Clinical Performance Standards:

Family-Based Mental Health Services

Updated September 2023

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1. PURPOSE

The Family-Based Mental Health Services (FBMHS) Performance Standards describe expectations for quality in service delivery for children and adolescents (hereafter often referred to as "youths") and their families whose treatment services are funded through Community Behavioral Health (CBH). The standards should be utilized as a guide for providers to design and monitor their programs.

These FBMHS Performance Standards reflect the core values and principles of the **City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS)** Practice Guidelines and Child and Adolescent Social Service Program (CASSP) and System of Care principles. They align with the **Commonwealth of Pennsylvania Code Title 55 Chapter 5260 Family-Based Mental Health Services**. The Standards aim to set foundational standards, promote continuous quality improvement and best practices, increase consistency in service delivery, and improve outcomes for youths and their families. FBMHS providers are strongly encouraged to prioritize consistent and active family engagement, deliver culturally and linguistically competent treatment for youths and their families, and conduct inclusive and ongoing discharge planning through collaboration with families, treatment providers, and community supports.

The DBHIDS Practice Guidelines support family resilience through community-based, least restrictive care whenever possible. Family-based level of care is the most intensive in-home, family-setting service in the CBH Continuum of Services for Children. FBMHS strives to promote in-home, community-based treatment so families can address challenging child and adolescent behaviors and patterns of interaction in the home, thereby reducing reliance on out-of-home placements such as psychiatric residential treatment facilities (PRTF) or foster care. In addition to supporting parents/caregivers, extended families, and other significant persons during the treatment process, FBMHS treatment seeks to help youths maintain community tenure by building further natural supports.

CBH developed these standards in collaboration with FBMHS providers through a process guided by best practice research, consensus, and state regulation. **The Philadelphia Child and Family Therapy Training Center**, system leaders, and families have reviewed the complete standards.

2. LICENSING REQUIREMENTS

All providers in the CBH Network must have a Family-Based Mental Health Services license, pursuant to the Commonwealth of Pennsylvania Code Title 55 Chapter 5260 Family-Based Mental Health Services.

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 youths and adolescents with serious mental illness or emotional disturbance who are at risk of psychiatric hospitalization or out-of-home treatment as well as their families. Therefore, FBMHS is essential in the CBH Continuum of Services for Children. It functions as one of various mental health services based in the community. FBMHS is relevant as a diversionary level of care. As a strengths-based community service, FBMHS supports youths, their caregivers, and other youths within the family unit broadly defined. The family's stability, integrity, and caretaking capacity are associated treatment targets. 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.

"Family" may be considered as a youth's family of origin, adoptive family, foster family, and family of choice, and may include primary caregivers or legal guardians, siblings, and other significant family members. FBMHS teams engage and collaborate with all identified members of a youth's ecosystem to effect meaningful change, including

parents/guardians/caregivers, siblings, extended family members, outside professionals, and community members. Treatment must be individualized, varied, and family-driven.

Treatment goals include:

- Enabling caregivers and family supports to care for youths by increasing their ability to effectively manage the mental and behavioral health challenges at home to reduce the need for treatment in out-of-home settings;
- strengthening and maintaining the family as a system;
- reducing or preventing the need for emergency rooms and other highly restrictive services;
- improving coping skills and psychosocial functioning of youths across settings; and
- teaching family members how to serve as advocates for youths.

Related objectives are:

- Strengthening and maintaining families by delivering individual and family therapy;
- empowering families and caregivers to gain and use skills to care for youths; and
- providing comprehensive, intensive, resolution-focused treatment, including psychotherapeutic and psychotropic medication interventions.

This intensive level of care requires coordination among families and caregivers, educational providers, and other treatment and community-based providers for youths and their families to be successful in their natural environments and remain in the community.

3. ADMISSION REQUIREMENTS

General clinical indications and appropriateness for services

Youths and adolescents under 21 years of age are eligible for FBMHS, which are all-encompassing and are intended to address the issues of the entire family, as those issues relate to youths. CBH recommends prescribers consider FBMHS as a preventative service, intervention service, or step-down service. Prescribers are expected to include a clear rationale for FBMHS that is supported by diagnostic, emotional, behavioral, and family considerations.

- Youth functioning demonstrates a chronic pattern of externalizing symptoms (e.g., aggression, defiance, reactivity, or elopement) or internalizing symptoms (e.g., self-injury, eating disorders, severe anxiety, or mood disorders) that have resulted in significant functional impairment that have caused negative consequences in multiple domains
- When risks of safety to self or others are manageable without treatment in an inpatient or PRTF
- When multiple systems are involved with youths or families, when there is a history of multiple treatments, or when there is a history of failed treatments.

