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Comparison Matrix

Intensive Voluntary In Home Mental Health Services for Cumberland/Dauphin/Lancaster/Lebanon/Perry

	Multi- Systemic Therapy (MST)	Functional Family Therapy(FFT)	Family Based Mental Health Services (FBMHS)
Target Population/Referral Process Guidelines	Youth, ages 12-17 (Adelphoi includes ages 10-17), engaging in chronic delinquent/antisocial behaviors (truancy, drug/alcohol use/sale, aggression, acting out at home/school, criminal behavior), serious disrespect, disobedience, running away, attention and academic problems, serious aggression towards people, resisting work or school tasks that require self-application, resisting conforming to other's demands, negativity, hostility, and defiance, impulsivity, oppositional attitudes, bullying, threatening, or intimidating others, initiating physical fights, using a weapon that can cause serious physical harm to others, destroying property, deceitfulness or theft, serious violation of rules such as curfew violations or school truancy or other antisocial or delinquent behaviors. MST is not typically appropriate when primary diagnoses are internalizing concerns. Youth with suicidal ideation or significant mood and anxiety diagnoses may not be appropriate.	Youth, ages 10-18. Youth presents with moderate to significant externalizing behavior including: acting out, aggression, truancy, substance use or others. Youth may have other mental health secondary diagnoses such as anxiety, depression or have attachment issues; however, the primary diagnoses must be related to the externalizing behaviors and internalizing concerns should be stable. Targets a wide range of youth from those with significant oppositional and defiant behaviors to youth at risk for or is stepping down from a treatment outside the home. One adult caregiver is willing to be involved in treatment. FFT is not typically appropriate when primary diagnoses are internalizing concerns. Youth with suicidal ideation or significant mood and anxiety diagnoses may not be appropriate. .	FBMHS are available for children up until the age of 21 who have Medical Assistance. The child/adolescent must be at risk for out-of- home treatment or placement due to severe social/emotional/behavioral disorders and/or mental illness. FBMHS is typically prescribed for youth with primary internalizing concerns where significant problems exist within the family system and may be contributing to the identified child/adolescent problem areas. This could include depression, anxiety, PTSD or other mood concerns. At times, FBMHS is prescribed for youth with behavioral concerns when they are deemed to be occurring in the context of larger family system issues by the prescriber. The child authorized for the service is called the identified patient (IP) but the treatment is implemented to the entire family system on the theoretical basis that the concerns for the IP are occurring due to dysfunctional interaction patterns within family. FBMHS is a more intense level of treatment than IBHS. It can also be used as a step-down treatment for a more restrictive level of care such as CRR/RTF and/or Inpatient.
Treatment Site	Session are held in the families' home or any other part of the ecology where change needs to occur (school, community, peer group, work site, etc.). Therapist have flexibility to move across all systems. Caregiver engagement in treatment is required. Youth engagement is not required for ALL sessions.	Sessions in the families' home setting with primary emphasis initially on engaging & motivating, then changing family emotional and behavioral interaction patterns. Later interventions focus more on interactions with larger comm. systems (school, workplace, etc.)	Sessions occur within the families' natural environment (home/school/community). FBMHS team provides support to both the IP and the remaining family members. Caregiver agreement to treatment is required.
Referral Source	Juvenile Probation, Children and Youth, hospitals, outpatient providers, Case Management Services, Schools, Residential Treatment Programs, Families, etc.	Juvenile Probation, Children and Youth, hospitals, outpatient providers, Case Management Services, Schools, Residential Treatment Programs, Families, etc.	Juvenile Probation, Children and Youth, hospitals, outpatient providers, Case Management Services, Schools, Residential Treatment Programs, Families, etc.

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Treatment	A family works with one therapist. Treatment focuses on the caregivers, youth involvement is not required for all sessions. Goal of treatment is to train parents to manage the youth's behaviors in the home, school and community. Long-term change is the goal with a focus on discharge planning. Goal is that, at the conclusion of treatment, family will not need formal services in the home. MST is an evidence based treatment that targets: Improving caregiver child-management practices Enhanced family affective relations Decreasing youth association with peers with negative/antisocial behavior Increasing youth association with prosocial peers Improving youth school or vocational performance Engaging youth in prosocial recreational outlets Developing a natural support network of extended family, friends and neighbors to help caregivers achieve and maintain such changes Reduce likelihood of out-of-home treatment.	A family works with one therapist. Structured phasic Family Therapy based intervention which empowers youth and parent figures(s) to change/replace maladaptive emotional, behavioral, and psychological processes within individual, the family, and with relevant extra-family systems – focus on what happens in the family relationship patterns that increase the likelihood of the youths' risky behavior. Caregivers, youth and all other children over the age of 10 that reside in the home take part in treatment. Develops skills that change the pattern. It is a systems based model of intervention/prevention which incorporates various levels of the client's interpersonal experiences to include cognitive, emotional and behavioral experiences, as well as intrapersonal perspectives, which focus on the family and other systems (within the environment) and impact the youth and his or her family system. FFT is a strengths-based model of intervention, which emphasizes the capitalization of the resources of the youth, their family, and those of the multi-system involved. The purpose is to foster resilience and ultimately decrease incidents of disruptive behavior for the youth. More specifically, some of the goals of the service are to reduce intense/negativistic behavioral patterns; improve family communication, parenting practices, and problem-solving skills; and increase the family's ability to access community resources.	The service is team delivered by a team of two trained clinicians. Treatment works with families and community supports to develop a treatment plan for the child and family. Therapists work with the identified youth, family members, teachers, and other community supports to help the youth and family develop positive problem solving skills and effective coping strategies to prevent out of home placement or as a step-down from an out of home treatment. FBMHS uses the Eco Systemic Structural Family Therapy (ESFT) treatment model. This treatment promotes adaptive interactions between all family members and enhances child and family functioning. It supports the child's resiliency and ability to cope, the caregiver's ability to be a source of emotional support to the child and the ability to be a source of consistent structure for the family. FBMHS also works with enhancing the effectiveness of the co-caregiver relationship in parenting and the effectiveness of outside supports to caregiving

