



P.O. Box 25010
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Family-Centered Treatment in Lieu of Service Program Requirements for Providers Effective January 1, 2026 (pending CMS approval)

For Arkansas Total Care requirements for referral and authorization: Refer to AR.CP.BH.504 Family-Centered Treatment in lieu of Service. All Family-Centered Treatment for Arkansas Total Care members must be pre-authorized before service starts.

Description of Service:

Family-Centered Treatment® (FCT) is a comprehensive, evidence-based trauma treatment model of intensive in-home services for at-risk children, adolescents, and their families. FCT is a preventive stabilization and reunification service designed to end cycles of maladaptive family functioning and break the multi-generational transmission of trauma. FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement, and other community-based services.

This is a time-limited, intensive intervention that is intended to accomplish the following as applicable:

- Prevent out-of-home placement for the member.
- Ensure successful transitions of care from residential services to home settings.
- Reduce presenting psychiatric or comorbid disorder symptoms.
- Provide initial and ongoing crisis response interventions.
- Ensure linkage to community services and resources.
- Improve youth and family functioning.

Children and adolescents eligible for FCT may be involved in the juvenile justice system, child welfare system, residing in out-of-home placements and in need for reunification, and may display severe emotional and behavioral challenges due to maltreatment (neglect, abuse), trauma (from domestic violence, sexual abuse, substance abuse, etc.), and/or serious mental health disorders. By improving youth and family functioning, FCT may be used:

- As a step-down program for youth leaving residential placements;
- To provide an alternative to out-of-home placement;
- When it is in the youth's best interest to receive services out of the home; or,
- To minimize the length of stay and reduce the risk of readmission.

FCT is one of few multifaceted home-based service models with extensive experience with youth with severe emotional and behavioral challenges, child welfare needs, and mental health diagnoses, as well as histories of delinquent behavior, otherwise known as crossover youth. FCT providers are expected to adopt a “no reject, no eject” admission approach and provide 24/7 crisis services as needed.



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Another guiding principle of FCT is that it is family centered. While the referred client is integral to the process, FCT is a family system model and includes family members when their behaviors or roles are critical to the progress of the referred family member (client). FCT highlights the importance of family voice and caregiver empowerment. By engaging the family system into services, FCT strengthens the family's problem-solving skills and operant family functioning systems, including how they communicate, handle conflict, meet the needs for closeness, and manage daily living tasks that are known to be related to poor outcomes for children/youth. The caregiver must be an active participant in the development of goals and delivery of interventions throughout services.

FCT places emphasis on support systems — both during and after services. FCT develops a system of community resources and natural support based on the youth and family's needs and preferences to enhance the individualized treatment plan. Building a network of support will also promote sustainable outcomes by providing the youth and family with resources to utilize after discharge. Other individuals/supports that may have key roles in the youth's wellbeing (e.g., caregivers, immediate and extended family, community members, stakeholders, psychiatrists, referral sources, other providers, community programming, etc.) are also viewed as critical to the success of FCT and are, at minimum, informed of progress. They can be more integrally involved based on the family's needs and preferences.

Family-Centered Treatment Goals and Objectives:

1. Enable family stability via preservation of or development of family placement or reunification by fostering necessary shifts in family functioning that underly the causes of family dissolution.
2. Address maladaptive behaviors affecting family functioning by experientially practicing new interactions and learning the underlying function of the behaviors while developing an emotional and functional balance so the family can cope effectively with present and future challenges.
3. Support discovery and effective use of the intrinsic strengths necessary for sustaining change and upholding stability by incorporating generational, cultural and systemic influences of trauma while harnessing the power of giving and instilling hope.

Four Phases of Treatment

FCT is comprised of four phases, with the entire family system and support networks being intentionally engaged across all phases.

- Phase 1, Joining and Assessment: Rapport building, especially with the caregiver(s), identify family strengths, gain acceptance and trust, and assess for systematic changes and adjustments. (Family-Centered Evaluation)
- Phase 2, Restructuring: Enactments (experiential practice) target repetitive emotional and behavioral patterns (e.g., family structure) to shift and develop healthier, more



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functional patterns. The family progressively takes ownership of the problems, a necessary prerequisite for progressing to Phase 3.

- Phase 3, Valuing Change: The family is challenged to question and define the reasons for the change. Sustainable change in a family system occurs when the emotional-behavioral changes made during restructuring are valued, seen as necessary by the family and thereby internalized.
- Phase 4, Generalization: Skill adoption and family success. The family becomes able to use strategies independently and plan how they will use their new competencies and confidence to navigate future predictable and unpredictable challenges.