3.2 Diagnostic Indicators for Services

The FBMHS treatment model is not tied to specific DSM 5 diagnoses. Accordingly, youths 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 youth's serious impairment with behavioral, social, and/or emotional regulation that presents significant barriers to successful functioning of the youths across settings. This significant functional impairment occurs in a social context that does not adequately support the development of a youth's social and emotional self-regulatory skills consistent with his or her cognitive and developmental status, and subsequently negatively impacts family dynamics and relationships.

3.3 Specific Clinical Indicators

In addition to general indicators and diagnostic considerations, there are specific clinical indications for FBMHS. These may be categorized in terms of youths and family risk factors and treatment considerations. Family risk factors are to be considered in relation to the functioning of the identified patient of FBMHS.

Youth risk factors may include the following:

- History of suicide attempts or ideation
- Current or history of running away or truancy
- 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 trauma
- Disruptive or troublesome behaviors such as delinquency, drug use, risky sexual behavior, and involvement with the juvenile justice system

Family risk factors may include the following:

- One or more youths 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 youth 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 or homelessness

Other reasons to consider FBMHS may include the following:

- Presence of multiple treatment providers involved with the family
- Youths who have had multiple treatment episodes at a lower level of care in which their needs have yet to be met
- Presence of multiple siblings with serious emotional challenges requiring multiple levels of care

3.1. Medical Necessity Criteria

Face-to-face assessments of youths performed by a physician, psychiatrist, or licensed psychologist, resulting in a Comprehensive Biopsychosocial Evaluation (CBE) with DSM (current version) diagnosis must prescribe this service as medically necessary for youths to access FBMHS. A complete list of admission and continued stay 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).

Appropriate services are determined after carefully considering evidence-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 a youth's individual circumstances through multiple sources of input.

FBMHS are considered medically necessary when youth behaviors must be treated in the context of the family to offer the expectation of improvement. At least one adult family member/caregiver must agree to actively participate in the service along with a youth. The initial plan shall be prepared, reviewed, and approved by the program director and clinical consultant, if required within 5 calendar days of the initial service. The plan shall be reviewed and updated at least once a month thereafter[6]. There must be youth and family involvement in the treatment planning process.

4. Referrals and Access

FBMHS providers are expected to cultivate their own referrals. FBMHS providers should continually educate referral sources about the service, program strengths, areas of specialization, and the appropriateness of referrals based on state guidelines and medical necessity criteria. Referral sources are expected to provide sufficient information to the FBMHS provider for providers to manage referrals appropriately and to not have to initiate services with a family only to find within the first several weeks of treatment that FBMHS are not the most appropriate services for the identified youths and families.

CBH manages and distributes referrals to the provider of family choice and/or specialty based on youth and family need. Providers are expected to maintain timely communication with CBH concerning the status of referrals and the actions they have taken upon receipt of referral.

Once CBH has made a FBMHS referral to a provider with accompanying documentation, providers are expected to contact families within one business day of receipt of referrals to offer available appointments convenient for youths and families, meeting families' needs to initiate services. This consideration supports family engagement. Providers are to notify referral sources and CBH if they believe the referral is incomplete and it is expected that the referral source provide whatever additional information is needed. FBMHS providers must make efforts to secure updated contact information from the referral source, CBH, DHS/CUA, and/or any other system that is involved before (when appropriate) when there are barriers establishing contact for an FBMHS intake.

All FBMHS programs are expected to have processes in place that meet the goal of obtaining sufficient information to determine the appropriateness of services in a timely manner. All programs are also expected to gather collateral information from referral sources and from initial contacts with families to determine how to best match teams to families.

One effective method toward achieving this goal is to have program directors or supervisors make the initial contact with referred families by phone or in person.

FBMHS are intended to be available as a diversion from inpatient services when youths experience crises but do not need services as restrictive as bed-based levels of care. Providers are expected to have a process for prioritizing referrals to be able to accept urgent referrals within one (1) business day. Considerations for an urgent referral may include a diversion from inpatient services when youths experience crises, but do not need services as restrictive as bed-based levels of care.

Providers are expected to accept and engage with all families referred to them by CBH. Providers should consider coordinating interagency team meetings with referral sources and families if there are difficulties engaging the families once services have begun.

FBMHS may encounter instances where a youth and family request a transfer to another level of care, or an alternative FBMHS provider, that may not be readily available. If the youth and family choose to wait an alternative FBMHS provider or authorized level of care, the current FBMHS provider is expected to encourage youth and family to remain connected and involved with their current treatment provider until the new referral is accepted. In the event that the youth and family elect to disengage, the current FBMHS program should also provide information to families on crisis options such as Children's Mobile Crisis Team (CMCT), Urgent Care Centers (UCC), or Philadelphia Children's Crisis Response Center (PC-CRC) walk-in crisis, or nearest children's hospital, if available in their area.

