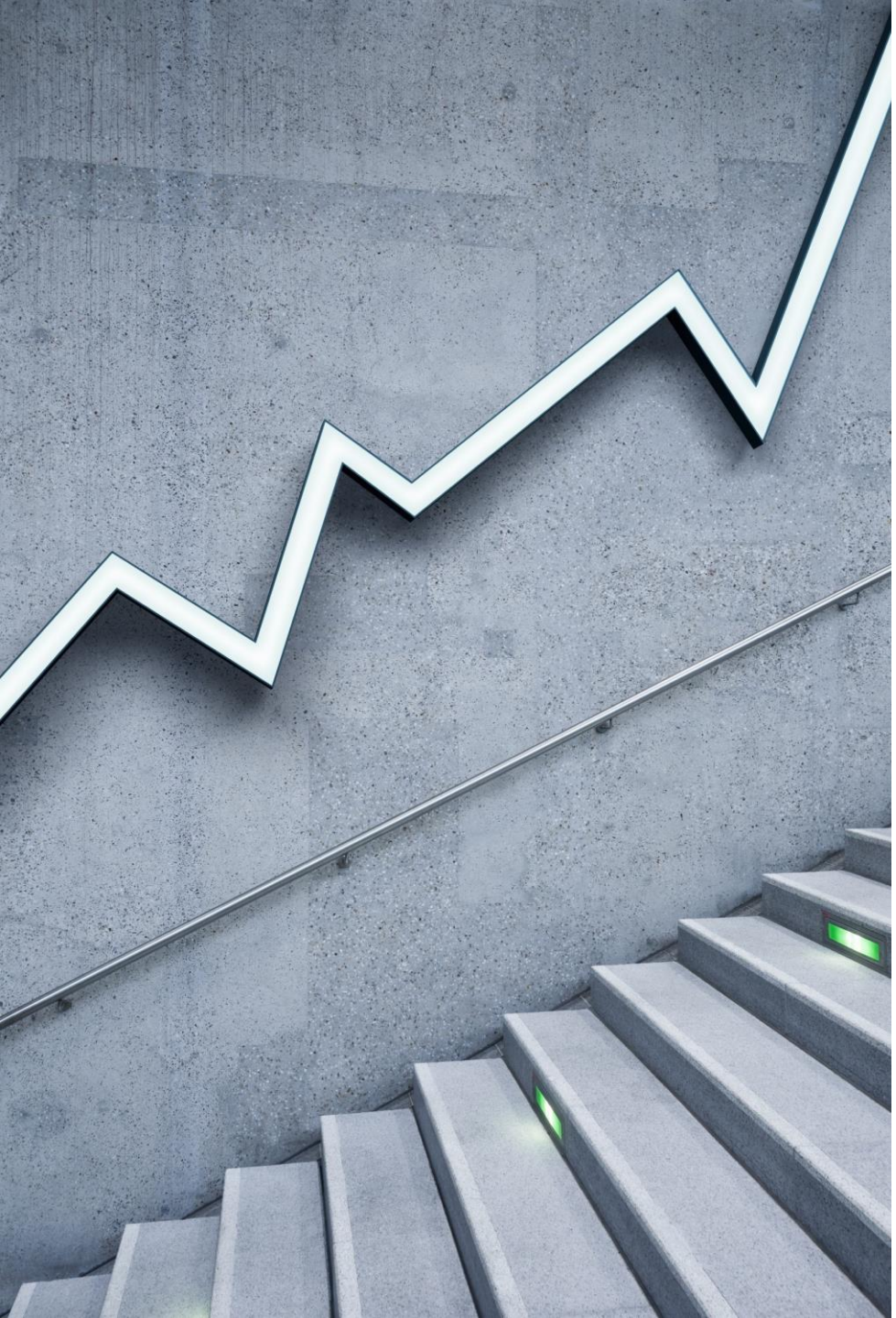

Child Welfare Progress Exchange Forms completed by Behavioral Health Providers

A Training for Network Providers

Southeast Florida BEHAVIORAL HEALTH NETWORK

Don't say you don't have enough time. You have exactly the same number of hours per day that were given to Helen Keller, Pasteur, Michelangelo, Mother Teresa, Leonardo da Vinci, Thomas Jefferson, and Albert Einstein.

