PerformCARE®

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Family Based Mental Health Services (FBMHS)

Practice Guidelines

Prepared by the FBMHS Practice Workgroup

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PURPOSE OF FBMHS Practice

Family Based Mental Health Services (FBMHS) Practices were developed through a series of meetings facilitated by PerformCare that included representatives from county, oversight, and network provider agencies, as well as consumer advocates. The product of these meetings is intended to serve four purposes:

- provide a common understanding of the FBMHS level of care and practice standards within a managed care environment
- promote continuous quality improvement and best utilization management practices associated with FBMHS
- increase the coherence and consistency of service delivery and adherence to the FBMHS practice
- improve service outcomes for Members and their families

The FBMHS Practice will clarify PerformCare's expectations for providers of FBMHS and serve as a basis for monitoring the quality of FBMHS treatment and programs. As such, these practices are not to be interpreted as regulations because FBMHS are governed by all applicable Pennsylvania laws, regulations, bulletins and policy clarifications. In particular, providers should comply with Pennsylvania Bulletin, Vol. 23, NO. 18, May 1, 1993 (Title 55, Part VII, Subpart D., Chapter 5260, Draft) and program licensing requirements. These documents should be the basis for FBMHS practice, and staff delivering these services should be familiar with these regulations. In addition, providers are required to comply with FBMHS practices outlined in PerformCare HealthChoices Policies and Procedures (CM-CAS-034, CM-CAS-035, CM-CAS-036, CM-CAS-037, CM-CAS-038, CM-CAS-040, CM-CAS-041, CM-CAS-044, CM-CAS-046, CM-CAS-051, CM-CAS-052). When relevant, these policies will be cited in this document. Providers are expected to have their own resource documents and should identify appropriate staff Members (e.g., Clinical Consultant, Program Director) to serve as subject matter experts, supervisors, and training coordinators.

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INTRODUCTION AND DESCRIPTION OF FBMHS

Pennsylvania Bulletin, Vol. 23, NO. 18, May 1, 1993 (Title 55, Part VII, Subpart D., Chapter 5260, Draft) defines FBMHS as a home-based treatment service for children and adolescents with serious mental illness or emotional disturbance who are at risk of psychiatric hospitalization or out-of-home treatment, and their families. This section will comment on the history, place in the continuum of care, treatment model, and goals of FBMHS from its inception in Pennsylvania to the present.

1. History and brief overview of FBMHS. FBMHS was Pennsylvania's original home and community service program. FBMHS is a specific adaptation of the Eco-Systemic Structural Family Therapy (ESFT) treatment model, which in turn is based upon the structural family therapy model developed by Salvador Minuchin in the 1970's. Led by the Children's Bureau of the Pennsylvania Office of Mental Health and Substance Abuse (OMHSAS), FBMHS was inaugurated in Pennsylvania in 1988. The FBMHS model was developed in partnership with the clinical leadership at the Philadelphia Child Guidance Center (PCGC), then refined and expanded through the ongoing work of PCGC's Family Therapy Training Center led by Dr. Marion Lindblad-Goldberg. First implemented in several counties and then expanded statewide, FBMHS became an in-plan HealthChoices service on February 1, 1997. It was designed as Pennsylvania's first statewide service based on the principles and objectives developed by the Child and Adolescent Service System Program (CASSP). These principles acknowledge that the child/adolescent (Member) is part of the family unit and that parents are the primary caregivers for their family members. Following these principles, FBMHS are delivered to the Member and family in their natural setting. These services seek to address the intensive treatment needs of Members and their families by providing a broad spectrum of services. At the conclusion of services, FBMHS treatment teams and providers facilitate the transition to community based supports and services that will promote continuation of treatment gains.

2. Place of FBMHS in the continuum of care service selection. FBMHS plays an important role on the continuum of care of mental health services for Members and their families. It functions as one of a variety of mental health services based in the community. FBMHS is relevant as a diversionary level of care for children at risk of, or returning from, out-of-home (CRR, RTF) or hospital (inpatient, partial hospital) treatment. As a strengths-based community service, FBMHS supports Members, their caregivers, and other children within the family unit broadly defined. The family's stability, integrity, and caretaking capacity are associated targets of treatment. For these reasons, FBMHS provides preventative as well as restorative treatment functions. Finally, FBMHS seeks to coordinate with other community, educational, legal, hospital, and human service systems.

3. FBMHS treatment goals and objectives. The consensus statement written by Dr. Gordon Hodas (2012) in collaboration with the FBMHS workgroup at OMHSAS is a recent expression of the clinical philosophy undergirding Pennsylvania's FBMHS program. Following this document, the original mandate of FBMHS has not changed over time. The primary function of FBMHS is to enable parents to care for their children who are seriously mentally ill or emotionally disturbed at home and to reduce the need for out-of-home treatments. Four broad goals emerge from this vision:
   - increase the ability of the family to manage a Member with a serious emotional disturbance
   - improve the psychosocial functioning of the Member across settings
   - strengthening family functioning may reduce the need for mental health-driven use of emergency rooms, psychiatric hospitalizations, and other highly restrictive services
   - prevent out-of-home treatments

   Related objectives are to strengthen and maintain families by delivering individual and family therapy, improving coping skills, empowering families and caregivers to gain and use skills to care for the Member, and serving as the Member's advocate. Desired outcomes include the Member remaining in the community--if possible, with the family and the primary caregivers being able to support the positive development of the Member, family members, and family unit. In addition, FBMHS assists with referrals to mental health treatment services for family members who may be unable or unwilling to participate in traditional outpatient programs. FBMHS assists in the transition to agencies, practitioners, and systems in the community who will provide services and support for the Member and family after FBMHS is discontinued.

4. Core FBMHS service components and treatment focus. FBMHS is designed to be a 32-week, home-based, team-delivered, and comprehensive service package. The team concept involves the use of two co-therapists, a clinical supervisor or program director, and representatives from the larger service system when appropriate. FBMHS components include the following core services:
   - therapeutic interventions that may include the Member and any combination of family members, and which will include individual or family therapy
   - assessment, psychoeducation, and skill development
   - family support services
   - school-based consultation and intervention
   - case management and service coordination

- 24-hour emergency coverage, crisis planning and crisis intervention
- transition and discharge planning
- outcomes evaluation planning

Based on CASSP principles, FBMHS are child-centered and family-focused. While the scope of FBMHS is broad enough to address the needs of all family members, the primary focus of intervention is the referred child, the primary caregiver(s) or legal guardians, and the family system as a whole. Yet, FBMHS assesses and incorporates the needs of all family members in treatment, including the Member's siblings as they relate to the identified patient. As FBMHS treatment is family-driven and therefore collaborative, the FBMHS team is expected to explore with the family the needs and possible service linkages appropriate for other family members, giving full consideration to both natural supports and community supports. Individual work can be done with other family members as long as it is directly related to the Member's treatment goals. If family members have individual treatment needs that are not directly related to the member functioning, then a referral for individual family member treatment is to be considered. The FBMHS team is expected to discuss referral options for individual services and supports and assist the family in accessing these resources. In particular, such referrals include mental health services for adults in the home over the age of 21.