4. OUTREACH

Upon initial contact with families, FBMHS providers are expected to discuss confidentiality issues with youths (when age appropriate) and families to obtain written permission to consult with others that will aid in the assessment, treatment plan development, and monitoring of the effectiveness of treatment interventions over the course of care.

Families should be given meaningful, written, and easily understood information describing services which should include details of what FBMHS "can and can't do." During initial contacts, providers are expected to clearly discuss with families what they can expect from the services, and what is expected of them as partners in the treatment team.

4.1. Engagement

FBHMS teams are encouraged to build a therapeutic alliance with each family member and collaborate with all community partners. The team is expected to engage with youths and their entire family systems through repeatedly expressing key beliefs and drawing on intentional behaviors, including presuming the best, acting as a partner, focusing on good intent and strengths, and joining with unconditional acceptance.

FBMHS providers are expected to demonstrate assertive, strengths-based, comprehensive, and family-centered efforts to engage youths and families in the treatment process. This should include a multi-faceted approach, taking into consideration the **DBHIDS Practice Guidelines**. This may require providers to go beyond making telephone contact. Other engagement options may include mailing letters, contacting referral sources, or making "pop up" visits in the community. Clinicians are encouraged to utilize their therapeutic engagement skills to effectively engage a youth and family. There will be occasions where clinicians may be presented with barriers to in-person attempts during the engagement phase. Providers should follow their agency policy when considering safety concerns. Supervisors should ensure clinicians are trained to use their best judgment and agency policy to maintain safety. In instances where engagement interventions are unable to be utilized, the clinician should document this to provide rationale of their decision process and notify the assigned clinical care manager (as soon as possible) to report the barrier with

engagement. Whenever possible, these efforts should occur consistently, for at least 30 days, before identifying the referral as a Failure to Connect (FTC). These efforts should be documented accordingly.

- Providers are expected to complete a treatment history review, also known as a "5-Day Info Share," with CBH to obtain additional collateral information that will assist the provider with engaging the family.

4.2. Monitoring of Standard

CBH will monitor the length of stay, including percentage of lengths of stay under 30 days, signifying a failure to engage family in treatment.

5. ASSESSMENTS

The assessment process is the grounding source for treatment because it teaches the team about the challenges they face and how the family operates. Clinicians should be trained to use an inductive approach to treatment that focuses on data gathering, hypothesizing, intervention, and assessment of family response (which becomes data gathering for the therapist), with the sequence repeating itself throughout the treatment process (Aponte & Van Deusen, 1991).

Assessments should be family-centered and strengths-based, prioritizing resources already accessible to the family. All identified family members and support people should contribute to assessment interviews. During the first phase of treatment, FBHMS teams are expected to complete a comprehensive family assessment. This assessment should include completing an EcoMap, Critical Events Timeline, Genogram, Negative Interactional Patterns (NIP), a safety risk assessment, and **Modified Family Assessment Form (MFAF)**. The findings from this family assessment are expected to be included in a psychosocial evaluation of the youth and family, including psychological, social, vocational, and educational factors important to the youth and family and the dynamics within the family unit. Providers should include the program psychologist or psychiatrist in this process, which should occur within the first 60 days of treatment. This psychosocial evaluation should be included in the treatment plan and referred to during treatment planning[6]. Teams should use these assessments to further identify the four primary targets of assessment and change, also known as *The Four Pillars of Ecosystemic Structural Family Therapy* (ESFT):

1. *Attachment*: Enhancing a caregiver's emotional connection with their youths
2. *Emotional Regulation (Coregulation)*: Addressing negative interactional patterns and problems in individual and family emotional regulation (what happens in the relationships that perpetuates the symptom)
3. *Co-Caregiver Alliance*: Balancing parenting styles
4. *Executive Functioning*: Activating a caregiver's ability to maintain a leadership role in the family, home, and community

Other tools should be utilized as appropriate. The assessment should aim to identify parenting and attachment styles, current challenges as prioritized by the family, youths' behavioral needs, any factors creating risk to youths' placement, and interaction patterns. Teams are encouraged to use *The Social Ecological Model* codeveloped by **The Philadelphia Child and Family Therapy Training Center** and the Center for Family Based Training to further understand how social conditions, including location and trauma, impact youths and families. Furthermore, the assessment should focus on areas of strength that can be utilized throughout the treatment process, both to bolster the family unit, the family's sense of competence and hope and to enhance treatment efficacy.

CBH recognizes providers that have a Pennsylvania State waiver regarding the use of the ESFT. These providers should utilize the state-approved treatment model and assessment tools associated with the service to develop the psychosocial evaluation of the youth and family.

5.1. Modified Family Assessment Form (MFAF)

The **MFAF** was created by the Philadelphia Child and Family Therapy Training Center to assess family and youth characteristics important to the ESFT approach. It is based on the Family Assessment Form (FAF) developed by the **Children's Bureau of Southern California (CBSC)**. CBH FBMHS providers are required to use the MFAF to support the development of meaningful service plans and help agencies monitor program outcomes more effectively.

