



Title:	Family Centered Treatment	Code:	H2022-22-HE (Core) / H2022-22-Z1 (3Months)/ H2022-22 Z2 (6Months)/ H2022-22-Z3(Encounter)
Type:	Medicaid	Group Code:	N/A
Effective Date:	2/1/2019	Units:	Month/Unit

Service Description	
<p>Family Centered Treatment® (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals, FCT treats the youth and his/her family through individualized therapeutic interventions. Children and adolescents eligible for FCT may be facing involvement in the juvenile justice system, out-of-home placements, and/or reunification and may display severe emotional and behavioral challenges due to maltreatment (neglect, abuse), trauma (from domestic violence, sexual abuse, substance abuse), and/or serious mental health disorders. By improving youth and family functioning, FCT provides an alternative to out-of-home placements or, when it is in the youth's best interest to be placed out of the home, to minimize the length of stay and reduce the risk of recidivism. FCT is delivered by an assigned therapist with a caseload of 4-6 individuals/families. FCT is supervised by a trained FCT supervisor.</p> <p>FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline practitioners' effective practice. FCT is one of few home- based treatment models with extensive experience with youth with severe emotional and behavioral challenges, dependency needs, and mental health diagnosis as well as histories of delinquent behavior, otherwise known as crossover youth. In addition, FCT is extremely cost- effective and stabilizes youth at risk and their families.</p> <p>FCT is based on eco-structural therapy and emotionally focused therapy. It focuses on addressing the functions of behavior, including system functions that look deeper than behavioral compliance getting, thus creating sustainable change and decreasing the likelihood of recidivism. Based on the understanding that families requiring such services may have experienced trauma, all phases incorporate trauma-focused treatment. Other characteristics of the model that set FCT apart are highlighted below.</p> <p>An evidence-based model, FCT is an enhancement on many models of treatment used as part of community-based services because it is a systemic model that works intensively and collectively with family members, thereby positively impacting the family system and decreasing the likelihood of further involvement into the system by any family member.</p> <p>FCT was designed to be flexible to meet the needs of youth, family, and their community. The practitioner-based model in large part had its formative years of development in North Carolina and has since been successfully established in several other states. FCT is provided by FCT Certified or in-training credentialed staff, who must complete the rigorous FCT certification program.</p>	

A distinct and meaningful difference of FCT is in determining whether a family is truly engaged in treatment or not. Many comparable models typically define engagement as two to three sessions. FCT, however, defines engagement in treatment as the completion of five sessions.

Transitional indicators are utilized to assist the family in recognizing how they are moving through the treatment process. These indicators are determined by the families' progress and not by designated timeframes. This allows the family system to move through treatment at a pace specific to their needs. It also enables the family to feel empowered in the FCT process. Fifteen fidelity measures indicate progression through the phases of FCT treatment. A unique feature of FCT is the Giving Back Project. As part of the FCT phases, the family engages in a project that strengthens their ties to the community, builds their self-esteem, and provides an opportunity to bond further and to practice the skills they've learned.

FCT outcomes compare favorably with the best in the field, especially on such key dimensions such as:

- Success in preventing out of home placement
- Reunification
- Engagement rates
- Customer satisfaction and
- Recidivism

Specific treatment techniques are integrated from empirically supported behavioral and family therapies including eco-structural and emotionally focused treatment. In addition to focusing on the youth, FCT also engages the family in treatment. FCT therapists strengthen the family's problem-solving skills and operant family functioning systems, including how they communicate, handle conflict, meet the needs for closeness, and manage the tasks of daily living that are known to be related to poor outcomes for children/youth. The therapist, in conjunction with the youth, family, and other stakeholders, develops an individualized treatment plan. Using established psychotherapeutic techniques and intensive family therapy, the therapist works with the entire family, or a subset, to implement focused interventions and behavioral techniques designed to:

- Enhance problem-solving
- Improve limit-setting
- Develop risk management techniques and safety plans
- Enhance communication
- Build skills to strengthen the family
- Advance therapeutic goals
- Improve ineffective patterns of interaction
- Identify and utilize natural supports and community resources for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains

FCT's personalized interventions are designed to strengthen the family's capacity to improve the youth's functioning in the home and community with a goal of preventing the need for a youth's admission to an inpatient hospital, psychiatric residential treatment facility, or other treatment setting. FCT utilizes a highly thorough and frequent session schedule to promote change for families with intensive needs.