ELIGIBILITY CRITERIA AND CLINICAL INDICATIONS

A complete list of admission criteria for FBMHS is found in the Commonwealth of Pennsylvania's *HealthChoices Behavioral Health Services Guidelines for Mental Health Medical Necessity Criteria: Appendix T* (1997). Following a face-to-face DSM (current version) assessment of the Member, a physician, psychiatrist, or licensed psychologist must prescribe this service as medically necessary in order for a Member to access FBMHS. Prescribers may use PerformCare's prescription letter format designed to ensure a thorough review of the Member/family strengths and needs, treatment history, and service options available on the continuum of care. Appropriate services are determined after a careful consideration of evidenced-based practices and service offerings associated with each level of care. Member eligibility for FBMHS will become clear when the following parameters are discussed, weighed, and applied to the Member's individual circumstances through multiple sources of input.

1. General clinical indications and appropriateness for services. FBMHS are designed for Members under 21 years of age who display serious mental illness or emotional disturbance. FBMHS are indicated when a Member's functioning demonstrates a chronic pattern of externalizing symptoms (e.g., aggression, rage, defiance, reactivity, elopement) or internalizing symptoms (e.g., self-injury, eating disorders, severe anxiety or mood disorders) that have resulted in significant functional impairment and negative consequences in multiple domains. FBMHS are indicated when the Member is at risk for hospitalization or treatment out of the home, or when risks of safety to self or others are manageable without treatment in an inpatient or residential treatment facility. FBMHS are also indicated as step-down services for Members returning to the family following out-of-home treatment, or as a diversion from a higher level of care. They are indicated when multiple systems are involved with the Member or family, there is a history of multiple treatments or there is a history of failed treatments. FBMHS are all-encompassing and are intended to address the issues of the entire family, as those issues relate to the Member. It is unlikely that siblings would also be receiving another intensive in-home/community support service during the time that FBMHS are working with the family.

   FBMHS are considered medically necessary when Member behaviors must be treated in the context of the family in order to offer expectation of improvement. However, at least one adult family member/caregiver must agree to actively participate in the service. Recommendation to continue FBMHS must occur by the treatment team every 30 days through an updated and revised treatment plan, and there must be significant family (including the Member) cooperation and involvement in the treatment process.

2. Diagnostic indicators. The FBMHS treatment model is not tied to specific DSM (current version) diagnoses. Accordingly, Members enter FBMHS with a variety of mental health diagnoses. If co-occurring disorders are present, the team should assess the need for adjunct treatment and coordinate referrals as clinically indicated. What is common to appropriate referrals is a Member's serious impairment with behavioral, social, and/or emotional regulation that significantly compromises the ability to function in major life domains. This significant functional impairment will occur in a social context that does not adequately support the development of the Member's social and emotional self-regulatory skills consistent with his or her cognitive and developmental status.

3. Specific clinical circumstances. In addition to general indicators and diagnostic considerations, there are specific clinical indications for FBMHS. These may be categorized in terms of Member and family risk factors, and treatment considerations. Family risk factors are to be considered in relation to the functioning of the Member/identified patient of FBMHS. Some risk factors may support more appropriate referral to services such as MST or specialized outpatient.

   Member risk factors may include the following:
   - at least one suicide attempt within the past three months
   - behavioral problems within the school setting of sufficient severity to warrant at least consideration of removal or exclusion from the school
   - current or history of running away or truancy
   - current or history of trauma display of disruptive or troublesome behaviors such as delinquency, drug us, risk sexual behavior, and involvement with the juvenile justice system

   Family risk factors may include the following:
   - one or more children at risk for or returning from out-of-home treatment
   - significant risk to caregiver(s) functioning (e.g., caregiver's untreated psychiatric disorder/substance abuse, history of unresolved trauma)
   - serious and unresolved conflict between separated or divorced parents
   - multi-generational conflict that impacts Member functioning
   - allegations/evidence of potential child abuse/neglect by the caregiver(s)
   - severe family dysfunction to the point that caregiver(s) may be unable to maintain the family unit
   - single caregiver with inadequate social, emotional, and community support
   - serious or chronic home permanency issues

Treatment considerations may include the following:

- presence of multiple siblings with serious emotional disturbance requiring multiple levels of care
- presence of multiple treatment providers involved with the family

A request for FBMHS from a designated prescriber should include a rationale for this level of care that is supported by the foregoing diagnostic, emotional, behavioral, and family considerations. A good rationale must demonstrate risk of out of home treatment by including information that clearly explains why the comprehensive, intensive, and integrative services of the FBMHS level of care are medically necessary to achieve treatment goals, rather than another less restrictive and less intrusive level of care.

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PROVIDER CONSIDERATIONS

1. Access guidelines. Providers are expected to respond rapidly to referrals. Once PerformCare has made a FBMHS referral to a provider with accompanying documentation, the provider is expected to contact the family within 24 hours to offer an available appointment that meets the family's needs. The FBMHS team is expected to initiate services as soon as possible upon receipt of a complete referral. Because FBMHS are intended to be available as a diversionary level of care, providers are expected to have processes in place to accept urgent referrals within 24 hours. If providers are unable to meet timely, access standards they are expected to inform PerformCare. The provider is to notify the family and any involved child service delivery system when FBMHS will be available and offer to aid the family in contacting another provider if desired. The provider should also inform the family that PerformCare is available to assist in obtaining any needed behavioral health service

2. Referral management. PerformCare manages referrals and sends them to the provider of family choice. Providers are expected to maintain timely communication with PerformCare concerning the status of referrals and the actions they have taken upon receipt of referrals. They are expected to notify PerformCare in the event that there is any difficulty contacting or engaging the family. Providers should assist in coordinating interagency meetings to include PerformCare along with the treatment team, family, and other stakeholders. Providers are expected to secure authorizations from parents/caregivers for releases of information, treatment histories, consultation permission, and any other documents essential to support the FBMHS treatment process. In the case of a referral for FBMHS as a step-down level of care from a RTF, PerformCare expects the provider to make reasonable efforts to obtain a comprehensive summary of the Member's treatment experience, coordinate discussion of transition goals, and engage the Member and family. Whenever possible, these efforts should occur 30 days prior to the RTF discharge date through opportunities such as participating in therapeutic leave and discharge sessions.