The MFAF has 19 questions and three Sections/Subscales:

1. Section I: Caregiver-Youth Relationship
2. Section II: Co-Caregiver Relationship
3. Section III: Executive Skills (Parenting)

According to the Philadelphia Child and Family Therapy Training Center, the goals of the MFAF include:

- Helping develop a comprehensive understanding of family strengths and areas of concern
- Strengthening and deepening a team's work with families and individual family members
- Helping teams collaborate with families by using concrete skills to forge new family patterns and develop a trauma- and tragedy-informed reframe
- Identifying areas of concern to integrate into the treatment planning process
- Identifying additional supports that individual family members may need in order to anchor and solidify change

The MFAF was not designed as a formal or structured questionnaire but a framework for clinicians to think about and document assessment information. Teams should seek supervision from program leadership for clinical considerations and implications surrounding use of the tool.

CBH developed a data capture tool that will assist providers with data collection. Providers should retain summary and outcome of goals information and use it during treatment planning. CBH will not collect this information but will collect and analyze the provider data capture tool once a year for the purpose of monitoring program outcomes and performance evaluation. A complete guide to administering the MFAF and outline of provider expectations can be found in the **CBH MFAF Training and Frequently Asked Questions**.

6. TREATMENT PLANNING

The identified youth is the focal point of treatment. Therefore, it is important to ensure that the youth, regardless of age, participates in the treatment planning process.

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 jointly with the youth and 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. CBH requires that treatment plans contain admission dates, date of initial treatment plan, date of current plan, and date next plan is due.

When developing and updating the treatment plan with the youth and family, the team is expected to utilize the findings from all assessments to formulate a comprehensive treatment plan that addresses the impact of patterns of interaction on the family and youth, as well as the youth's behavioral or mental health challenges.

Treatment plans must be:

- Reflective of comprehensive treatment formulation and includes the following domains (when applicable) – individual/behavioral, family/community, medical, education, financial, substance use
- Individualized, specific, objective, and measurable
- Written so that the youths, families, and school staff can easily understand and follow it
- Compassionately and effectively addressing the etiology of conflict, rather than focusing solely on containment of behaviors
- Include de-escalation and safety plans for any target behaviors that risk harm or injury to self or others.
- Include interventions for target behaviors and emphasize antecedent management to prevent crisis situations
- Criteria and schedule for determining when a goal should be revised, specified clearly (i.e., advancement and regression criteria)

7. EVIDENCE-BASED PRACTICE

FBMHS is an 8-month (up to 32 weeks) comprehensive family therapy treatment designed for youths and adolescents under 21 years of age. In keeping with best practice and Pennsylvania state requirements, ESFT is the treatment model for FBMHS service delivery.

ESFT, developed by Dr. Marion Lindblad-Goldberg and colleagues at the Philadelphia Child and Family Therapy Training Center, is an empirically supported adaptation of Dr. Salvador Minuchin's structural family therapy model. It is a trauma informed, strengths-based, systemic treatment for youths and families experiencing behavioral or relational challenges. ESFT is an effective treatment for youths with moderate to severe behavioral challenges and/or families with high levels of conflict, including families with youths who are at risk for out-of-home placements.

Based on the understanding that an individual's functioning is linked to relational patterns at home and in the community, ESFT addresses interactions among family members and between the family and community. Caregivers are supported via skill-building, psychoeducation, and self-care interventions to manage their own emotional or developmental challenges and to enhance problem-solving and other parenting competencies. Family sessions enact growth-promoting interpersonal experiences and facilitate skills practice. ESFT therapists coach family members to practice new skills within the community and connect families to community supports to sustain the gains made in therapy. ESFT aims to improve youth behaviors, enhance affective regulation among family members, and increase stability in the home

environment. The standard of family treatment in many settings and levels of care, ESFT aligns with DBHIDS priorities for family engagement in treatment.

Using ESFT, FBMHS focuses on treating the family relationships in which youths' symptoms emerge. This youth-centered and family-focused level of care is delivered by a team composed of two clinicians who look at the interconnected relationships in the home and how they perpetuate the symptomatic cycle.

Treatment focuses on the four pillars of ESFT mentioned above (attachment, emotional regulation, co-caregiver alliance, and executive functioning). Teams should use the *ESFT Logic Model* developed by the ESFT Training Center Consortium or the six stages of ESFT implementation for model implementation and to drive ESFT intervention *(Ecosystemic Structural Family Therapy: An Overview as Applied to Pennsylvania's Family-Based Mental Health Services Program, 4.12.21).*

If a provider has a waiver regarding the use of the ESFT from the state, CBH will recognize the provider as a FBMHS exception program within its network. The provider should utilize the state-approved treatment model associated with the service.

