



CHILD Family-Based Mental Health Services (FBS)

PROGRAM DESCRIPTION

Family-Based Mental Health Services (FBS) integrate mental health treatment, family support, and casework so that families may continue to care for their children whose emotional and/or behavioral challenges place them at significant risk of out-of-home placement. FBS are provided 24/7 for up to 32 weeks. FBS includes assessment, aftercare planning, referral, and service linkage. Services are delivered primarily in the family's home by a two-person team, consisting of a master's level clinician and bachelor's level professional.

While the primary goal of FBS is to reduce the need for out-of-home placement of children and adolescents, the two-person team also works to strengthen and maintain families by means of therapeutic intervention to:

- Develop healthy coping skills
- Teach parenting skills
- Provide psycho-education
- Advocate for the child or adolescent

FBS can begin up to 30 days prior to discharge from an RTF. If a child was authorized for FBS prior to admission to an RTF, then the FBS team can make up to 6 service contacts during the first 30 days in RTF treatment to aid transition. If a child is admitted to an inpatient hospital setting, then FBS may provide 1 contact hour per week during the hospitalization for up to 30 days.

Medical Necessity Criteria for Family-Based Services (Appendix T)

Admission Criteria (Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

- A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55, Public Welfare 5200.3). A psychiatrist, physician or licensed psychologist determines that the child is eligible and recommends the FBMHS program (State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(1));

AND

- B. Other less restrictive, less intrusive services have been provided and continuation in this less intensive level of care cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;

OR

Child has been discharged from an Inpatient Hospitalization or a Residential Treatment Facility, and other less restrictive, less intrusive services cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;

AND

- C. Behaviors indicate manageable risk for safety to self/others and child must not require treatment in an inpatient setting or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS

- A. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child,

AND

1. The family recognizes the child's risk of out of home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family;

AND/OR

2. The child is returning home and FBMHS is needed as a step down from an out-of home placement;

AND

- B. The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one of the following:

1. Suicidal/homicidal ideation
2. Impulsivity and/or aggression
3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4. Psychomotor retardation or excitation.
5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6. Psychosocial functional impairment
7. Thought Impairment
8. Cognitive Impairment

AND

- C. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;

AND

- D. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment in the home and family involvement to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or tentative remission;
OR
- E. There is an exacerbation of severely impaired judgment or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in the home is severely compromised, and intervention involving the child and family is necessary;
OR
- F. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;
OR
- G. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.

Continued Care Criteria (Must meet I and II)

I. DIAGNOSTIC EVALUATION AND RECOMMENDATION

- A. Recommendation to continue FBMHS must occur:
 - 1. By the treatment team every 30 days through an updated and revised treatment plan, and
 - 2. By a psychiatrist, licensed psychologist, or physician at the end of 32 weeks, with an updated diagnosis;AND
- B. There is significant family (including the child) cooperation and involvement in the treatment process.
AND
- C. An updated treatment plan by the treatment team indicates child's progress toward goals, the progress of the child and family as a unit, and revision of goals to reflect documented changes, and the child and family involvement in the treatment planning process.

II. SEVERITY OF SYMPTOMS

- A. Child and the family are making progress toward goals, and the treatment team review recommends continued stay;
OR

- B. The presenting conditions, symptoms or behaviors continue, such that family and natural community supports alone are insufficient to stabilize the child's condition;

OR

- C. The appearance of new conditions, symptoms or behaviors meeting the admission criteria.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE DOCUMENTATION

- A. Child must be reevaluated every 30 days for the purpose of updating the treatment plan and continue to meet Requirements for Continued Care.
 - 1. The review of the child being served must:
 - a. Clarify the child's progress within the family context and progress toward developing community linkages; and
 - i. Clarify the goals in continuing FBMHS; and
 - ii. The need for continuing FBMHS if continuation beyond 32 weeks is recommended; and
 - b. Whenever FBMHS service is considered for a term greater than 32 weeks:
 - i. A psychiatrist, licensed psychologist, or physician must update the diagnosis; and
 - ii. Review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources; and
- B. Child demonstrates:
 - 1. Measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation); *or*
 - 2. Increased *or* continued behavioral disturbance with continued expectation for improvement (indicate rationale in the treatment plan);

AND
- C. Treatment plan is addressing the behavior within the context of the child's problem and/or contributing psychosocial stressor(s)/event(s);

AND

- D. Treatment plan is updated to reflect recommendation to continue care.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

- A. The treatment team, determines that FBMHS:
1. Up to 32 weeks of FBMHS services has been completed; and/or
 2. The service results in an expected level of stability and treatment goal attainment for the intervention such the child meets:
 - a. Expected behavioral response, and/or
 - b. The FBMHS program is no longer necessary in favor of a reduced level of support provided by other services, or
 3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to offering further FBMHS; or
 4. Creates a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR

- B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent (14 years old or older) requests a reduction in service or complete termination of the service.