   Referral assessment. Referrals will be made based on member/family's choice of providers. FBMHS programs are expected to devote special attention to determining viability of referrals and will include a number of considerations both general and specific. A viable referral will involve the informed consent and commitment of the family to work with the treatment team. Providers should obtain sufficient information from the referral source and initial contacts with families to secure the best possible match between families and treatment teams. Providers are responsible for continually educating children's service delivery systems (e.g., school districts, BHRS providers, OP therapists) about FBMHS, OMHSAS requirements, medical necessity criteria, program

strengths and limitations, and areas of specialization. Using the interagency meeting, initial team/family meetings, and other relevant forums, providers are expected to screen referrals and engage families in discussions to consider discharge from FBMHS to other service options that may best meet the Member's needs if a determination is made that FBMHS are not the viable clinical option they were expected to be at the time of referral.

Specific issues at referral. When the referral is accepted, FBMHS teams are expected to assess specific concerns that may impact the viability of the referral. These concerns may involve safety, trauma, substance abuse, domestic violence, and special needs and should involve a discussion for adjunct treatment or additional community supports as clinically indicated. Providers are expected to work closely with families to resolve safety issues, contract with families on conditions of participation, assist family members in accessing any specialized services, and in general to make a determination whether it is clinically appropriate to continue the FBMHS level of care. Such a determination must be made in a timely manner, documented, and communicated to the family, PerformCare, and the prescribing physician/psychologist. This assessment and communication process may occupy the early stage of treatment. The FBMHS team is expected to coordinate and facilitate a team meeting/ ISPT meeting with the family to openly discuss the recommendations for service continuation. Likewise, the family may determine that FBMHS are not the best service option to meet the Member's needs. Whatever the final decision about FBMHS continuation, it is essential that the decision be reached in a collaborative fashion that reflects the CASSP principles of child-centered and family-focused care.

3. Family engagement and support criteria. Providers are expected to collaborate with the family to determine when services will be delivered based on family need and to show reasonable efforts to engage the family in treatment. During the initial stage of contact with the family, the FBMHS team is expected to discuss confidentiality issues, obtain written permission to consult with others who will participate in any part of the treatment process, and collaboratively monitor the effectiveness of treatment interventions over the treatment period. Providers should supply families with written and understandable descriptions of services. Providers are expected to manage family expectations about what FBMHS can and cannot do by maintaining ongoing discussions of what is expected of families as partners in treatment. Recipients of FBMHS must be willing to invest the necessary amount of time and effort to ensure the best possible outcome. PerformCare expects that the provider and family will formalize family understanding and commitment to participation in writing.

   FBMHS are most effective when relevant caregivers agree to share responsibility for the support of the Member with other interagency team Members in order to meet the goals mutually developed by the family and team. To ensure a strength-based treatment

process, FBMHS teams will work with families to identify and incorporate into treatment natural supports and community resources. The treatment must include objectives that seek to develop a viable network of personal, family, and community linkages.

Efforts should be made to engage key adults, natural supports, and other community systems involved as stakeholders. As one clinical indication of FBMHS is the presence of multiple service systems in a Member's life, treatment teams will seek to understand the evaluations, goals, and interventions of each system. These levels of input should be used when developing a comprehensive treatment plan that reflects the roles and responsibilities of each member of the interagency team.

4. Interagency Service Planning Team (ISPT) meetings. The provider utilizes the ISPT meeting as a tool to clarify participant expectations, review treatment goals and progress, ensure coordination of care, gain consensus and agreement on treatment outcomes and methods, address barriers to treatment effectiveness, and establish accountability for all those assisting in treatment. At a minimum, providers are responsible to convene three meetings: the initial ISPT within 30 days of the start of services (PerformCare HealthChoices Policy and Procedure CM-CAS-010), the 150-day planning meeting (as outlined in PerformCare HealthChoices Policy and Procedure CM-CAS-051), and a discharge planning meeting prior to the termination of services. ISPT meetings should be used more as clinically indicated. The FBMHS provider is responsible for contacting and including all natural and community supports, agencies, systems, and key professionals in the meeting. Providers consider the convenience of the family and the attendance of key members of the interagency team, including PerformCare, when scheduling ISPT meetings.

Prior to the meeting, the FBMHS team and the family should discuss the ISPT meeting process, define ground rules and goals for the meeting, and prepare for the active and productive participation of the family in the meeting. Discharge planning should be part of all treatment team meetings in order to emphasize the time-limited feature of FBMHS. A standardized agenda for the ISPT should include the following core components:

- referral concerns
- expectations and hopes of the Member/family for treatment
- strengths and needs of Member/family
- treatment goals--recovery/resiliency, general, specific and across systems
- involvement of formal and informal supports
- establishment of linkages with relevant systems
- barriers and obstacles to treatment

- progress toward discharge
- documentation of the meeting including participants, action items, target dates, and parties responsible for completion of assigned tasks

5. Clinical staff guidelines. An important key to the effectiveness of FBMHS is treatment fidelity. This is defined as the pursuit of the goals of coherence and consistency in the implementation of the ESFT model. Accordingly, a critical component of achieving treatment fidelity--and therefore positive treatment outcomes--is quality control in the selection, training, and supervision of FBMHS staff. In recognition of this essential ingredient of treatment effectiveness, Pennsylvania policymakers have mandated and funded extensive ongoing training and supervision for FBMHS staff. FBMHS practitioners are expected to acquire expertise in terms of a sufficient knowledge base, clinical skills, and treatment responsibility to deliver FBMHS effectively. Providers are referred to the updated training and supervision procedures identified in the most recent OMHSAS document on this subject (Issue Clarification # 04-2012; July 11, 2012). Providers are expected to monitor the effectiveness of treatment delivery.

   FBMHS staff qualifications and expectations. FBMHS is a comprehensive, intensive, and home-based service that involves two co-therapists functioning as a professional team. The supervisor or program director is the third Member of this team and oversees the work of the co-therapists. Providers should assign supervisors as small a caseload as possible to allow for individualized and intensive interventions as needed by each family. Under normal circumstances, this caseload would permit one supervisor for every 40 active cases.

   Providers may address the duties of case supervision by designating a program director or clinical consultant (who meets all required qualifications). The case supervisor engages in both administrative and clinical activities. Administrative supervision involves review of all case treatment plans and problems or concerns. Clinical supervision involves building staff skills in assessment and treatment intervention, as well as monitoring fidelity to the treatment model.

   Two master's level (mental health professional) therapists *or* a master's level and bachelor's level (mental health worker) constitute the co-therapy team. Current regulations permit a team to have two bachelor's level practitioners if one of the practitioners has obtained specialized certification through one of the FBMHS training centers. The master's level practitioner must have a graduate degree in the field of human

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services plus two years of clinical experience. The mental health worker must have a bachelor's degree in a field of human services plus one year of experience in a child-related service system. Potential staff Members must be receptive to a systemic, strengths-based clinical orientation. Recruitment of FBMHS therapists should target applicants demonstrating job experience in working with children and parents together.