7.1. Monitoring of Standard

CBH expects all FBMHS providers to have an Evidence-Based Practice and Innovation Center (EPIC) designation in ESFT by June 30, 2024. If providers have a waiver exempting them from using the ESFT model, EPIC designation is expected in another Evidence-Based Practice (EBP) that complements your treatment approach by June 30, 2023.

8. CLINICAL SERVICES

8.1. Family Therapy

Family therapy is a major modality for FBMHS, and much of the clinical time will be spent with youths and key family members. Sessions should be based on the ESFT model and the understanding that youths' challenging behaviors are symptomatic of the larger systems of which they are a part (i.e., family, school, community). Thus, interventions should target family members who have regular interactions with identified youths, including caregivers, siblings, and grandparents. Clinicians should coach family members to practice productive interaction skills within their larger communities, creating parallel and sustainable changes within these systems.

8.2. Individual Therapy

Individual therapy should occur in a systemic context with the ultimate goal, when possible, of moving toward family therapy and other sustainable venues for problem-solving and support. Individual therapy can occur with any family member as needed; however, if more targeted support is required, the FBMHS should refer that individual to separate therapy services, such as specialized outpatient treatment or substance use treatment services. In such a case, the FBMHS team shall remain the driver of treatment and should ensure collaboration and continuity of care.

8.3. Crisis Support

FBMHS shall have 24/7 availability of FBMHS (or equivalent on-call staff) phone and in-person crisis support as needed. Family-based teams should develop trust and confidence with families so that they are more likely to access FBMHS available crisis services when needed. Staff must be prepared to provide crisis support at any hour of the day, with a goal

of de-escalating crises, building skills, and avoiding restrictive levels of care or hospitalization if possible. This support is expected to occur over the phone and, when clinically indicated, in person.

Family-based teams should create preventative crisis safety plans with families early in treatment reflecting families' strengths and preferences for coping and including tools to be used in crises. Crisis safety plans should be family-centered and developed in collaboration with both youths and caregivers from the beginning of and throughout the treatment process as clinically indicated. For example, the crisis safety plan should be developed, reviewed, and/or revised:

1. At intake,
2. after crisis events,
3. when the treatment plan is reviewed,
4. following a higher level of care (e.g., Acute Inpatient, Acute Partial, Crisis Stabilization Unit), and
5. during discharge planning.

The crisis safety plan should include a clear de-escalation process and should help support families and youths in re-establishing equilibrium and in avoiding out-of-home assessment and placement. The plan should be revised following each use to ensure it meets the needs of the youths and families on an ongoing basis and includes any new insights and ideas regarding how to avoid or de-escalate crises.

FBMHS teams should coach families in using crises as opportunities to promote growth and change as much as possible. FBMHS teams are expected to identify areas of opportunity for resolutions in crisis situations. Caregivers and youths should be viewed as whole and capable, using their strengths to hold their belief in their recovery. By doing so, the team is working to prevent iatrogenic harm. FBMHS programs should establish risk assessment and response protocols to address dangerous situations, as well as standards for workflow and response times.

For further guidance around crisis management, FBMHS providers should refer to *Supporting Youth and Their Parents in Crisis Training for Philadelphia Home-Based Teams*, developed by Kappy Madenwald, M.S.W.

8.4. Monitoring of Standard

CBH will monitor community tenure for youths receiving Family-Based Services (FBS), as defined by visits to Crisis Response Centers (CRCs), use of mobile crisis, and admission to Acute Inpatient Psychiatric (AIP) and Partial Hospitalization Programs (PHPs).

8.5. Case Management

Assertive case management is a core component of FBMHS. FBMHS teams should work closely with families to assess needs and develop connections to community and other resources (e.g., medical, transportation, legal, etc.) to further support and/or develop families' autonomy, strengths, and skills, as well as to bolster effective aftercare planning. Coordination and consistent collaboration with other youth-servicing systems is also required. These linkages include but are not limited to schools, after school programs, summer camps, spiritual leaders, community activities, outpatient mental health clinics, youth protection and social service agencies, juvenile justice programs, and substance use disorder programs. It is critical for all teams to develop close coordination with medical providers to be able to work with families regarding the medically complex needs of their youths.

8.6. Family Support Services

Family Support Services (FSS) are funds included in the FBMHS program budget in Pennsylvania for the provision of concrete supports and basic needs, including food, shelter, and clothing, to help sustain the family system. Family support funds should also be applied to activities supporting treatment goals. For example, FSS could be utilized for enrollment in community activities, summer camp, etc. Family activities may also be funded through this source, but teams should have a clear treatment rationale and connection to treatment goals. For example, if a family avoids taking youths on family outings because the youths often create a scene, funds might be used to attend a typical activity to work on family interaction to support a more successful outcome. In this instance, the team can facilitate skill transference from clinician to family/caregiver, supporting sustainability within the family system. If a FBMHS is uncertain if the use of FSS is appropriate, it should consult with its assigned CBH provider relations specialist and/or clinical care manager.