Trauma in Families

FCT is an identified SAMHSA [National Child Traumatic Stress Network](#) (NCTSN) trauma intervention. Trauma, particularly in vulnerable families, often affects both individuals and the entire family system, leading to issues such as anxiety, depression, behavioral problems, and interpersonal conflict. FCT addresses the impact of trauma on the whole family, not just the individual. By focusing on healing the family dynamic, FCT helps strengthen relationships, improve communication, and promote long-term recovery.

How FCT Addresses Trauma

FCT recognizes that trauma does not just affect one person in isolation, but ripples through the family structure, affecting communication patterns, parenting styles, and conflict resolution strategies. Trauma-informed approaches in FCT help families:

1. **Understand the impact of trauma:** Family members learn how trauma influences their behavior, emotional responses, and relationships. This includes exploring how past traumatic events influence current family dynamics, particularly in areas like communication and problem-solving.
2. **Address trauma in the context of family roles:** FCT works with the family system to highlight how roles and behaviors within the family may be shaped or even reinforced by past trauma. This could include understanding why certain members may withdraw, react aggressively, or engage in maladaptive behaviors.
3. **Build resilience and coping strategies:** By helping families process their trauma in a safe, supportive setting, FCT fosters resilience and develops coping mechanisms that are both individual and systemic. The goal is to help the family function better despite the challenges posed by trauma.
4. **Integrate trauma-based interventions:** Trauma-informed interventions are woven into the process, such as trauma processing, cognitive-behavioral techniques, and strategies to reduce re-traumatization. These interventions are tailored to the specific needs of the family and its members.

Best Practice



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When/where applicable, best practice of in-home services are paramount. All FCT practitioners must understand and abide by best practice for in-home services including but not limited to: safety of client/family/others and 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. FCT-licensed organizations will follow the best practices outlined in “A Core Elements Approach to Child Welfare In-Home Services,” a publication by the National Resource Center for In-Home Services. The publication can be accessed [here](#).

Target Population

Children with behavioral and/or emotional needs who are transitioning from out-of-home placements, who are at risk for out-of-home placements, who have multi-system involvement (behavioral health/mental health, child welfare, juvenile justice), and/or who have family system issues that are causing functional impairment across one or more life domains that are not able to be addressed at an outpatient level are the target population. FCT is utilized with voluntary and involuntary referrals. FCT practitioners are highly trained in techniques to engage with families who have been reluctant to engage in services.

Characteristics of Population to be Served (Including Clinical and Demographic):

Families that may be an appropriate referral to FCT include but are not limited to the following, and must meet medical necessity as defined by the applicable PASSE:

- Families that have not fully engaged in previous treatment modalities.
- Significant family functioning issues resulting in functional impairments.
- Member stepping down from a higher level of care.
- History of child welfare involvement in the last 12 months.
- History of juvenile justice involvement in the last six months.
- History of youth experiencing a behavioral health emergency room visit and/or hospitalization in the last six months.
- History of multiple school suspensions within the last 12 months.
- History of crisis intervention in the last six months (may include, but is not limited to: law enforcement involvement, crisis line calls, mobile crisis services, hospitalization, emergency crisis bed stay).
- History of physical/verbal/sexual/emotional abuse.
- History of physical/emotional neglect.
- Parent or caretaker with substance use diagnosis.
- Parent or caretaker is a survivor of domestic violence.
- Parent or caretaker with a mental health diagnosis.
- The loss of a parent or caretaker to divorce, abandonment, or death.
- Parent or caretaker is incarcerated.



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- A traumatic event or developmental trauma that is significantly impacting the stability of the family or individual members of the family.

Services Included in the FCT Model

Designed to promote permanency goals and to reduce length of stay in residential facilities, FCT treats the youth and their family through individualized therapeutic interventions that promote the overall health and well-being of the entire family system.