Caseloads for each co-therapy team are not to exceed eight families. Because the team is expected to display a "whatever it takes" approach to serving families, and because programs are expected to respond rapidly to family needs, the FBMHS staff must be available to families 24 hours a day, seven days a week. Due to the intensive nature of FBMHS, concerns about performance, staff turnover, and staff burnout are prevalent among providers. The loss of a FBMHS worker represents a serious threat to the effectiveness of services and meeting the needs of Members and their families, to say nothing of the personal, professional, and financial cost to the individual therapists and their agencies. Providers are expected to engage in best practices to prevent burnout and promote job satisfaction through enhancement of the therapist's professional knowledge, development of treatment skills, and use of appropriate respite opportunities. In the temporary absence of a FBMHS therapist, the program director who meets the requirements for a Mental Health Professional (MHP) or a Mental Health Worker (MHW) may function as a FBMHS therapist with the understanding that it is in the best interest of the family to afford them a fully functioning team that includes a MHP/MHW. This accommodation is expected to be brief and infrequent.

FBMHS staff training. All staff--therapists, clinical supervisors, clinical consultants--are required to receive ESFT training from one of three approved training centers in Pennsylvania (Philadelphia Child and Family Therapy Training Center; University of Pittsburgh Medical Center Presbyterian/Western Psychiatric Institute and Clinic; Center for Family Based Training; or another DHS approved specialized training program. Staff are required to attend periodic booster sessions after completion of Core training. Staff are required to complete the certification process either by exam or through FBMHS competencies as described in Issue Clarification #4-2012.

FBMHS staff supervision. The function of the supervisor is to render clinical oversight to all aspects of FBMHS delivery. This oversight includes the therapist as an individual, the co-therapy team, and the FBMHS program as a whole. It involves the following core components:

- group supervision sessions
- weekly team or individual supervision sessions
- consultation regarding all aspects of therapy planning and delivery
- development of staff cohesion as co-therapists (team building)

- promotion of professional development of staff
- discussion of challenges in delivering services
- documentation of all supervision sessions including content and interventions
- routine observation of co-therapists in the field or by video with relevant feedback
- review of team documentation including treatment plans and progress notes

In order to adhere to these core elements of supervision, supervisors are expected to make their own learning contracts with the appropriate training centers, and in turn develop learning contracts with each supervisee. Supervisors will strive to ensure fidelity to the ESFT model, support team strengths, help teams to develop their individual roles and responsibilities with the families they serve, and enhance the therapeutic impact of team strategies and interventions.

In addition to training in core competencies of the ESFT model, supervisors must attend all trainings that involve presentations from their staff. Supervisors must also obtain certification as Certified FBMHS Supervisor from the approved training center director. In collaboration with the training center, the supervisor will make a learning contract with all staff members.

SERVICE DELIVERY

FBMHS programs are expected to provide treatment services that include assessment, crisis planning and intervention, therapy, and case management support. Service linkage, coordination of care, family support and advocacy are also key components of FBMHS. Given the complexity of Member/family needs and the varied types of services delivered, providers should monitor the balance of services delivered to ensure that proper attention is given to all the treatment needs of the Member. For example, case management and advocacy goals must be balanced with clinical treatment goals.

1. Assessment issues. Assessment of Member and family needs guides the treatment plan in determining the intensity and breadth of treatment delivery. Within the first week of treatment, the FBMHS team should address two tasks: obtaining from previous provider(s), data about past treatment experience that could impact current treatment effectiveness, and working with the family to identify the service goals. Early goals begin with safety concerns, crisis planning, and family engagement in treatment (building the therapeutic alliance and therapeutic system). Creating the therapeutic system is expected to be a time-intensive process that fully utilizes allotted service delivery hours and finishes by the end of the first month of service. Service delivery hours may require extended contact with the family during this initial period of treatment. Programs are expected to include families in a comprehensive orientation process in order to promote

engagement. During the first month of service, the team should review recent assessments and conduct assessment activities tailored for Member needs, the results of which are incorporated into the FBMHS treatment plan. These assessment activities should incorporate a collaborative, family-focused, recovery/resilience approach that addresses the strengths and needs of other individual family Members and the family as a unit. Then the team should explore with the family any possible service linkages or supports for other family members. Ongoing assessment activities to measure functional improvements are essential as the treatment period unfolds. Resources for assessment tools and strategies are suggested in the Reference section of this practice document.

2. Emergency coverage, crisis planning, and crisis intervention. Two primary goals of crisis planning are ensuring the safety of the Member and family, and minimizing the need for hospitalization or other out-of-home treatment. Given the requirement for FBMHS to be available 24 hours/day, 7 days/week to provide crisis intervention services, providers are expected to have policies in place detailing processes for handling family emergency calls and responding in the most therapeutic way. Such processes should be implemented at the first contact with the family and should involve the following components:
   - training of staff Members on crisis response skills including de-escalating a crisis, communicating with any facility involved if de-escalation is unsuccessful, supporting the Member/family in the home or at a facility, diverting hospitalization when clinically appropriate, and employing post-crisis interventions (e.g., debriefing participants, review of treatment plan)
   - monitoring by clinical supervisors of crisis response effectiveness and continued quality improvement of this service
   - providing families with written material explaining how to access intervention services

   The FBMHS team is expected to formulate individualized safety/crisis plans. Families and treatment teams work collaboratively to define a crisis, understand how families respond to crises, identify antecedents to prior crises, and formulate detailed action steps to follow in the event of a crisis. Crisis planning should include the following core components:
   - identification of all possible family resources in case of crisis
   - documentation and signatures by the family and treatment team
   - attachment to the overall treatment plan
   - regular review at monthly treatment plan meetings
   - distribution as defined through family choice to other stakeholders or potential responders (staff personnel, interested service systems and providers, natural/community supports)
   - respite, transportation, or communication options available to the family

- review of crisis plan following any crisis situation and assessment of crisis outcomes to be used in crisis planning improvement
- development of strategies that the family can use to prevent future crises

3. Treatment process. FBMHS providers are expected to foster a service delivery atmosphere that incorporates Members and their families as full partners in the treatment process. The service planning process is expected to identify initial priorities for services and establish a progressive course for treatment. By explaining the ESFT model, providers orient the family to the relational, structural, and eco-systemic perspectives that shape treatment from the outset. As for the treatment plan, it is an evolving document that functions as a map for what the team and family hope to achieve and how those goals will be attained. This document serves as an agreement with all involved parties regarding their responsibilities for the services to be delivered. The FBMHS team should incorporate discussion about discharge issues (e.g., concerns, barriers, dates) into this process.