H. JACKSON BROWN, JR.

Purpose

This Child Welfare Progress Exchange Form (CWPEF) is a communication tool between behavioral health providers and the child welfare system (investigations and dependency). It provides a limited snapshot of a client's progress toward treatment as related to child welfare plan goals.

Forms are completed at assessment (either due to a call from the Substance Abuse Call Center (SACC) or general assessment), every 30 days (best practice) and at case closure. Completed forms are uploaded to the Child Welfare's Information system, currently known as Florida Safe Families Network (FSFN). This form does not take the place of other necessary collaborations and communications between parties.

Location of the FORMS

Follow link provided to access Progress Exchange Forms

Access to the Progress Exchange Form may be found at https://www.cognitoforms.com/SoutheastFloridaBehavioralHealthNetwork/SEFBHNChildWelfareProgressExchangeForm

Once the link is used a new CWPEF will be available for inputting new client data.

Sections

There are three (3) major sections in the CWPEF:

1. Demographics

2. Case Information

3. Treatment Information

Section 1: Demographics

A CW Progress Exchange Form (CWPEF) can be an Initial; **an** Update (best practice) every 30 days; or a Final Update/Case Closure **Form**

An initial form can information resulting from a SACC (Substance Abuse Call Center) LINE assessment or general assessment for Substance Misuse and/or Mental Health treatment.

This form is dynamic. Each response may lead to new questions, so the form may change to be responsive to the answers. For example, if it is indicated that the case is with Investigations – windows will open asking for the Investigator demographics.

After timeframes are established for the CWPEF, demographics follow:

Client name

FSFN (Child Welfare's data system – Florida Safe Families Network) ID

If the case is involved with Investigations or Dependency and staff involved

County of residence

Program the client is attending; Agency providing the service; Clinician name/contact

EXAMPLE

Southeast Florida
BEHAVIORAL HEALTH NETWORK

SEFBHN - Child Welfare Progress Exchange Form

This Progress Exchange Form is a communication tool between behavioral health providers and the child welfare system (investigations and dependency). It provides a limited snapshot of a client's progress toward treatment as related to child welfare plan goals.

Instructions for Behavioral Health Providers: Please complete upon first contact with client and update with a new form every 30 days. Completed forms should be uploaded to the Child Welfare's Information system, currently known as Florida Safe Families Network (FSFN). This form does not take the place of other necessary collaborations and communications between parties.

This is a(n):
Progress Update

Demographics and Contact Information

Client Name

FSFN Case #

Client County of Residence
Palm Beach

Provider MR#

Case Type
Dependency

Provider Agency Name
Housing Partnership

Provider Phone
(561) 841-3500

Program
Village for Change

Case Information

- This section reviews the sources of information and collaterals contacted to conduct the assessment.
- A description of the allegations and the concerns presented at the time of the Progress Exchange Form being filled out.
- Additionally there is a date listed of the prior Progress Exchange Form that was filled out.

Case Information

EXAMPLE

**Information in this section requires the behavioral health provider to speak with child welfare professional and/or look-up in FSFN. Access to FSFN may be requested through SEFBHN.*