- Family-based trauma services
- Youth and family skills training
- Behavioral interventions
- Analysis of maladaptive behaviors that lead to home disruption
- Implementation of behavior plans
- Relationship/attachment building between youth and family members
- Active coaching with family members to identify and replace maladaptive behaviors with new positive behaviors
- Empowering families to develop goals for themselves toward improving family functions
- Crisis interventions 24 hours per day, seven days per week

In order to facilitate the integrated, systemic work inherent to the FCT model, intensive case management services are required. These services include:

- Psychoeducation: Impart information about the member's diagnosis, condition, and services to the member, family, caregivers, or other individuals involved with the member's care
- Initial and ongoing assessment, including data collection and progress reporting
- Initial and ongoing service planning
- Linkage and referral to paid and natural supports
- Case consultation and coordination across multiple involved agencies, when applicable
- Collaboration with the PASSE Care Coordinator

The practitioner, in conjunction with the youth, family, and other stakeholders, develops an individualized FCT service plan. Using established psychotherapeutic techniques and intensive family systems interventions, FCT works with the entire family, or a subset, to implement focused interventions designed to target the intersection of trauma symptomology and the areas of family functioning. Families participate in pre-mid-post-trauma/family functioning assessments for service planning and progress reporting.

FCT services include both direct face-to-face and indirect contacts, and collaboration with various stakeholders such as schools, child welfare, juvenile justice, primary care, other providers, and other relevant systems. However, most contacts are direct, either with the individual or other family members. FCT is an in-person service. Telehealth is only allowable



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under the direction and written approval of the FCT Foundation and the PASSE and should be minimal and time-limited if needed.

Communication between involved agencies and the licensed FCT provider is required at least monthly, or more often if needed, throughout FCT services. At a minimum, communication includes participation in the Child and Family monthly meeting. Involved agency participation is encouraged for Care Coordinators, DCFS/DYS case workers, probation officers, court-appointed Special Advocates, and outpatient behavioral health providers. Discharge planning will be a critical part of transitioning, and all agencies need to collaborate and include the family in the development of aftercare planning.

Services Outside of the FCT Model

A) For Arkansas Total Care members:

- i. A mental health evaluation completed by a licensed mental health professional employed by the licensed FCT provider resulting in a mental health diagnosis shall be utilized to indicate eligibility for FCT services and inform a referral for FCT services.
- ii. An FCT referral may be completed by the current outpatient mental health provider, inpatient provider, PASSE Care Coordinator, child welfare worker, juvenile justice worker, or other involved community agency representative.
- iii. The FCT provider accepting the referral is responsible for completing the Prior Authorization process with Arkansas Total Care.
- iv. If a child is preparing to discharge to a caregiver's home directly from a residential setting, and if FCT services are pre-approved by the PASSE, the FCT practitioner may begin FCT services during the time the child is on therapeutic home visits up to 45 days prior to discharge and the encounter billing rate may be used for each day an FCT-specific service is provided in the home setting.
- v. A child should continue to receive medically necessary outpatient mental health services such as individual therapy and/or medication management. This is not a requirement of the FCT model, although Arkansas Total Care requires individuals to receive therapy during the FCT course of treatment. If outpatient services are necessary, they may be billed separately from the monthly FCT rate. If this applies, the outpatient mental health service provider must have an up-to-date treatment plan that reflects FCT services are taking place.
- vi. Clinical responsibility and oversight, including crisis responses, of the client referred to FCT services only transitions to the FCT provider after the initiation of FCT services begins.

B) If the child is not already in a PASSE, they are not eligible for FCT services. In those cases:



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- i. A mental health diagnosis/evaluation must be completed by a licensed mental health professional. This may be billed under the fee-for-service Counseling and Crisis Services Manual.
 - ii. The mental health diagnosis/evaluation must contain recommendations about the type of outpatient or specialty services that would benefit the child and reduce or alleviate mental health and/or behavioral symptoms.
 - iii. Based on the outcome and clinical opinion of the licensed mental health professional, if the child is determined to be in need of HCBS, that child must be referred for an Independent Assessment.
 - iv. If the child is placed in a PASSE, then a referral for FCT services may be completed and forwarded to an agency who provides FCT services.
 - v. If the FCT service provider agrees with the need for FCT services, that agency will complete the Prior Authorization process and submit it to the assigned PASSE.
 - vi. If the Prior Authorization is approved by the PASSE, FCT services can begin.
- C) During the provision of FCT services, no other HCBS should be provided. Only services from the Arkansas Medicaid Provider Manual for Counseling and Crisis may continue, if medically necessary.

Service Frequency, Intensity, and Duration

Services include both direct face-to-face and indirect contacts and collaboration with the school or other involved systems. However, most contacts are direct, either with the individual or other family members. Generally, FCT practitioners provide a minimum of two direct multi-hour sessions per week and adjust this as indicated by the youth and family's evolving needs. Service intensity is monitored by the FCT Foundation. Service duration is approximately six months. However, duration of services may be extended due to clinical complexity. Temporary use of virtual support must be pre-approved by the FCT Foundation. Services must include 85% of direct clinical work with the family.