9. MEDICATION MANAGEMENT

While psychiatry is not indicated in the Commonwealth of Pennsylvania Code FBMHS, timely access to psychiatric services should be delivered in accordance with the **DBHIDS Practice Guidelines** and **CBH Provider Manual** for prescribing practices. FBMHS providers are expected to develop a plan for ensuring access to psychiatry as part of their FBMHS service delivery. It is best practice to include a psychiatrist as a part of the interdisciplinary team. Therefore, FMBHS teams are expected to maintain regular, collaborative contact with the prescribing physician and should provide collateral information to support the evaluation and assessment process whenever possible.

10. CARE COORDINATION/LINKAGES

The implementation of FBMHS is also based on the foundation of the **Children and Adolescent Service System Program (CASSP) principles**. FBMHS providers are expected to incorporate these principles within their approach to service delivery and treatment.

FBMHS providers are expected to be creative and savvy in treatment. CBH suggests using the CASSP principles throughout the course of treatment to inform the treatment approach with youths, families, systems partners, and other community and/or natural supports.

10.1. Overlap of Services

According to state regulations, FBMHS may overlap with other levels of care when clinically appropriate to meet the needs of youths. If a family member other than the identified patient requires individualized mental health or behavioral services, the necessary services must be obtained from other mental health service providers. The FBHMS team is expected to facilitate this process.

10.1.1. Crisis Services

Youths who are authorized for FMBHS should not be concurrently authorized for crisis services, such as Crisis Mobile Crisis Teams (CMCT). However, in instances where families may bypass FBMHS crisis support, and a crisis service such as CMCT is dispatched, it is the expectation that the FBMHS provider collaborate with CMCT to co-manage crises families are experiencing. Once youths are in a safe setting, the FBMHS team is expected to take the lead and collaborate on transitioning youths and families from the crisis level of care safely back to the community. Please note, it is expected for the FBMHS team to be present at the crisis location as soon as possible to meet youths and families and support the crisis intervention.

10.1.2. Acute Services

A FBMHS overlap of up to 30 days may occur with acute service levels of care, such as AIP or PHPs. It is expected that the FBMHS team actively collaborates with other service providers on a consistent basis to facilitate successful and sustained community re-integration. This includes joining with the acute treatment team, providing clinical insight, and assisting with the conceptualization or reassessment of youths and family system challenges or needs.

FBMHS teams are expected to participate in Interagency Service Planning Team (ISPT) meetings, individual, family, and caregiver sessions with youths and families at the AIP or APHP and in the community. FBMHS teams are also responsible for ensuring that timely follow-up medication management appointments are secured for youths prior to discharge from acute levels of care. If it appears that a youth may require more than 30 days of AIP, the FBMHS team should contact the designated Clinical Care Manager (CCM) to discuss the course of treatment.

10.1.3. Psychiatric Residential Treatment

When youths are expected to transition to FBMHS from Psychiatric Residential Treatment Facility (PRTF) placement, it is expected that the assigned FBMHS team ensures a comprehensive overlap and thorough hand-off from residential treatment to community-based level of care. To achieve this, FBMHS teams are expected to overlap the service up to 90 days with the PRTF provider to facilitate successful and sustained community re-integration for youths.

A comprehensive FBMHS overlap with PRTF level of care must include:

- FBMHS team participation in interdisciplinary/treatment teaming and discharge planning meetings
- Collateral and information gathering with PRTF providers to support skill transference between clinical teams
- FBMHS team participation in joint family sessions with PRTF providers
- Individual, family, and caregiver sessions with youths and families at PRTFs and in the community
- Co-development of crisis safety plans with the PRTF providers
- Care coordination and case management when indicated

FBMHS programs should follow the procedures for providers seeking to utilize telehealth for delivering behavioral health services within the Pennsylvania issued by The Office of Mental Health and Substance Abuse Services (OMHSAS). This information can be found in bulletins **OMHSAS-22-02: Revised Guidelines for the Delivery of Behavioral Health Services Through Telehealth — July 1, 2022, OMHSAS-22-02: Attachment A — July 1, 2022**.

10.1.4. Intensive Behavioral Health Services (IBHS)

IBHS regulations indicate that youths who may have increased need for support may have IBHS Behavior Consultants (BCs) and Behavior Health Technicians (BHTs) authorized concurrently with FBMHS in the school setting only. BHTs cannot be supervised by a Mental Health Professional (MHP) from FBMHS as a MHP does not meet the criteria outlined by Pennsylvania IBHS regulations.

If BCs and BHTs are considerations while youths are receiving FBMHS, an ISPT meeting must take place to coordinate the treatment plan and ensure that each provider has a clear understanding of roles and treatment services provided. For example, an IBHS service provider's treatment plan should not include components of family therapy. The family level of care must provide the primary therapeutic service, and this treatment should be referenced in the IBHS treatment plan.