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Case Management Function of the Service	Therapists target all barriers to family success. This can include assisting the family with transportation, meeting instrumental needs, and accessing other services and then teaching the family to manage these barriers on their own.	After youth & family have adopted positive coping patterns, will link with other resources to enhance skills and provide additional resources. This will be a focus during the end phase of treatment.	Team will work with family to help provide necessary resources within the community.
Services that can occur at the same time	Psychiatric medication management. All other therapy services must be discontinued. Service can begin 30 days prior to CRR-HH or RTF discharge.	Exclude families currently engaged in family therapy; partial hospitalization, inpatient hospitalization. Services can begin during therapeutic leaves 30 days prior to CRR-HH or RTF discharge.	Adjunct therapy services are authorized based upon the individualized needs of the youth. Service can begin 30 days prior to CRR-HH or RTF discharge. Specialized services can also be authorized as an adjunct service for trauma, eating disorders, gender identity issues, etc.
Treatment Duration	4-6 months, minimum of 2 sessions per week.	Youth and family receives FFT for approximately 3 to 5 months and the family receives on average, 14 sessions, with the length of time and frequency dependent upon family risk factors. FFT sessions with families can range from as little as 8 therapy sessions to as many as 26 therapy sessions, with families who have significant needs, under the direction of the clinical lead and/or FFT national consultant.	8-months – 32 weeks, 5-10 hours of service per week
Client Families/Staff	5 families per therapist	10-12 cases for a full time therapist	6 to 8 families per team. Varies by agency.
Staff Availability Including On-call	Therapists maintain flexible schedules and meet with the families, in their homes, when it is convenient for them. On call to families 24/7, therapist rotate on call. Treatment services are available during day, evening and weekend hours	Expectation that staff will work flexible schedule based upon needs of the family. No requirements for 24/7 on-call system; however OMHSAS requires that a plan for 24-7 crisis management be a component of the program.	Expectation that staff will work flexible schedule based upon needs of the family. FBMHS team and/or agency will provide 24/7 support through an on-call service.

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Crisis support & Facilitate hospitalization	Families have access to a therapist for crisis situations 24/7. MST does not facilitate hospitalization but will coordinate with Case Management or Crisis Intervention Services when needed.	The therapist will assist in crisis situations when needed. FFT does not facilitate hospitalization, but will coordinate with Case Management or Crisis Intervention Services when needed. Agency provides crisis triaging by phone 24/7 and warm hand off to local crisis entities	. Teams facilitate voluntary hospitalizations and work with Crisis Interventions Services regarding involuntary hospitalizations.
Expected Treatment Outcomes	Youth will eliminate delinquent behaviors and positive changes will be sustained and managed by the caregivers without the need for additional services. Further, treatment goals for the case have been met and sustained, whereby the youth has few significant behavioral problems and the family is able to effectively manage any recurring problems and functions reasonably well for at least 3 to 4 weeks. The team has gathered evidence and documented the caregivers have the knowledge, skills, resources, and support needed to handle subsequent problems.	Increase protective factors and reduce risk factors through behavior change. Reduce risk of out of home treatments and/or alternative school settings and future incidents of delinquent behaviors.	To reduce the likelihood that the IP will need out-of-home treatment or placement. Outcomes also include strengthening the bond/support within the family.
Discharge planning	Discharge planning begins in Month 1 with goals aimed at teaching the families the skills they will need to maintain youth success. All families develop their own "Long-Term Maintenance" family plan that they can reference should they encounter barriers in the future. All long-term plans are provided to the referral sources as well.	Discharge goals are set during phase 1 of treatment. During phase 3, FFT assists families in accessing community supports as well as developing a relapse prevention plan to support the family after discharge	The FBMHS team will help prepare the family for discharge. The FBMHS team will recommend and locate appropriate treatments upon discharge. Treatment progress including discharge goals are reviewed and updated at monthly treatment team meetings. Discharge conversations begin on the 1st day of treatment. Planning should be heavily discussed around 90 days prior to discharge for purposes in ensuring that step down services can be obtained prior to discharge

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Extension of Services Offered	No extensions. Maximum length of treatment is 6 months.	Booster sessions are provided to families after therapy is completed if the family experiences minor setbacks. These must be used within a year after discharge. Booster sessions are a limited amount of sessions that are permitted to occur within a very brief period of time. FFT encourages 1 to 3 sessions within a 2 week time frame; however, booster sessions are contingent upon authorization from the payer source.	Due to the length of time families are served by the FBMHS team, reauthorization of the treatment is not standard. Treatment teams may request extensions on an individual basis.
Availability of Family Support Funds	Small flex account for funding rewards for families and assisting with immediate instrumental needs.	Family support funds are not available.	Family support funds are available to support short-term immediate needs of the family. Policy for accessing funds varies by agency. Family Support Services are a combination of services and goods that are identified with the family and consistent with the treatment plan and goals. FSS funds are available when community resources are not available or sufficient. Families should be able to self- sustain the supports ongoing when FBMHS is no longer involved.