   Treatment plan. An initial treatment plan addressing the issues that led to Member referral for FBMHS should be initiated within five days of the first day of service. A comprehensive treatment plan should be developed with the family and completed within the first 30 days of the initiation of services. This treatment plan should be updated at least every 30 days throughout the treatment period and treatment plan reviews must be documented. The planning process and resulting treatment plan should address the strengths and needs of each family member and clearly define goals, objectives, interventions, and discharge dates. All goals and objectives reflect the ESFT model, are specific and measureable, and have realistic, practical meaning for families. The treatment plan should be inclusive of therapy goals, crisis planning goals, case management goals, and family support/advocacy goals as appropriate. As teams discuss with families the overall goals, both individual and family, they will narrow the discussion to prioritize specific goals and objectives. Teams assist families to focus on a few meaningful, attainable goals for the 32-week length of care. The identified goals should require the intensity of FBMHS. Goals are subject to change, should be replaced with new or more relevant goals if prior goals are met, and should be flexible enough to incorporate key individuals as needed while maintaining treatment fidelity by adherence to the 32-week authorization period. Goals are monitored continually, revisited at monthly treatment reviews, and modified as treatment unfolds. This process helps the family to see progress and readiness for discharge. Goals that can be achieved with a less restrictive level of care can be identified through the discharge planning process.

   Treatment plan and system support. After obtaining the consent of the Member and family, the team is expected to distribute copies of relevant parts of the treatment plan to

the interagency service planning team. With the permission of the caregiver(s) (and Member if over 14 years of age), the plan should be shared with key representatives from other child serving systems involved with the Member in order to ensure consistency of treatment across the eco-system. The treatment plan should convey how services will be coordinated and integrated so as to avoid gaps or redundancies in service. The team is responsible to convene any meetings necessary to ensure cohesion in service delivery. Treatment plans should be focused on meeting mental health treatment needs and should reflect the importance of building support systems and community linkages. This promotes the strength-based principles of family self-sufficiency, healthy interdependency, and skillful application of interventions independently of professional support.

Treatment plan and discharge. From the start of treatment, the planning process should lead to a discussion with the family about discharge goals. Treatment teams should prepare families for transitioning out of FBMHS and make it an essential part of all treatment reviews. This should be revisited on a regular basis so that all treatment participants understand the time-limited feature of the FBMHS model and agree about the date of discharge.

Treatment plan and supervision. The treatment plan is a valuable tool in supervision. In supervision, teams are expected to review plan implementation on a case-by-case basis to assess the effectiveness of treatment, adhere to treatment fidelity, and facilitate the skill development of therapists. Supervisors are expected to monitor the use of treatment time/unit allotments to ensure that the intensity of treatment is appropriate for the stage of treatment, Member and family treatment needs, and monthly unit ceilings.

Treatment plan review. Providers are expected to organize FBMHS services around a three-fold treatment review process: 1) monthly reviews; 2) ongoing reviews as needed; and 3) treatment review updates with PerformCare at designated timeframes during the authorization period. Monthly reviews include the Member/family with the team and may include the supervisor and other treatment stakeholders in a discussion that reviews treatment experience, addresses obstacles to treatment progress, and discusses discharge planning regarding future services and connection to community and natural supports. Ongoing treatment progress should be reviewed regularly with the family, giving the opportunity to test the impact of treatment particulars with the family. The treatment review process requires that from the start of FBMHS the FBMHS team complete treatment review updates to PerformCare at 30-day and 120-day timeframes. In addition, the treatment review process requires a 150-day treatment team meeting and 170-day outreach to PerformCare, or more often as needed based on the individual needs of the Member/family (PerformCare HealthChoices Policy and Procedure CM-CAS-051). This

involvement acknowledges PerformCare as a partner in the treatment experience and reflects eco-systemic considerations.

4. Team services. Fidelity to the ESFT model and positive treatment outcomes are closely associated with the quality of team-delivered services. Ideal management of FBMHS programs will involve provider assessment of team utilization at the team and program levels. The role of each team Member working with a given family must be clearly understood among participants, communicated in treatment plans, documented in progress notes, and monitored in clinical supervision. In particular, it is crucial that supervisors continually evaluate the level of team involvement with families, the maintenance of good interpersonal boundaries, and the adherence of treatment to primary goals in order to prevent diversion of treatment focus.

   Service balance, intensity, and disruption. It is the provider's responsibility to ensure that the team's time meets the 60%/40% ratio of team-delivered units to member-delivered units. The expectation is that the majority of the service is team delivered and based on 60% productivity (refer to policy clarification FB-01 and FB-02). In the event of disruptions in team cohesion (e.g., staff vacancy, changing team composition, vacation) the provider is responsible to maintain treatment integrity by ensuring that gaps in service delivery are minimized and service continuity and intensity are upheld to a reasonable degree. In those rare circumstances of team disruption when one FBMHS clinician may have to deliver services without a partner, the provider is expected to have a contingency plan to address such disruptions and to restore the team-delivered service as soon as possible.

5. Documentation of treatment. As the treatment plan is a guide to service delivery, so documentation of treatment is confirmation that services have been delivered in conformity to the treatment plan. The documentation of service provision is outlined in MA 1101.51. Progress notes should clearly indicate the mental health interventions provided the response to the interventions, the relation of the interventions to the treatment plan, and the progress toward goal achievement. Narrative descriptions of the session are not considered sufficient to meet this expectation. Progress notes should show the modality of treatment, the participants, the focus of the session, and key ESFT methods used in the session. Providers maintain documentation of treatment plan reviews. Such documentation includes participants and signatures, agenda issues, modifications to treatment plans, action items, individual/family/team responsibilities, target dates, and discharge information (e.g., dates and aftercare plans).

6. Case management support. Case management services are important FBMHS program components because they promote the twin goals of community connectedness and

family autonomy. In delivering this aspect of FBMHS, the team works closely with the family to assess its needs and develop links to those community resources that best meet its needs, or promoting the service relationships that the family has already established. These resources may include but are not limited to medical care, vocational services, legal services, welfare provisions, educational support, and mental health services not provided through Medical Assistance. The delivery of case management services should improve the family's ability to access these services on their own. While advocating for the family is part of the family support role of the team, the primary focus of responsibility is on improving the communication between the family and outside agencies (e.g., the educational system). By building family strengths in accessing and relating well with community entities, sustainability of gains after the end of treatment is promoted.

7. Coordination of care. Fidelity to the ESFT model designates the FBMHS team as the lead clinicians in treatment. The team and provider work together to acquire sufficient information about all other systems involved with the Member/family in order to streamline coordination of care. Efficient care is promoted by the following actions:
   - clarification of all roles and boundaries
   - education of all systems on the role of FBMHS
   - identifying and addressing barriers to engagement of the family with other systems
   - utilization of the ISPT to address coordination of care issues
   - identification of discharge resources such as outpatient care and natural supports
   - maintenance of current releases of information

Service linkages. The FBMHS team will target particular service systems on a case-by-case basis to ensure that care is coordinated and optimized. These systems include but are not limited to:
- physical health, including contact with the PCP and documentation of a physical examination within the past 12 months
- child welfare services
- juvenile probation
- educational and vocational institutions
- case management units and county mental health resources
- psychiatry
- community recreation, afterschool, and child care programs

Special consideration must be given to three types of service linkages: the educational system, professionals managing psychotropic medication prescription and delivery, and

any other mental health or substance abuse level of care (LOC) delivered during FBMHS. When treatment plans include goals related to school issues, FBMHS teams are expected to meet with school staff--with the family when possible--prior to the delivery of any services in the school setting. The team will define the purpose, scope, and relevance to treatment of any interventions in the school. The team will maintain regular contact with school personnel, especially if the Member displays difficulty in functioning once FBMHS starts. The FBMHS team is expected to offer intervention strategies that the school can implement.

