A. Short-term Family Integrated Treatment (S-FIT) 9-1-2015

Definition

The Short-term Family Integrated Treatment (S-FIT) service is a brief, 1-15 day residential treatment option providing stabilization and assessment for DCF involved youth experiencing an immediate behavioral health crisis that precludes them from remaining in their existing placement. Rapid crisis resolution and transition back into the home environment is the focus of this service. As such, the primary goals of the program are to: stabilize the youth and family (adoptive, biological, foster, kin, relative) and their extended social system; assess strengths and needs; identify/mobilize community resources; and coordinate services to ensure rapid reintegration into the home. S-FIT serves as an alternative to *unnecessary* emergency department visits, psychiatric hospitalization and higher levels of care and is designed to prevent placement disruptions. The focus of the intervention is on addressing the immediate source of the youth's behavioral dyscontrol while providing targeted assistance to caregivers that will allow them to resume caring for the child safely in the home environment.

S-FIT may also serve as a brief, temporary structured respite placement ranging from one to several hours on a daily basis for youth with behavioral health challenges who are in immediate need of a safe, therapeutically informed placement while alternative plans are made for a more permanent living arrangement.

Authorization Process and time Frame for Services

All youth considered for the S-FIT must be between the ages of 12-17. All children referred to the S-FIT must have a diagnosable behavioral health condition and a viable, identified, caregiver(s) available to participate in the treatment. All Beacon authorization reviews for admission to S-FIT must occur within 2 hours of receipt of referral and supporting documentation. Once authorized, Beacon will contact the identified program to alert them to the referral and share basic clinical information. Parents/Guardians including DCF staff will follow-up with the provider to make admission arrangements and the youth will be transported for admission within 12 hours of authorization. After hours referrals will be handled through the CARE Line for youth DCF involved. All others can be made directly to the SFIT program. Once admitted, the child's care will be monitored by Beacon through concurrent review to ensure treatment and discharge planning is underway and to monitor progress toward reunification with family.

Level of Care Guidelines:

A.1.0 Admission Criteria

A.1.1 Severity of Symptoms and Functional Impairment,

A.1.2 Diagnosable ICD 10 behavioral health disorder

A.1.3 Symptoms and impairment must be a result of a psychiatric or co-occurring substance use disorder,

A.1.4 Acute (within past 48 hours) presentation of the following behaviors consistent with at least one of the following,

A.1.4.1 Recurrent suicidal threats and/or gestures with moderate risk of self-injury; or

A.1.4.2 Recurrent self-mutilation that requires non-urgent medical intervention and that presents some potential for danger, e.g., through infection; or

A.1.4.3 Recurrent deliberate attempts to inflict serious injury on another person; or

A.1.4.4 Reckless behavior suggesting an unwillingness to consider potential for risk to self or others (e.g. fire setting, psychosexual behavior problems; reckless driving; and other risk-taking behavior;) or

A.1.4.5 Impulsive, defiant, antagonistic or provocative behavior with potential for risk to self or others; or

A.1.4.6 Agitated and uncontrolled behavior including acts of violence against property or persons; or

A.1.4.7 Dangerous or destructive behavior; or

A.1.4.8 Recurrent psychotic symptoms/behavior that pose a significant risk to the safety of the child/adolescent or others, or markedly impaired functioning in one or more domains; or

A.1.4.9 marked mood lability resulting in severe functional impairment; or

A.1.4.10 intimidation/threats of aggression with moderate to high likelihood that they will be acted upon and result in serious risk to others.

A.2.0 Intensity of Service Need

A.2.1 Individual requires structured, therapeutically informed out of home treatment <u>without</u> 24-hour medical monitoring as evidenced by either:

A.2.1.1 The above symptoms cannot be contained, attenuated, evaluated and treated in a home type living situation with any combination of outpatient and intensive ambulatory services due to :

A.2.1.1.1 Child/Adolescent presents moderate risk for requiring restraint/seclusion as evidenced by the use of such during the 7 day period immediately preceding admission. Restraints could be administered with fewer than 3 persons and did not present high risk of serious injury to self or others. Seclusions were not locked; or

A.2.1.1.2 Child/Adolescent requires 24-hour awake supervision in order to safely manage behaviors in above or due to high AWOL risk, or

A.2.1.2 Documented efforts to provide intensive community-based treatment (e.g., , extended day treatment/intensive outpatient treatment, home-based services, intensive intervention within the school environment) while the child is living in a home type setting*.(,e.g., birth, relative, adoptive, foster, therapeutic foster, or group home*) have been implemented within the past month and have not resulted in safe, manageable behavior in the home setting; or

A.2.1.3 Necessary, less restrictive intensive community-based services needed to support the child/adolescent in a home setting are not currently available and clinical issues require this level of care as an appropriate alternative.

A.3.0 Continued Care Criteria

A.3.1 Severity of Illness

A.3.1.1 Symptoms and impairment must be a result of a psychiatric or substance use, or developmental disorder,

A.3.1.2 Clinical or treatment circumstances consistent with one of the following:

A.3.1.2.1 Child/Adolescent has exhibited behavior consistent with admission criteria within the past 48 hours; or

A.3.1.2.2 Child/Adolescent has been prevented from engaging in above qualifying behavior due to use of 1:1 supervision, frequent checks (q15), physical restraint or locked seclusion; or

A.3.1.2.3 Child/Adolescent's history, current presentation, and treatment progress strongly suggest that discharge to a lower level of care presents a high likelihood of deterioration in the patient's condition, high-risk behavior, and the inability to continue to make progress on treatment goals. This might be evidenced by notable deterioration in behavioral functioning during or immediately following contact with caregiver or during transitions to and from school.

A.3.2 If the child/adolescent does not meet the above criteria, continued treatment may still be authorized under the following circumstances:

A.3.2.1 Child/adolescent has clear behaviorally defined treatment objectives that can reasonably be achieved within 3-5 days and are determined necessary in order for the discharge plan to be successful, and there is no less restrictive environment in which the objectives can be safely accomplished; or

A.3.2.2 Child/adolescent can achieve certain treatment objectives including appropriate pharmacological treatment, in the current level of care and achievement of those objectives will enable the child/adolescent to be discharged directly to the community rather than to another restrictive setting; or

A.3.2.3 Child/adolescent is expected to transfer to another family or treatment setting within 3-5 days of anticipated or designated discharge date and continued stay at this level of care, rather than an interim placement can avoid disrupting care and compromising the stability of the child/adolescent. Continued stays for this purpose may be as long as 5 days; or

A.3.2.4 Child/adolescent is scheduled for discharge, but the community-based aftercare plan is missing critical components. The components have been vigorously pursued but are not available (including but not limited to such resources as placement options, psychiatrist or therapist appointments, therapeutic mentoring, etc.). Referral to the child's DCF Area Office for review by the Managed Service System is indicated.

Note: Making of Level of Care Decisions

In any case in which a request for services does not satisfy the above criteria, the ASO reviewer must then apply the document Guidelines for Making of Level of Care Decisions and in these cases the child/adolescent shall be granted the level of care requested when:

1) Those mitigating factors are identified and
2) Not doing so would otherwise limit the child/adolescent ability to be successfully maintained in the community or is needed in order to succeed in meeting child/adolescent treatment goals.