Information Sources Reviewed
Prior Progress Exchange Form

Allegation/Presenting Concerns
Client is a 42-year-old female referred for services by DCF SACC. Information from previous assessment 4/10/19: Client reported DCF involvement began at the end of January 2019. Client reported that DCF said "I didn't give my baby her medicine 1 day and her heart rate was up." Client reported that school called regarding her 8 year daughter having missing medication at the school. Client reported that she tested positive for cocaine and marijuana, however she denied use of cocaine. Client reported that her daughter was removed and is currently in foster care with unsupervised visitation. Client reported that she also has a 14 year old daughter that is not part of the case.
UPDATE 1/15/20: Client reports that she had engaged in outpatient services with VFC until she "lost touch" with her therapist after the office was temporarily close due to a hurricane. Client reports that she had attempted to contact her therapist but did not hear back from her. Client reports "I just left it alone until court," at which point client was told that she was unsuccessfully discharged from treatment. As a result, client was referred to be re-assessed for services. Client reports that she has two daughters (9 and 15) and one son (21). Client reports that her 15-year-old is residing at home with the client. Client reports that her 9-yearold is in foster care, and her son is currently incarcerated.
Collateral Information: DCM Supervisor reported that client has a history of self-medicating, especially with marijuana. DCM reported that client tested negative for marijuana but positive for cocaine and benzos in

November around the time of Thanksgiving. Client denied using these substances at that time but stated "I was having a hard time falling asleep and took some pills that my sister offered me" without knowing what the medication was. DCM

Supervisor reported that client's case would be transferred to DCM Lerraine Nelson. After the initial phone call, assessor later requested a copy of the drug screen results from Thanksgiving as well as the results from any screens completed after Thanksgiving. However, assessor did not receive a response from either the DCM or DCM Supervisor.
Client reports that she first began smoking marijuana at age 30 with a total lifetime use of 11 years. Client reports that her use became regular at age 34. In the past 30 days, client reports that she has smoked marijuana on one occasion two weeks before her assessment.
Client denies intentional cocaine use but reports that she has tested positive for cocaine with DCF in the past and reports that the cocaine may have been in her marijuana.
Client reported willingness to engage in recommended services and to cease substance use due to DCF involvement as well as treatment program requirements. Client displayed poor judgment as evidenced by continued substance use despite ongoing DCF involvement. Client displayed lack of insight as evidenced by difficulty taking responsibility for actions leading to assessment as well as minimization of the negative effects of substance use on client's life. Client presented as cooperative as evidenced by her willingness to answer questions and admitting to use history. Client presented with euthymic mood and congruent affect. Client appeared to be oriented on time, place, person, and reason.
Client meets ASAM criteria for outpatient services. Client's risk can be managed at this level of care. Client will benefit from individual therapy to address current stressors associated with DCF involvement, to gain insight into
substance use, and to develop healthy coping skills.

Date of Prior Progress Exchange Form
1/10/2020

EXAMPLE

Treatment Information

EXAMPLE

The information contained in this area is here to give the reader a picture of the needed treatment, history, and recommended level of care. The first question helps understand the need for services:

The client was assessed and does not meet criteria for behavioral health services at this time.
No

Current Treatment Information

Primary Diagnosis
Cannabis Use Disorder

Secondary Diagnosis
Cocaine Use Disorder

Tertiary Diagnosis

Prior Treatment History for Substance Use or Mental Health
Client reported engaging in one previous episode of substance use treatment with Village for Change. Client reports that she was unsuccessfully discharged.

Treatment information continued…

- *Recommended ASAM or LOCUS level of Care section:* will tell where the client needs to be referred to such as outpatient or residential.
- If client is not receiving that level of care, please justify why not and interim services provided later in the document.
- CPI's/DCM need these recommendations for referrals for those parents involved in SACC Hotline.
- Urine Drug Screen results will also be present with dates and results.
- If a parent is prescribed medical THC, please provide that information in the narrative treatment information. It will be important to be consistent throughout the document.

EXAMPLE

Recommended Level of Care Assessment Tool Used
ASAM Continuum

Recommended ASAM Level of Care
1 - Outpatient (Outpatient Treatment, Aftercare)

Is the client receiving the recommended level of care at this time?
Yes

Have any drug screens been completed on this client in the past 30 days?
Yes

Results of Past 30 Days of Urine Drug Screens

Urine Drug Screen 1

Date of Screening
2/14/2020

Result
Positive

Tested For:
Amphetamines
PCP
THC
Opiates
Alcohol
Cocaine
Benzodiazepine
Barbituates
Methadone
Methamphetamines
Morphine

Positive For:
THC

Urine Drug Screen 2

Date of Screening
2/28/2020

Result
Positive

Same Test As Above
Yes

Positive For:
THC

ASAM and LOCUS are standardized types of assessments a provider uses to help their decision- making for a level of care recommendation.

