Family Treatment and Rehabilitation (FT/R)

Therapeutic and Treatment Model Education Session
ACS Children’s Center
June 24, 2019
Overview

- Designed to work with families who have one or more members (parent or youth) with a substance use and/or mental health challenge.
- Uses a team-based approach to assess, diagnose, and treat family members.
Populations Served

• FT/R model addresses the safety and well-being of a child when a parent’s or caregiver’s substance use or mental health challenge places the child at risk of removal from the parent or caregiver.
• Model also serves families in which a child in the home has a substance use or mental health challenge.
• FT/R also serves families with an infant with a positive toxicology.
• Model serves children birth to 18 years old; up to age 21 if exiting foster care.
Core Components

• Casework Contacts
  ▪ Phased approach
• Supervisory review
• Clinical Diagnostic Team
• Standardized screening and assessment tools
Casework Contacts: Phased Approach

- **Initial Phase:**
  - Staff should engage the family, collaborate to determine goals, and monitor safety and risk factors, urine drug screening, and compliance with medication (if appropriate).
  - Families receive at least 2-3 visits per week in the home (at least 6 per month)

- **Baseline Phase:**
  - Families should have achieved a baseline level of sobriety or stability and the focus of the work is to gain a deeper understanding of family dynamics.
  - Families receive at least 1 visit per week in the home.

- **Stabilization Phase**
  - Families have made progress toward goals and contacts are made at a reduced rate.
  - Families receive at least two visits per month in the home.

- **If there is a relapse, contacts increase to initial phase requirements.**
- **Some contacts may be made by specialized rehabilitative or supportive services staff—but if those staff do not make contacts, Case Planners are responsible for all required contacts.**
Supervisory Review

• Supervisor and/or Program Director must document all decisions made regarding a phase change in Connections.
  ▪ Documentation is required in all three (3) phases.
• Supervisor must clearly document the following in the progress notes:
  ▪ The CDT assessment that supports decision to increase or decrease frequency of casework contacts and/or home visits; and
  ▪ The current frequency of contacts in accordance with standards and/or the provider’s decision to move the family to a higher level of contact.
• Supervisor must document information about monthly case reviews and team meetings, including the family’s functioning at the time of each case review or team meeting, in Connections and PROMIS.
Clinical Diagnostic Team (CDT)

The CDT is composed of, but is not limited to:

• Program Director
• Supervisor
• Psychologist or other clinician
• Case Planner
• Case Aide
• CASAC
• Medical staff
• Any consultants the agency has on staff to support the program
Clinical Diagnostic Team (CDT)

• Meets in first 30 days of family’s initial treatment phase to assess needs and inform treatment plan.
  ▪ Determines most appropriate treatment goal(s) for each family member based on assessed needs and/or recommendations from CPS.
• Holds monthly clinical team conferences, for families where monthly reviews are necessary, to review progress, assess ongoing needs, and identify and address barriers to achievement of goals
  ▪ Must be used for any phase changes and for any safety and risk concerns.
  ▪ Can be used to prep for FTCs; address engagement challenges or lack of progress.
• Convenes in the event of a relapse to assess the current safety of and risk to any child(ren) residing with parent or caregiver.
Standardized Screening and Assessment Tools

• Required in initial phase of treatment to develop a service plan that will meet the needs of the family:
  ▪ Modified Mini Screen
    ▪ Mental health screening
  ▪ The UNCOPE
    ▪ Substance use screening
  ▪ The CRAFFT
    ▪ Behavioral health screening for youth under 21
  ▪ ACS Domestic Violence Screening Tool
Staffing Requirements

- Core staff:
  - Program Director
  - Supervisor
  - Case Planners/Therapists
  - Licensed Mental Health Clinician
  - Credentialed Alcohol and Substance Abuse Counselor
  - Case Aides
  - QA/QI Specialists (1 per organization)
  - 2 conference facilitators
- Additional clinical staff available as consultants

- Caseload ratio: 1:8
- Supervisory ratio: 1:4
- Supervisors do not carry cases.
Training Requirements

• ACS-mandated onboarding core training
• Annual trainings as per ACS policies and guidance
• Additional training relevant to FT/R program and population:
  • Indicators of mental health and/or substance use challenges;
  • Identifying and treating youth/adults with mental health and/or substance use challenges;
  • Dual diagnoses
  • Medication (self and prescribed);
  • Adolescent substance use, engagement, and motivation for treatment;
  • Assessment of substance use and/or mental health conditions and impact on parenting
  • Use of standardized assessment tools
Average Length of Service

The average length of service for the FT/R model is 12 months.
Outcomes

Indicated Investigation within 6 months after services (2018 average)

• Special Medical: 4.2%
• General Prevention: 5.0%
• **Family Treatment/Rehabilitation:** 7.2%
• Evidence-based models: 6.4%

Foster care within 6 months after services (2018 average)

• Special Medical: 0%
• General Prevention: 0.65%
• **Family Treatment/Rehabilitation:** 1.0%
• Evidence-based models: 0.8%

FT/R providers will be expected to participate with ACS on a comprehensive evaluation of the model.
Quality Assurance/Quality Improvement

• Each agency will have a Quality Assurance/Quality Improvement Specialist.
• These staff will be expected to participate in the ACS QA/QI Learning Community and APA CQI convenings.
Quality Assurance/Quality Improvement

• Standard QA/QI activities + special attention to:
  ▪ Systems to ensure casework contact and documentation requirements are met for each phase of the FT/R model.
  ▪ Protocols for Clinical Diagnostic Team, to support strong decision-making.
• QA/QI staff will also play a key role in program evaluation activities.
Implementation Support

• Program Officer, Division of Prevention Services
• Best Practices Coaches, Office of Prevention Technical Assistance, Division of Prevention Services
• Clinical Consultation Program, Division of Child Protection
Thank you!

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