FBMHS providers are expected to consistently collaborate with IBHS providers during treatment. Treatment plans should be coordinated so that they support consistent treatment goals and interventions to youths and families.

10.1.5. Outpatient Services

According to Pennsylvania FBMHS regulations, identified youths may receive psychiatric medication with FBMHS. If a youth is receiving outpatient medication management through an outpatient provider at the start of FBMHS, and the family chooses to remain with the outpatient provider for psychiatric medication management, CBH will honor this request. If the outpatient psychiatric services provider requires concurrent outpatient therapy with the psychiatric services, it is suggested that a youth receive no more than two outpatient therapy sessions per month. FBMHS teams should collaborate with outpatient therapists to encourage the consistent therapeutic understanding of youths and families.

FBMHS can be authorized concurrently with specialized outpatient therapy services, such as Dialectical Behavioral Therapy (DBT), Parent-Child Interaction Therapy (PCIT), and Trauma-Focused Cognitive Behavioral Therapy (TFCBT). Consideration of concurrent services should occur for outpatient specialty therapy if youths are assigned to general FBMHS teams. The teams are expected to collaborate with therapists providing specialized therapy to ensure consistency in message and support a mutual understanding of youths' and families' needs and the roles of the therapists involved.

10.1.6. Targeted Case Management

During the course of FBMHS, TCM services are limited to no more than two (2) billable contacts if the youth was engaged in TCM prior to admission into FBMHS. During the last thirty (30) days prior to discharge, eight (8) TCM contacts are permitted during this period of discharge from FBMHS[6, 7].

10.1.7. Systems Partners

Coordination with past, current, and prospective community and systems partners is critical. Linkages with systems such as **Philadelphia DHS Community Umbrella Agencies (CUAs)** and the **Juvenile Justice Center** will be essential to ensuring youths remain connected to safe and supportive resources during treatment and post-discharge. FBMHS teams should collaborate with these systems to support youths' and families' understanding of and compliance with youth welfare or juvenile justice supports.

Special coordination will be required for transition-age youths who may have complex needs. This may include consideration for specific adult services such as Assertive Community Treatment (ACT), case managers, or housing programs (when needed).

10.1.8. School

FBMHS teams are expected to collaborate with school counselors and special education liaisons, observe youths in the academic environment, collaborate with schools to assist with family engagement, attend school meetings when necessary (e.g., Individualized Education Plan meetings), and assist caregivers with advocating for youths' educational needs.

10.1.9. Community and Natural Supports

FBMHS teams are expected to assess community and natural supports using ecomaps and genograms. If ecomaps/genograms reveal areas of need within family systems, the teams are expected to assist families with identifying and accessing additional community and natural supports that that will contribute to the success of overall family function.

11. DISCHARGE PLANNING

Discharge planning is a collaborative process that starts at the beginning of treatment and is reviewed throughout the course of treatment. Discharge planning may vary based upon youth risk and the FBMHS provider's clinical opinion. The discharge planning process should begin at the beginning of treatment and include a discharge planning meeting with the youth, family, provider, systems partners, and a CBH CCM.

Providers are expected to identify strengths of and challenges to discharge and make these focal points in the treatment process as completion approaches. Effective methods of addressing these challenges should be documented and used to assist in successful discharge planning. In many cases, prior to discharge, the FBMHS provider must schedule and facilitate a discharge planning meeting; in these cases, the provider should notify all systems partners to ensure the relevant participants are present to discuss and agree upon discharge options and team recommendations. Discharge planning should support successful transition to the next level of care and should help families prepare for the inevitable challenges of such a transition so higher intensity services can be avoided as much as possible.

Discharge planning meetings can occur at the designated provider agency, in the community (i.e., school placement, library, CUA agency), at a safe and approved location of the youth/family/provider's choice, or via telehealth (when permitted).

A discharge planning meeting should occur at least 60 days before the last cover date of treatment. This allows time for recommendations to be communicated to the evaluator for after care when clinically indicated and ensures continuity of care by allowing providers time to link the youth and family with aftercare, resources in the community, and natural supports. The FBMHS team can conduct the discharge planning meeting earlier if there is a family who may benefit from an extended planning process.

In addition, if the family disengages from the discharge planning process prematurely, the FBMHS provider must follow up with CBH and other systems partners to plan appropriate alternative after care recommendations despite an unplanned discharge.