FCT therapists are expected to provide a minimum of two multiple-hour sessions per week and increase this as indicated by the youth and family's evolving needs. Frequent, intensive therapy in the context of the family/home setting facilitates sustainable change via immediate and on-site enactments or coaching to parents, offering support where and when suggestions are most needed. Phone contact and consultation are provided as part of the intervention. In addition, unlike other in-home models, the first and last month of FCT treatment—joining and discharge respectively—are not tied to the minimum standard due to the titration up and down of service provision.

With FCT, a therapist is available 24 hours a day, seven days a week during each phase of FCT to provide additional support and crisis services as indicated.

When/where applicable, best practice standards of in home therapy are paramount. All FCT therapists are expected to understand and abide by best practice standards for in home therapy including but not limited to safety of client/family/others & self, coordination of services including medical, on-call and crisis service, quick and timely responses to intake of services, and interventions that are timely, accessible, and not experimental in nature.

Population to Be Served

Children with behavioral and/or emotional needs, ages 3-2. There is a mental health or substance use diagnosis, other than a sole diagnosis of I/DD and significant family functioning issues; that would benefit from family systems work.

Entrance Process

Entrance Criteria:

- A. There is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; **and**
- B. there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity).

Child functioning multi-stress situations **as evidenced by difficulties in one or more of the following areas:**

Problem Solving defined as difficulty achieving a variety of basic, developmental and crisis tasks such as problem or task identification, communicating the problem, exploration of alternative solutions, implementation of selected approaches and evaluation of efforts.

Communication, defined as difficulty achieving mutual understanding, and using methods such as indirect, masked and direct and masked and indirect communication making the message ambiguous or clouded.

Role Performance, defined as the ability to fulfill their role as parent, assign roles to family members and carry out behavior of the role.

Affective Responsiveness, defined as the ability to express welfare and emergency emotions, affection, warmth, support, fear anger and disappointment.

Affective Involvement, defined as being secure and autonomous and able to meet the emotional/security needs of each other.

Behavioral Control, as defined by the family's management style in physically dangerous situations, meeting psychological needs and socialization behaviors.

Utilization Management

Continued Stay Criteria:

The beneficiary is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the beneficiary's PCP; or the beneficiary continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.

AND

One of the following applies:

- a. The beneficiary/family is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
- b. The beneficiary/family is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the beneficiary's premorbid level of functioning, are possible; or
- c. The beneficiary/family fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The beneficiary's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

Discharge Criteria:

The beneficiary meets the criteria for discharge if any one of the following applies:

- a. The beneficiary has achieved goals and is no longer in need of FCT services;
- b. The beneficiary's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
- c. The beneficiary is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
- d. The beneficiary or legally responsible person no longer wishes to receive FCT services; or
- e. The beneficiary, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

Eligibility Criteria

Members with emotional and/or behavioral needs; ages 3 to 20. Available only for individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized treatment services.

Treatment Program Philosophy, Goals, and Objectives

The evidence-based model Family Centered Treatment[®] (FCT[©]) is founded in the belief that families seemingly stuck in a downward spiral can make positive, lasting changes. Resilience theory holds that children and families have the capacity to function well in the face of significant life challenges. Because of this belief, all aspects of treatment value the youth and family's voice in the process and employ strength-based approaches that focus on hope rather than on deficits, challenges, and barriers. The intention is to promote permanency goals while preserving the dignity of youth and families within their culture and community.