Expected Outcomes:

- Decrease in trauma symptomology
- Decrease in psychiatric or substance use disorder symptoms
- Reduction of hurtful and harmful behaviors affecting family functioning
- Improved functioning in the home, school, and community settings
- Increased utilization of learned coping skills and social skills
- Increased utilization of natural supports in the community
- Increased capacity to monitor and manage behavior
- Increased rates of family engagement in services
- Increased rates of permanence
- Decrease in the number of crisis episodes requiring psychiatric emergency department and psychiatric inpatient stays



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- Decrease in the length of stay in out-of-home placements (e.g., inpatient, crisis facilities, group homes, Psychiatric Residential Treatment Facility (PRTF) care, and other residential placements)

Targeted Length of Service: Six months on average

Utilization Management

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to eligible beneficiaries. Refer to policy ARTC.UM.21 Family-Centered Treatment in Lieu of Service on Arkansas Total Care's requirements for Prior Authorization.

Continuation of Benefits

The client 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 client's plan of care and Person-Centered Service Plan; or the client continues to be at risk for out-of-home placement due to a mental health diagnosis based on current clinical assessment, history, and the tenuous nature of the functional gains. Additionally, the client must continue to meet medical necessity criteria as established by the applicable PASSE, and one of the following applies:

- The member/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 Treatment Plan and Person-Centered Service Plan; or,
- The member/family is making some progress, but the specific interventions in the Treatment Plan need to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible; or,
- The member/family has yet to make progress, or demonstrate regression, in meeting goals through the interventions outlined in the Treatment Plan. The member's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations should be revised based on the findings. This includes consideration of alternative or additional services.

FCT is designed to be a time-limited service. Therefore, all requests to extend services beyond six months will be carefully reviewed for appropriateness on a case-by-case basis.

Discharge Criteria

The member meets the criteria for discharge if support systems for the family have been put into place, and any one of the following applies:

- The member has achieved goals and is no longer in need of FCT services; or,



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- The member's level of functioning has improved with respect to the goals outlined in the Treatment Plan, inclusive of a transition plan to step down to a lower level of care; or,
- The member is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services; or,
- The member or legally responsible person no longer wishes to receive FCT services; or,
- The member, based on presentation and lack of improvement despite modifications in the Treatment Plan, requires a more appropriate best practice treatment modality.

FCT Staffing and Program Requirements

FCT is delivered by an assigned Qualified Behavioral Health Professional (QBHP) with a human service-related bachelor's degree. The QBHP is FCT-certified or in the process of completing FCT certification. An FCT practitioner caseload must allow each family to receive adequate service intensity and allow practitioners to respond to urgent needs and crises. For a fully dedicated practitioner, this is usually four to six cases. Five cases, on average, are ideal with practitioners going up to a sixth case when they have a family nearing discharge.

FCT team members are required to have supervision by a licensed individual who has attained their FCT supervisor certification, or a supervisor in the process of completing FCT supervisor certification. FCT supervisors may supervise up to 10 FCT practitioners. FCT practitioners and supervisors sit on an FCT team that meets weekly to conduct peer supervision, case consultations, trainings, and other tasks as directed by the FCT Foundation.

In addition, the provider agency must be licensed by the FCT Foundation to provide FCT services. Providers must comply with all standards set forth in their FCT License Agreement. All staff must maintain the required certification, which includes all recertification requirements. The FCT Foundation monitors and tracks staff training, supervision, and skill development, all of which is documented by the Foundation and/or the FCT supervisor. Upon successful passing grade completion of the three training components, including the Wheels of Change® online audio/visual training course, demonstration-based competency of the required 16 FCT core skills, and demonstration-based performance evaluation to assess competency, the FCT Foundation will issue certification as an FCT practitioner to the staff member. Once a practitioner is certified, evaluation of their skill and performance does continue via the use of ongoing supervision, team meetings, and family feedback.

The FCT Foundation has processes developed to monitor individual practitioners, as well as the overall agency's performance, to ensure fidelity to the FCT model.

Training and Certification

The FCT training and certification program, including Wheels of Change, ensures that FCT staff are 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



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assist families affected by past trauma. Wheels of Change is a component of a structured certification process that utilizes the five aspects of training modalities: teaching, observing, performing the required task or skill, observation with structured feedback to assess competence, and evaluation. Successful completion results in certification in FCT by the FCT Foundation.