Clients on a **Medication Assisted Treatment (MAT) protocol** prescribed by a doctor or nurse practitioner will yield a "positive" screen for their prescribed MAT medication.

Treatment Attendance

- Attendance at appointments is logged along with missed and rescheduled appointments. This gives you an idea of progress with treatment.
- CPI's/DCM use this information for knowledge about progress and compliance with treatment.
- Stages of change and the definition is also present for easier understanding.

EXAMPLE

Treatment Attendance

Sessions/Appointments Attended:	Missed Sessions/Appointments:	Rescheduled Sessions/Appointments:
3	1	0

Stages of Change: *Motivational Interviewing is based on the understanding that we encounter Individuals in varying stages of readiness for change. Stage-appropriate strategies for engaging Individuals in making healthy lifestyle changes are identified with each drop-down. An important concept is that stage-appropriate interventions minimize the risk that Individuals will push back and lose ground by resorting to an earlier stage of change. The stage the Individual is currently in should be identified, selected and updated routinely by the behavioral health provider.*

Stage of Change
Action

Individuals in this stage are actively implementing a plan for change.

- Identify any unexpected hurdles and help Individual define coping strategies
- Help Individual to identify new sources of support
- Track progress with Individual

Treatment Plan

As providers, its important to give a quick glimpse into treatment plan goals and progress.

General concept and themes are acceptable. Remember your audience and the confidential nature of your plans.

The target goal gives you an idea when the goal should be accomplished.

EXAMPLE

Treatment Plan

Treatment Plan Goal 1

Goal	Progress Towards Goal:	Target/Completion Date
Client identified desire to build self-esteem.	Engaged and actively working towards goal	5/10/2020

Treatment Plan Goal 2

Goal	Progress Towards Goal:	Target/Completion Date
Client identified desire to improve familial relationship	Engaged and actively working towards goal	5/10/2020

Treatment Plan Goal 3

Goal	Progress Towards Goal:	Target/Completion Date
Client identified desire to increase social support system	Engaged and actively working towards goal	5/10/2020

Treatment Plan Goal 4

Goal	Progress Towards Goal:	Target/Completion Date
Client has identified desire so maintain her sobriety	Engaged and actively working towards goal	5/10/2020

You should see some goal(s) in alignment with the parent's case plan goals. If not, speak with the Clinician.

Recommendations

- Integrated Recovery Maintenance Plan is in reference to assisting parents with their recovery efforts. This is done with input from information in FSFN and reports from Child Welfare staff.
- This end section of the Progress Exchange Form is the overall general recommendations for the parent. Please be specific for the CPI's/DCM so nothing is left up to their interpretation.

EXAMPLE

Have you created an Integrated Recovery Maintenance Plan with input from Child Welfare?

Yes

Recommendations/Justification

Client is recommended to engage in outpatient treatment services which includes 1 hour of individual therapy per week until treatment goals are met.

Final Thoughts

- Child Welfare Progress Exchange Forms shall be uploaded into FSFN (by Provider) after 3-5 days of a Network Provider seeing a parent.
- They should be uploaded into the File Cabinet under a SAMH note by a staff member who has access to FSFN (not all staff will).
- There will be an initial Progress Exchange Form from an assessment and then updates when a parent is in treatment every 30 days until discharge.
- Once a Parent has completed treatment there will be a Final Update/closure Progress Change Form.
- If you have questions or concerns about the status of a Progress Exchange Form, feel free to contact your Supervisor for clarification or reach out to SEFBHN.

Questions/Answers?

- How do I know where/how to upload the Progress Exchange form in FSFN?
- How often should I complete the Progress Exchange Form and upload to FSFN?
- ASK Your Supervisor or if your Agency needs assistance, please contact Jill_Sorensen@sefbhn.org or 561-203-2485