FCT's origins derive from practitioners' efforts to find practical, commonsense solutions for families faced with forced removal of their children from the home or dissolution of the family, due to both external and internal stressors and circumstances. FCT is an alternative model grounded in the use of sound and research-based treatment. Personalized techniques are integrated from empirically supported behavioral and family therapies and services are provided frequently, with FCT therapists available 24/7 to support the youth and family when needed. Addressing needs while observing strengths and patterns of interaction as they are happening allows skilled practitioners to help families create change in the core components of family functioning.

Another guiding principle of FCT is that it is family centered. While the referred client is integral to the treatment process, FCT is a family system model of home-based treatment, and treatment can and does occur with other members when their behaviors or roles are critical to the progress of the referred family member (client). All phases of FCT involve the family intensively in treatment. During the assessment phase, the family defines their "family constellation," and those members are invited to participate in the structural family assessment and subsequent treatment activities as directed. Other individuals who may have key roles in the youth's wellbeing (e.g., caregivers, stakeholders, psychiatrists, etc.) are also viewed as critical to the success of FCT and are, at minimum, informed of treatment progress. They can be more integrally involved based on the family's need.

In addition, FCT places emphasis on the value of support systems—both during and after treatment. FCT develops a system of community resources and natural supports based on the youth and family's needs and preferences to enhance the individualized treatment plan by providing opportunities for further skill development. Building a network of support will also promote sustainable outcomes by providing the youth and family with resources to utilize after discharge.

The overarching objective of providing FCT to families is to keep children safe and thriving in their home environment. Specifically, the objective of FCT is to provide an alternative to out-of-home placements, minimize the length of stay in out-of-home placements, and reduce the risk of additional out-of-home placements by improving child/youth and family functioning. To achieve this, targeted goals for FCT include:

- Decrease in crisis episodes and inpatient stays
- Decrease in the length of stay in inpatient and crisis facilities
- Decrease in emergency room visits
- Successfully engage families in treatment (target = 85% of families)
- Maintain low recidivism rate (target = less than 10% of clients will require future FCT services minimally six months post discharge because of an increase in sustainability and stability due to focus on family functioning)
- Reduce or eliminate symptoms, including antisocial, aggressive, violent behaviors or those symptoms related to trauma or abuse/neglect
- Achieve permanency goals (target = 80% of clients will either remain in their home, reunite with their family, live independently or have a planned placement upon discharge)
- Improve and sustain developmentally appropriate functioning in specified life domains
- Enable family stability via preservation of or development of a family placement

- Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution
- Reduce hurtful and harmful behaviors affecting family functioning
- Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's intrinsic or unresolvable challenges
- Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the therapist
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability

Service Exclusions

EPSDT Special Provision

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

- 1) That is unsafe, ineffective, or experimental or investigational.
- 2) That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

EPSDT and Prior Approval Requirements

- 1) If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- 2) IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *NC Tracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problem.

Staffing Requirements

Provider Requirements

FCT providers must meet the provider qualification policies, procedures and standards established by the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the requirements of 10A N.C.A.C 27G and NC G.S. 122C, and any competencies specified by the NC Division of Medical Assistance (DMA). Provider must ensure clinicians and staff that provide FCT meet the requirements to deliver FCT. Clinicians performing FCT must be enrolled in the FCT online training system and must complete the first 4 units of training before they can begin seeing families. The clinicians are expected to achieve full FCT certification within their first year of hire/enrollment into the training system.

Provider must be accredited through a national accrediting body or achieve national accreditation within 1 year of contract with the MCO or request a waiver to extend the timeframe to get this completed. This version supersedes previous versions.

In addition, the provider agency must maintain FCT licensure through the FCT Foundation, and all staff must maintain the required certification, which includes all recertification requirements and field observations. The FCT Foundation, monitors and tracks staff training and certification development. Upon successful passing grade completion of the three training components including the Wheels of Change on line audio/visual training course, field-based practice of the required FCT core skills and field-based performance evaluation to assess competency, FCT Foundation will issue certification as an FCT clinician to the staff member.