The team will maintain contact with any treating medical professional who prescribes and monitors psychotropic medications for the Member. FBMHS should collaborate with the family to provide information for psychiatric management. When during the course of treatment additional psychiatric or specialized need becomes apparent, the team should collaborate with the family to seek additional assessments (e.g., neuropsychological assessment). The team should assist the family in meeting any challenges to satisfactory medication management, such as scheduling problems, transportation barriers, or medication noncompliance. The FBMHS team is expected to facilitate a psychiatric and/or medical evaluation when clinically indicated for all consumers of FBMHS as needed.

FBMHS must coordinate care among services and service providers when FBMHS are delivered in combination *with any other mental health or substance abuse LOC*. This coordination of care involves providing when needed clinical guidance and recommendations on the direction of treatment to provider agencies that jointly serve Member families receiving FBMHS. In order to ensure consistency in treatment and goals, the FBMHS team is expected to take the clinical lead and share the responsibility with other mental health treatment providers for the development of treatment goals and interventions for the providers to implement with the family. It is important for the FBMHS team to collaborate with PerformCare to address unnecessary duplication of services and to ensure cohesive service delivery. This can be accomplished through regular meetings or ongoing discussions with the involved providers to ensure good coordination of care.

When a pattern of shared cases emerges, two general considerations must be addressed. First, linkage agreements should be established to detail the nature of the working relationship between the two organizations. FBMHS providers are expected to collaborate with other involved service providers for ongoing communication and implementation of interventions agreed to during the process of an ISPT meeting, as well as, the development of the comprehensive treatment plan, or formation of a service linkage agreement. A team meeting should occur to address any concerns regarding implementation of interventions and barriers to progress as needed. Second, the FBMHS

team is responsible for clinical oversight as it relates to the treatment of the Member and other siblings with mental health needs in the family. This means that FBMHS will act as the clinical lead for the Member and the family's treatment as appropriate. On occasion, the continuation of a TSS in school concurrently with FBMHS may be clinically indicated for very complex cases to provide additional support and assistance to the Member with FBMHS. The use of TSS for the identified Member in school concurrently with FBMHS is reviewed on a case-by-case basis and is considered an exception.

When a TSS is approved to be delivered concurrently with FBMHS, PerformCare has identified the expected roles of the BHRS provider and the FBMHS team (PerformCare P&P CM-CAS-052). In collaboration with the BHRS provider, the FBMHS team will develop a detailed treatment/positive behavior support plan for the delivery of TSS in the school setting. Taking clinical leadership, the FBMHS team directs treatment and incorporates the TSS goals with the Member into the larger FBMHS treatment plan. The plan should outline the behavioral intervention strategies to achieve the TSS goals as well as daily documentation standards for the TSS (e.g., charting the Member's progress). The BHRS provider will collect and submit the required information to PerformCare if reauthorization of TSS is continues to be medically necessary. In order to meet all regulatory supervision requirements, the BHRS provider must supply both the administrative oversight (e.g., timesheets, training requirements) and the clinical supervision of the TSS. PerformCare expects that the FBMHS and BHRS providers will collaborate on a team meeting to discuss the need for reauthorization of TSS prior to obtaining a continued stay evaluation and submission of reauthorization request to PerformCare. Any duplication of services should be discussed. The family/Member (when clinically indicated) and PerformCare are required to participate in the team meeting. Participation by the school should be strongly encouraged if TSS is being provided in the school setting. All team members are expected to actively participate in treatment/ISPT meeting for ongoing collaboration. (in person or telephonic is preferred but written feedback/input is acceptable). As the FBMHS, team works directly with school staff and advocates with the family for appropriate and indicated school-based supports, two benefits are expected: a stronger relationship between the family and school system, and a decrease in or discharge from TSS services during the course of FBMHS treatment.

8. Family support services (FSS). In the ESFT model of FBMHS, FSS must be delivered in a way that promotes the achievement of therapeutic goals and objectives. The overarching therapeutic orientation of all FSS activities will influence how FSS are delivered in a variety of ways.

The FBMHS team will introduce the family to the FSS component of care at beginning of treatment to emphasize its function as enhancing the family's capacity for independence, competence, and self-healing. The team will explain the FSS role as that of a tool--one of many such instruments available through FBMHS that, if used properly, will help the family achieve its long-term, growth-oriented goals. To avoid giving the impression that FBMHS programs are social service agencies, FSS should be introduced after discussion of clinical concerns and development of clinical goals. FSS includes the following (secondary) provisions to be used as needed to pursue (primary) therapeutic treatment goals:

- support funds (e.g., enrollment in community programs, purchase of therapy tools)
- respite care (e.g., planned breaks, emergency-related breaks, day camps)
- essential life services (e.g., food, clothing, shelter)
- family advocacy (e.g., parent support groups, accompanying parent to school regarding IEP issues for Member)

Every FBMHS program should establish clear guidelines detailing the conditions under which FSS funds are to be used. OMH 91-19 (Transmittal of General Family Based Mental Health Services Program Issues) delivers guidelines for utilizing FSS funds that may be incorporated into provider policies and processes, as well as caveats to prevent misuse of FSS funds that may undermine the primary goals of treatment. PerformCare emphasizes the importance of observing the following essential elements of these guidelines:

- The FBMHS team should assess family financial obstacles for which FSS money could effectively be utilized to improve family functioning The FBMHS team should determine if the provision of FSS funds contributes to the achievement of therapeutic goals on the treatment plan
- The use of FSS funds should meet the unique cultural needs of the member and family. One’s cultural is an integral part of one’s life and needs to be considered in all part of treatment and recovery.

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TRANSITION CONSIDERATIONS

Aftercare plans and discharge considerations are important parts of FBMHS clinical guidelines and are consistent with the four-stage treatment process of the ESFT model. The following discussion is based upon and seeks to apply relevant PerformCare HealthChoices Policy and Procedure documents (CM-CAS-034, CM-CAS-040, CM-CAS-044, CM-CAS-046, CM-CAS-051, CM-CAS-052). Discussions about longitudinal planning should occur as the FBMHS team constructs the therapeutic system. Discharge planning is reviewed at each monthly treatment plan meeting and target dates for termination of treatment are revisited. Preparing the family for termination involves ongoing work with the Member and family along several lines that consolidate gains, facilitate transition to other levels of care, and anticipate future challenges so as to promote long-term growth experiences.