FCT staff complete an intensive online competency-based, standardized training 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 staff must develop and maintain trauma service competency. To demonstrate the skills necessary to assess and address 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 Wheels of Change 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

Demonstration-based competency 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.

FCT Practitioner Training

All FCT practitioners must be fully certified in FCT within 12 months of their initial hire via the official FCT certification program, Wheels of Change. The FCT Foundation grants practitioner certification when practitioners pass and show competence in 16 different required components using a variety of methods such as skills-based competency training, peer and individual supervision, and monitoring of FCT-developed quality assurance measures. All practitioners must complete recertification per the organization's signed FCT License Agreement.

FCT Supervisor and Leadership Training



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FCT's management and supervisory components are integral to the model fidelity and client outcomes that are achieved. All FCT supervisors must be fully certified in FCT supervision within 12 months of their initial hire via the official FCT certification program, Wheels of Change. The FCT Foundation grants supervisor certification when supervisors pass and show competence in required components. All supervisors must complete recertification per the organization's signed FCT License Agreement.

The FCT supervision curriculum guides staff in delivering each FCT phase effectively and teaches supervisors how to develop highly competent and committed practitioners. There are supervisory documents that help guide the process to ensure that supervisors are adhering to and producing high fidelity to the model.

FCT Trainer (Levels 2–4) Training:

All FCT trainers must be fully certified in their trainer certification within 12 months of starting their specific trainer regimen (Level 2, 3, or 4) via the official FCT certification program, Wheels of Change. The FCT Foundation grants trainer certification when practitioners pass and show competence in required components. All practitioners must complete recertification per the organization's signed FCT License Agreement.

FCT trainers work weekly with FCT staff to ensure adherence to the fidelity of the model and ensure quality services with FCT session observation. In addition, the trainers model the skill and provide practice experiences to teach and coach FCT staff. They also observe staff in the community or via video recordings 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.

FCT Supervision

FCT includes supervision by a certified/trained FCT supervisor. Both peer and individual supervision is provided as part of the FCT model. All providers are required to adhere to the supervision guidance and standards provided by the FCT Foundation. FCT supervisors provide supervision of FCT and regional office staff. FCT supervisors are selected by the provider based on credential qualifications, experience, leadership skills, family systems orientation, and team leadership skills.

FCT practitioners receive a minimum of two hours of peer supervision and individual supervision based on practitioners' performance on a weekly basis. This is a combination of peer supervision (FCT team), individual supervision, and in-session and on-call supervision support. Peer supervision occurs in FCT teams that 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 consultation. The FCT supervisor is available to each employee and may refer the employee to other FCT directors/trainers for consultation. Each supervision session, whether provided in the community, office, or on the phone (on-call),



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is recorded by the FCT practitioner on a supervision form indicating direction given. The form is signed by the FCT practitioner and person providing supervision and is then entered into the FCT practitioner's personnel file.

FCT incorporates situational leadership skills that teach supervisors to attenuate supervision based on practitioners' performance and demonstrated skill level. A new practitioner, or one with performance concerns, needs more one-on-one supervision than a competent, confident FCT-certified practitioner. FCT supervisors, and ultimately, the agency's Clinical Director, are responsible for ensuring staff are providing FCT services within their scope of practice, regardless of whether they are licensed to practice independently.

Use of the nationally recognized best practices family system's case review process (family mapping, intervention, goals, and strategies (John Edward's MIGS)) is utilized, and strategies determined are reviewed during team meetings and individual supervision. Weekly team meetings are comprised of FCT supervisor, 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 services, allows for specialty expertise to be brought in at critical junctures, and focuses highly on effective FCT practitioners' use of self. Supervision notes, team meeting minutes, and case reviews are tracked and monitored for adherence to the model via the provider QA process and FCT Foundation implementation process.

This model supports an average caseload of five families at any given time. Experienced practitioners may be assigned to six families on a short-term basis, such as in the case of one family being close to transitioning out of FCT services, but there is a new family that needs to be assigned to start services quickly. However, less experienced practitioners may be able to effectively serve four families, such as in the case of the practitioner having an overly complex family or serving a large geographical region. The FCT supervisor is responsible for identifying and assuring appropriate caseload sizes for each practitioner.

Staff providing FCT services and carrying a full caseload of five families may not provide other HCBS during the same timeframe.