Provider organizations are required to maintain all other FCT Foundation licensure standards as outlined in a licensure agreement.

Provider organizations must:

- Demonstrate the ability to submit FCT fidelity and adherence documentation for all families in receipt of FCT

- Ensure that a minimum threshold, as set by FCTF Board given stage of implementation, of all active and discharged FCT families have fidelity documentation completed and submitted for *last phase of treatment completed*.

- Ensure that a minimum threshold, as set by FCTF Board given stage of implementation, of all active and discharged FCT families have adherence/dosage documentation completed and submitted for the *last phase of treatment completed*.

Supervision:

Staff must be licensed or associate licensed.

All staff, licensed and associate licensed, must be fully certified in FCT within twelve months of their initial hire via the official FCT certification program, Wheels of Change®. Certification is granted through the Family Centered Treatment Foundation (FCT Foundation) when staff pass and show competence in required components.

- All staff must demonstrate field-based competency in 16 core skills related to the FCT model to complete the full FCT certification process. These field-based competencies are completed during direct observations of the therapist's sessions with clients by a certified FCT Trainer.

- All staff must complete a minimum of 10 hours per year of Continuing Education. This is monitored by the Clinical Director.

- All staff must be recertified in FCT every 2 years

FCT understands that for effective services to implement and perform to scale, effective supervision is essential. Through rigorous training and oversight, FCT supervisors provide critical key clinical oversight to their teams and with guidance through the FCT Foundation. Both peer and individual supervision is provided as part of the FCT model. FCT Supervisors provide supervision of therapists and regional office staff. FCT Supervisors are selected based upon credential qualifications, experience, leadership skills, family systems orientation, and team leadership skills.

FCT therapists receive multiple hours of supervision per week. This is a combination of peer supervision, individual supervision, as well as field and on call supervision support. FCT expectations dictate that therapists should receive no less than two (2) hrs. of supervision per week, but often average five (5) combination hrs. or more. Peer supervision occurs in FCT teams which meet no less than weekly for clinical case supervision and oversight. The FCT Supervisor, designated licensed staff members, or other FCT Directors/Trainers provide individual supervision or consult. The FCT Supervisor is available for on-call to each employee and may refer the employee to other FCT Directors/Trainers for consultation. Each supervision session, whether provided in the field, office, or on the phone (on-call), is recorded by the FCT therapist on a supervision form indicating direction given. The form is signed by the therapist and person providing the supervision and is then entered into the therapist's personnel file.

Use of the national recognized best practices family system's case review process (family mapping, intervention, goals and strategies; aka John Edward's MIGS) is utilized and strategies determined are reviewed during the next team meeting. Weekly team meetings are comprised of FCT Supervisor, and staff who are FCT certified or are in the process of certification, and the FCT Trainer, where applicable. The mixture of expertise, licensure, certification, and experience at each team meeting provides continuity of care, alternative perspectives on treatment, allows for specialty expertise to be brought in at critical junctures AND focuses highly on effective therapist *use of self* (process that examines what the therapists are bringing into the treatment process themselves). Supervision notes, team meeting minutes and case reviews are tracked and monitored for adherence to the model via the FCT Clinical Practice Team.

FCT Management and Supervisory Training

It is required that FCT Supervisors undergo their own FCT Supervision Certification or are enrolled in the FCT Supervisors course and have a minimum of two years of service delivery of FCT or Licensed/Associated Licensed and a Certified Supervisor in FCT or enrolled in the FCT Supervisors course.

FCT's management and supervisory components are integral to the model fidelity and client outcomes that are achieved. Therefore, all direct supervisors of frontline staff are required to complete the FCT Supervisory Certification Course which includes an experiential practice-based component. The requirements for the FCT Management and Supervisory Course also include the successful completion of the online training curriculum as well as the assignments associated with each unit. There are eight units in the online curriculum and FCT Supervisor Certification is overseen by the FCT Foundation.