1. Discharge planning. Providers must include PerformCare and the ISPT in all discharge planning and aftercare referrals (PerformCare HealthChoices Policy and Procedure CM-CAS-040). Initial dialogue about discharge planning and aftercare should begin as early as the first session of treatment. The initial 30-day treatment plan should include preliminary discharge plans that should be modified, as needed at each regular treatment plan reviews. Providers and FBMHS teams should manage family expectations for length of treatment from the earliest treatment contacts. This includes defining an episode of FBMHS treatment as 32 weeks as well as explaining weekly service unit (intensity) allotment. Providers are expected to carefully manage utilization of service intensity and duration. Any requests for unit increases or extensions of FBMHS beyond the initial 32 weeks are viewed as rare occurrences and based on the members treatment needs (refer to PerformCare P&Ps CM-CAS-044 & CM-CAS-051). The provider's FBMHS director or equivalent staff person is expected to review any extension or unit increase request prior to submission to ensure that the request is well supported and clinically indicated. A psychologist or physician advisor at PerformCare will review these requests on a case by case basis to determine medical necessity for extension of services. Overall duration and intensity of service should be regularly reviewed for continued appropriateness in the program.

2. Pre-discharge considerations. Helping families prepare for discharge is an important provider responsibility. Indicated strategies may include scheduling less frequent sessions, using rituals of celebration, or rehearsing plans to meet anticipated difficulties upon discharge. Providers are expected to identify challenges to discharge and make these increasingly prominent parts of the treatment process as the date for termination approaches. These challenges from the Member or family may include the emergence of crisis behavior, emotional disengagement from the team/family therapeutic bond, or barriers to identifying appropriate aftercare service options in a timely manner. Providers

are expected to use effective methods of addressing these and similar challenges to successful discharge. Providers should frame these challenges as opportunities for the family to independently manage behaviors using the therapeutic techniques that they have acquired. Prior to termination, the provider must hold an ISPT meeting and notify all stakeholders (e.g., referral sources, administrative case management).

In routine discharges from FBMHS, the relevant participants (providers, family, and other ISPT members) should discuss and agree upon options and team recommendations for any needed aftercare services 60 days prior to the end of treatment. The team's recommendation should be communicated to the evaluator for after care when clinically indicated. To ensure continuity of care, providers should link families with sources of aftercare community and natural supports. If the family disengages from the transition process prematurely (e.g., failing to attend a pre-discharge evaluation) the provider should contact PerformCare to plan appropriate interventions.

3. Sustainability. Promoting Member and family participation, collaboration, autonomy, and internalization of skills are important aspects of the FBMHS model. FBMHS theoretical assumptions such as the inherent competence of individuals and the family as its own best resource for change are supported by child-centered and family focused CASSP principles. Therefore, the FBMHS team seeks to build recovery and resiliency skills in treatment participants that can be implemented apart from the involvement of professional mental health providers. Treatment should strengthen the problem-solving, decision-making, and self-regulating abilities of families. Identifying crisis plans, connections with natural supports and utilization of community resources are important factors in maintaining the positive changes made in treatment and preventing regression or return to higher levels of care. Treatment plans and progress notes should include documentation of how the FBMHS is addressing sustainability as it relates to other aspects of treatment as well (e.g., financial commitments, educational plans, case management).

4. Service options. Discharge level of care recommendations should build on the family's strengths and skills that were learned during FBMHS and should begin at the start of treatment. Discharge planning should include recommendations for mental health services for siblings and caregivers when appropriate, by matching individual needs with services. At all treatment team reviews the team should consider if a different treatment modality/level of care may better meet the ongoing clinical needs if there is a lack of expected progress. This would be addressed at the 150 and 170 day concurrent reviews with PerformCare so that there will be a seamless and timely transition to additional services as needed. Request for extensions of FBMHS will be closely examined to determine the ongoing rationale for continuing the service beyond 32 weeks.

There will be situations in which FBMHS is not meeting the needs of the Member and family (e.g., clinical indication of out of home treatment, insurmountable barriers to clinical engagement). In such cases, the provider is expected at a minimum to perform the following actions:

- frame the situation in positive terms for the family
- discuss other treatment options with the family
- provide adequate discharge planning beginning at the time circumstances indicate the need
- assist the family in identifying additional natural or community supports
- involve appropriate community resources (e.g., CASSP meeting)

5. Unplanned discharges from FBMHS. In the event of an unplanned discharge, the provider is expected to contact PerformCare and the case management representative to give updates and discuss service options.

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EVALUATION OF TREATMENT OUTCOMES

OMHSAS requirements (Department of Public Welfare, 1993, Draft) specify two outcome goals of FBMHS services:

- increase the capacity of families to manage a child or adolescent with serious emotional disturbance
- thereby reducing the need for of psychiatric hospitalizations and out-of-home treatment of children and youth

PerformCare considers the incorporation of member and family outcomes in FBMHS to be an essential part of the overall evaluation of FBMHS as delivered by a provider agency. Therefore, PerformCare strongly supports and encourages providers to design and implement a treatment evaluation (outcomes) program. The general purpose of a FBMHS outcomes program is to show the relationship between goals and objectives of treatment, the treatment model employed, and results for members/families.

1. Provider responsibilities. While providers have flexibility to develop their own programs, an outcomes evaluation program should be consistent with the provider agency's quality improvement plan and include clearly defined program goals as well as valid and measureable results related to these goals. Such an evaluation program should consider including the following elements:
    - satisfaction data from the Member and family
    - effectiveness data reflecting the Member and family psychosocial functioning pre-and-post FBMHS treatment
    - pre-and-post-treatment administration and scoring of standardized assessment tools with appropriate psychometric properties
    - follow-up contact with families to obtain information regarding key aftercare issues (e.g., use of community resources, psychiatric hospitalization, consolidation of treatment gains, use of BHRS)

  - ESFT treatment adherence assessment
  - quality improvement procedures to address satisfaction survey and functional assessment result.

- 2. Measurement tools. Goldberg, Dore, & Stern (1998) devote an entire chapter to evaluating treatment outcomes for home-based services and include many appropriate evaluation tools for every stage of treatment. PerformCare recommends the use of the Child & Adolescent Needs & Strengths (CANS) assessment for the objective measurement of outcomes in FBMHS. It should be administered at least at the start, half way into treatment and the end of treatment. PerformCare has a recommended version of the CANS, which may be obtained by contacting your Provider Account Executive at PerformCare.

