)

All FIS should enter their FIS Staff ID no matter whether they were funded through local initiative or the statewide appropriation specific to FIS. Any WIS functioning as FIS for pregnant/post partum women should also be assigned a FIS Staff ID.

The FIS should record their 12-digit staff ID number on all applicable substance abuse data sets, especially the Client Specific Service Event, to be constructed as follows:

- The first two digits are for the staff's education level (01 thru 07)
- The third digit is a dash (-)
- The next three digits (4th thru 6th) must always be **FIS**
- The next six digits (7th through 12th digit) can be any alpha numeric number. This is a number assigned and used by the provider to uniquely identify the FIS staff. This can be a position number, a

made up assigned number, part of the FIS's name, or whatever the provider chooses to use.

The complete FIS ID should look like this: **02-FIS000000** or **03-FIS123456**

COMPUTER ACCESS

It is desirable for FIS to have assigned laptop computers with security controls and procedures to ensure confidentiality of client data, since their jobs require movement among multiple sites: e.g., homes, dependency drug court, child welfare offices, and substance abuse treatment provider facilities. This supports efficiency and accuracy in maintaining entry of information about contacts and clinical information, and provides them with ready access to information about the families they support when working with others involved with the family. Internet access and private email addresses also should be a regular resource to FIS for the purposes of case management coordination, performing clinical research, and networking with other FIS throughout the state.

TRAINING

FIS are expected to attend an annual statewide FIS forum/training and other work-related professional development opportunities that are offered depending on funding available through the provider. The FIS provider should seek out training opportunities for cross-training FIS in substance abuse/mental health/child welfare issues and intervention, as well as Family Team Conferencing. FIS also must receive staff training as required by Rule 65D-30, F.A.C.

BARRIERS TO TREATMENT AND INCIDENTAL FUNDS

There are limited incidental funds in each circuit to be used to support successful outcomes for families receiving FIS services. Funds are used for the purpose of removing barriers to a person's successful participation and completion of treatment and to support the substance abuse treatment plan. These funds should only be used if no other fund source can be identified. Examples of appropriate use include the provision of childcare, transportation, storage of personal belongings during short-term residential treatment, educational/vocational assistance, support for housing/utility costs, and clothing.

Determination about the use of incidental funds should be made on an individual basis. Some clients are especially needy of this type of support and may require a greater share of the available funds from this resource than other families in the

FIS caseload. Any expenditure of incidental funds should be documented in the individual's clinical record.

Procedures and criteria for accessing and using incidental funds and the method to account for expenditures are developed cooperatively between the FIS service provider and the DCF contract manager. The contract should require development of operating procedures, incorporating these criteria and procedures with provisions for monthly reporting. Operating procedures shall be approved by the contract manager.

Each month, a report will be made which details year-to-date expenditures and the balance of the FIS provider's incidental fund account, along with the corresponding incidental request form submitted to the substance abuse contract manager for reimbursement. (The form is attached to the model contract's FIS exhibit/FIS provider contract.) The expenditure of the FIS incidental funds will be reflected in the incidental expense cost center on the monthly invoice.

The following minimal information must accompany requests for incidental funds:

- Name of FIS accessing funds
- Funds spent on behalf of (client name)
- Referral type (protective investigation/supervision)
- Date of request
- Description of goods/services requested
- How the purchase is related directly to the FIS intervention plan
- Goal/reason for purchase amount requested
- FIS and approving authority signature with date

EVALUATION OF FIS SERVICES

The FIS provider should work with the local CW/CBC to evaluate the effects of FIS services on the joint system goals presented at the beginning of these guidelines. At the option of the circuit, the DCF circuit contract manager may choose to incorporate specific objectives related to FIS in the contract and delineate a method for measurement. It is critical that the FIS provider ensures that FIS enter their Staff ID on data forms submitted to the SAMH Data Warehouse so data can be collected about clients served and services provided by FIS. Intervention services provided by FIS can be captured even if the individual does not enter substance abuse treatment. CBCs should work cooperatively and strategically with FIS service providers to improve entry into and retention in substance abuse treatment for their families with an identified substance abuse treatment need. Successful implementation of the FIS function and initiative is critical to successful outcomes on these measures.

EXCEPTIONS TO THESE GUIDELINES

It is recognized that there may be unique situations where some provisions of these guidelines are inconsistent with the most desirable local program model to support the goals for this initiative. This is due to unique local geographic and service delivery challenges and resources, or lack thereof. If this situation exists, the circuit SAMH Program Office may request from the Headquarters Substance Abuse Program that an exemption be permitted to specific provisions. This request should clarify the conflict with the guidelines and present an alternative strategy that would best support improved child welfare outcomes for substance-involved families in that area. It is not anticipated that many exceptions will be requested/required.