The FCT Supervision curriculum consists of learning key concepts on how to guide staff in delivering each phase of treatment effectively. There are supervisory documents that help guide the process to ensure that supervisors are adhering to and producing high fidelity to the model.

When applicable, FCT Trainers work weekly with FCT therapists to ensure adherence to the fidelity of the model and assure quality services with field observation. In addition, the trainers model the skill and provides practice experiences to teach and coach therapists. They also observe therapists in the field or via videotape to assess competency in the core required FCT skills. FCT Trainers are expected to undergo a specific process, overseen by the FCT Foundation, to verify Trainer status.

Family Centered Treatment® Training:

The FCT certification program, including Wheels of Change®, ensures that each FCT therapist is trained in the principles of youth-guided, family-driven empowerment and can identify and assess child abuse/neglect, domestic violence, and substance abuse issues, as well as how to assist families affected by past trauma in times of crisis. Wheels of Change® (WOC) is a component of a structured certification process that utilizes the five aspects of training modalities: teaching, observing, performing the required task or skill, being observed with checklists to assess competence, and evaluation. Successful completion results in certification in FCT by the FCT Foundation.

FCT therapists undertake and successfully complete an intensive competency-based, standardized training/certification process. This knowledge-based portion of the certification process includes testing of knowledge, audio visual learning, discussion boards, and videos of core skills in practice. FCT staff are trained in direct mental health services, long- and short-term mental health interventions designed to maintain family stability, individual and family assessments, Community- Based Partnerships, Cultural Competency, individual, family, and

group counseling, individualized service planning, 24-hour crisis intervention and stabilization, skills training, service coordination and monitoring, referrals to community resources, follow-up tracking, and coordination with local stakeholders.

Trauma Focused Training:

Because all families are assessed for trauma at the onset of services, all FCT therapists must maintain a level of competency in this area. In order to demonstrate the skills necessary to assess trauma, staff must undergo comprehensive trauma-based training. These skills include recognizing the presence of trauma through interactions and assessment tools and developing personalized interventions to address trauma as identified. The subjects covered in the guided online Trauma Based Training component of the WOC program units include:

- i. Essential Elements of Trauma Treatment (Why do we utilize Trauma Treatment?)
- ii. Trauma Assessments, FCT Trauma Treatment and Creating a New Narrative
- iii. Practical Tools and Implementation

Field-based practice of the required core skills and supervision occurs simultaneously as trainees take the online course.

Additionally, it is best practice to cite and address trauma and trauma impact in safety plans, when/where applicable.

Expected Outcomes

- Decrease in crisis episodes and inpatient
- Decrease in the length of stay in inpatient and crisis facilities
- Decrease in Emergency Room Visits
- 85% of families will successfully engage in treatment
- Less than 10% of clients will need future FCT services minimally 6 months post discharge because of an increase in sustainability and stability due to focus on family functioning
- 80% of clients will either remain in their home, reunite with their family, live independently, or have a planned placement upon discharge

Targeted Length of Service

National target standards are 6 months, with the national average at 6.4 months (n=>2,000 families) It is important to note that in scenarios where reunification or 'unknown' reunification is the objective the national benchmarks for 6 months of service differs. When permanency or reunification is in question additional time to work with the family/caregivers/child is often warranted, extending the treatment time to 9-11 months. The rationale for this is several fold:

- o Additional time is often needed to assess safety and permanency needs in the early months
- o Frequently systems (courts) exceed 6 months to make a ruling surrounding permanency
- o The underlying complex dynamics of the systems involved: extreme distrust of the agencies and resistance to intervention and treatment require much longer treatment times for developing trust necessary for effective engagement and adjustments that often occur to the permanency plan.