12. CULTURAL HUMILITY, COMPETENCE, AND STRENGTHS-BASED TREATMENT

All FBMHS providers are expected to support the development of cultural humility and literacy regarding gender, age, race, ethnicity, spirituality/religion, gender identity, and sexual orientation within their programs and amongst their staff through adherence to the **National Culturally and Linguistically Appropriate Services (CLAS) Standards**. Key components include:

- Open, respectful communication with youths and families to better understand culturally-based values and belief systems that need to be considered when learning and practicing new self-regulation/supportive skills
- Documentation of all initiatives to further develop the cultural literacy and sensitivity of staff and interventions to improve the overall equitability of their programs
- Presence of a diverse and culturally and linguistically competent workforce (all levels of agency leadership and direct care professionals)

- Ability to accept and accommodate the needs of LGBTQIA youths, including respecting and accounting for gender identity and sexual orientation in treatment, ensuring special medical needs are met for transgender youths, and that youths' selected names and pronouns are used consistently, regardless of setting or audience.

It is expected that youths and families referred to FBMHS will comprise of varying racial and socioeconomic backgrounds, and providers must be culturally and linguistically competent and have experience working with families with diverse backgrounds, identities, and related needs. They must be prepared to treat and support families whose needs are heavily impacted by social determinants and risk factors, including health complications, substance use challenges, poverty, histories of homelessness, unstable or inadequate housing, and violence in their communities. Providers should also be skilled in identifying strengths related to the youths' and their families' cultural and spiritual heritages and practices and brought about by family members and significant others involved in youths' lives.

Providers should also be affirming of LGBTQIA populations, ensure that services are delivered in a manner that is welcoming to people from diverse cultures, and have the resources to work with individuals and families who speak languages other than English.

FBMHS providers must ensure knowledge and skills to meet a range of special communication needs (e.g., limited English proficiency, deaf and/or hard-of-hearing, visually impaired, autistic spectrum disorder). FBMHS providers are expected to reach out to the broader community to increase their expertise and bring in experts/peers/families with experience of similar needs to support youths and families.

FBMHS providers are expected to have a language access plan in accordance with DBHIDS. This plan must be developed and implemented for all non-English speaking youths and their families.

13. STAFFING AND TRAINING GUIDELINES

It is critical that FBMHS providers employ strategic hiring procedures to identify highly qualified candidates who can support the FBMHS mission to provide systems-minded, family-centered, and growth-oriented treatment. Given the diversity in racial and socioeconomic backgrounds of families who receive FBMHS treatment, hiring strategies should aim to form teams whose diversity reflects that of the individuals served and whose training, background, and approach to working with families aligns with the FBMHS mission.

All FBMHS programs are required to adhere to the **Pennsylvania Title 55, Part VII, Subpart D., Chapter 5260, Issue Clarification #4-2012** (or written OMHSAS Policy Clarification 04-2012) and complete ESFT training from one of three approved training centers in Pennsylvania. Providers should refer to this regulatory guide frequently to ensure the program meets State and CBH requirements.

13.1. Supervision

The supervisor's function is to provide clinical oversight for all aspects of FBMHS delivery, including the therapist as an individual, the team, and the FBMHS program as a whole. Effective supervision enhances the clinician's professional skills, knowledge, and competency in providing quality care, aiding in professional growth and development. Skilled supervision improves outcomes for the families served and the program. Supervision should also include training, review, and oversight of CBH clinical, quality, and compliance protocol adherence.

In the temporary absence of a FBMHS therapist, the program director and/or supervisor who meets the requirements for a MHP is expected to 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. This accommodation is expected to be brief and infrequent and should include providing therapy in person or via telehealth, case management and other coordination of care

activities, attendance at and/or facilitating interagency meetings, and telephonic or telehealth contact with the families and youths.

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 youths and their families. Providers are expected to engage in best practices to prevent burnout and promote job satisfaction through enhancement of each team member's professional knowledge, development of treatment skills, and use of appropriate respite opportunities.

APPENDIX: REFERENCES

1. Commonwealth of Pennsylvania (1997). *HealthChoices Behavioral Health Services Guidelines for Mental Health Medical Necessity Criteria*: Appendix T. Harrisburg, PA: Department of Welfare, Commonwealth of Pennsylvania.

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3. Johnston, P., Jones, C.W., and Lindblad-Goldberg, M. *Clinical Supervision in PA FBMHS: Recommendations for Best Practices*. Office of Mental Health and Substance Abuse Services. Bureau of Policy and Program Development. HealthChoices Behavioral Health Policy Clarification. (Issue Clarification #04-2012; July 11, 2012).

4. *Supporting Youth and Their Parents in Crisis Training for Philadelphia Home-Based Teams*, Kappy Madenwald, M.S.W.

5. Ecosystemic Structural Family Therapy (ESFT) An Overview as Applied to Pennsylvania's' Family-Based Mental Health Services Program, 4.12.21.

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7. Department of Public Welfare Office of Mental Health Policy Clarification, Control #FB-07, "FBMHS Relationship to ICM." (Clarification 5221.22 (a) & (d) and proposed 5260.22 (b) 3)).