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Appendix A:

Special Issues: FBMHS in conjunction with other levels of care

FBMHS are comprehensive, intensive, and highly flexible. As a result, these services perform a variety of functions in relation to other levels of care. They are meant to deter or follow out of home treatments (e.g., RTF, CRR-HH), or be delivered when this level of care is indicated through meeting medical necessity criteria. The following PerformCare Policy and Procedure documents are meant to support providers of FBMHS and families in making decisions, coordinating care, and understanding under what conditions FBMHS should be requested in conjunction with other services.

CM-CAS-034 Family Based Mental Health (FBMH) provider transfer process

CM-CAS-035 Family Based Mental Health (FBMH) provider transition process for families moving between Fee for Service (FFS)/County funding and PerformCare

CM-CAS-036 Family Based Mental Health (FBMH) services in the emergency room

CM-CAS-037 Family Based Mental Health (FBMH) services prior to or during placement in a Residential Treatment Facility (RTF) or CRR-Host Home

CM-CAS-038 Family Based Mental Health (FBMH) Services in conjunction with Targeted Case Management (TCM)

CM-CAS-040 Discharge planning from FBMH Services

CM-CAS-041 Family Based Mental Health Services (FBMHS) and use of Family Support Services (FSS)

CM-CAS-044 Family Based Mental Health network provider process to request additional units during an authorization period

CM-CAS-046 Overlapping PerformCare funded services with Family Based Mental Health (FBMH)

CM-CAS-051 Procedure for prior authorization and extension requests for Family Based Mental Health Services (FBMHS)

CM-CAS-052 Family Based Mental Health Services provided concurrently with BHRS

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Appendix B:

Special Issues: Cultural Competency and Strengths-Based Treatment

Cultural competence is a set of behaviors, attitudes and policies that unite to empower stakeholders, provider agencies, teams, Members, and families to produce positive treatment outcomes in cross-cultural settings. Underlying the concern about cultural competency and confirmation of Member and family strengths is the assumption that contextual factors influence positive outcomes of FBMHS on a variety of levels. Cultural sensitivity and attention to family characteristics known to influence positive developmental outcomes and the capacity for change (i.e., strengths) are necessary for the FBMHS team to establish a firm, therapeutic working alliance. The FBMHS therapists must convey the attitude that they understand the family and its Members and are working with them and for them. FBMHS cannot proceed effectively unless there is a caring, collaborative relationship with the family that is based on mutual respect and accountability. Therefore, providers are expected to train staff in cultural competence in the organization's interactions with families and in key aspects of treatment: the initial assessment, development of the treatment plan, therapeutic interventions, and team training and supervision.

Incorporation of cultural competency and strengths orientation into FBMHS treatment will involve, at a minimum, the following components of service.

1. Organizational culture. Policies and procedures should reflect a cultural competence framework, which states the need for sensitivity to specific mental health needs in culturally diverse populations. This may include training provisions for administrative as well as clinical staff in cultural competence, or changing discriminatory policies and practices. Staff orientation should include information about differences between children of European populations and children of diverse non-European backgrounds relevant to the process of treatment: developmental expectations, parenting practices, expressions of distress, explanation of mental illness, relational and family patterns and adaptive/coping behaviors. Providers are expected to maintain documentation of all initiatives to further develop the cultural competence of staff and programs

2. Assessment. This phase must include in-depth investigation of interaction styles, religious beliefs, family rituals, culturally based values, and any characteristics of Member/family life that they consider important. Cultural competency and strengths-based treatment conveys a commitment to learn from the individuals involved and to acknowledge the uniqueness of each Member of the family. Strengths must be named and explained to the family in the context of the problems the therapy is supposed to

address. FBMHS teams should use strengths discussions to reframe key aspects of the presenting problems and to raise hope for positive change.

3. Treatment planning. Good treatment plans are based on a relationship of mutual trust with the family that reflects a solid understanding of family strengths, preferences, and resources. Therapeutic interventions will incorporate and build on these strengths and resources. Treatment strategies and interventions will seek to link family competencies to recovery from chronic problems in functioning.

4. Training and supervision. Cultural competency is stressed in the ESFT model and current FBMHS training program. Supervisors are expected to make cultural competence a continual focus of team and individual therapist development.

5. Transition planning and outcomes measurement. FBMHS teams are expected to incorporate contextual factors in discharge planning. A culture and strengths based orientation should lead to well-informed transition-of-care strategies, identify natural supports, and link with non-aversive and protective professional services. The result should be to support ongoing stability in the home and community after service discharge. Assessment of the cultural competence and sensitivity of the FBMHS program may be done in a variety of ways such as Member and family satisfaction surveys or Member complaints.

Appendix C:

Special Issues: FBMHS with Members who have an Autistic Spectrum Disorder

There are a number of issues that must be taken into consideration before recommending and delivering FBMHS to Members who experience the social, communication, emotional and behavioral difficulties associated with an Autism Spectrum Disorder (ASD).

In many cases, the problem behaviors that represent the primary risk of out of home treatment or more restrictive services (e.g., physical aggression, self-injury, property destruction) are primarily attributable to deficits associated with an ASD (e.g., difficulties with expressive communication, understanding the actions of others, coping with change, sensory disturbances) and are not necessarily related to dysfunctional patterns of family interaction. In these situations, best practice indicates that the treatment approach involve a coordinated course of treatment guided by a Behavioral Specialist Consultant for persons with an ASD diagnosis (BSC-ASD) who is trained in the application of Applied Behavior Analytic procedures, including Functional Behavior Assessment (FBA). However, in situations where maladaptive patterns of family interaction interfere with family implementation of ASD interventions, or result in severe deterioration of Member functioning, or put the Member at risk of out of home treatment, then FBMHS may be the appropriate level of care. In such cases, the BSC-ASD may be added to or continue with the FBMHS treatment team.

When delivering FBMHS to ASD Members and their families, the FBMHS team should demonstrate the following clinical competencies: 1) delivery of primary components of FBMHS; 2) core knowledge of ASD and ASD treatment; 3) psychoeducation of family regarding mental health needs of a Member with ASD; and 4) assistance of family with implementation of evidence-based treatments for the behavioral and mental health needs of the ASD Member. In some cases, this can be accomplished by a FBMHS team that has been specially developed and trained in the treatment of an ASD. In other cases, this may be accomplished through a BSC-ASD that can work with the FBMHS team and the Member/family in order to facilitate the ASD support component of the FBMHS treatment. Regardless, in situations where FBMHS is indicated and approved for ASD Members and their families, it is the provider's responsibility to

ensure that the appropriate level of ASD knowledge and experience is available as part of service delivery.

FBMHS is a comprehensive treatment where the FBMHS design typically limits the need for additional mental health services. On occasion, the continuation of a TSS in any setting concurrently with FBMHS may be clinically indicated and medically necessary for very complex cases to provide additional support and assistance to the Member with FBMHS. The use of TSS concurrently with FBMHS is reviewed on a case-by-case basis and is considered an exception. .

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