ATTACHMENT A

MENTAL HEALTH SERVICES CATEGORIES AND PROGRAM INFORMATION

Instructions

The Sonoma County Department of Health Services (DHS), Behavioral Health Division (BHD) is accepting applications to provide treatment services to youth and transition age youth clients with serious emotional disturbance and serious and persistent mental illness. Please review the following youth continuum level of care information and requirements in preparation for your application.

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BACKGROUND AND PURPOSE OF RFA

The County seeks to award a contract or multiple contracts to Mental Health Youth Services programs that enable the Mental Health Plan (MHP) to accomplish the following:

- Provide appropriate coverage and capacity across all regions of the county; applications that support the County's efforts to provide services in West County (Monte Rio, Guerneville, Sebastopol), North County (Cloverdale, Windsor, Healdsburg), Central County (Santa Rosa), South County (Cotati, Petaluma, Rohnert Park), and East County (Sonoma Valley) are of particular importance.
- Provide bi-lingual, bi-cultural, and culturally sensitive/competent services where appropriate.
- Provide services to children and youth ages 0 through age 20 and Transition Age Youth ages 18 through age 25.
- Provide services to underserved populations including children ages 0 – 5, LatinX and LGBTQQI populations.
- Promote continuity of care; CBOs or collaborations of CBOs that provide the most complete range of services will be better positioned to provide continuity of care for clients whose needs change over time.
- Support program and service delivery models that are proven to be effective; proposers that utilize Evidence Based Practices (EBP) and can demonstrate their ability to implement those practices with fidelity are desired.

YOUTH SYSTEM CONTINUUM OF CARE

DHS-BHD seeks to maintain a robust continuum of support for youth consumers of Specialty Mental Health Services. This continuum includes the following:

- Outpatient Services: including clinic & home-based specialty services, services in support of Full-Service Partnership (FSP) services, and newly required Behavioral Health Services Act (BHSA) and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) evidence-based practices (EBPs) that include:
    - High Fidelity Wraparound (HFW), Functional Family Therapy (FFT), Multisystemic Therapy (MST), Parent Child Interaction Therapy (PCIT),
    - Coordinated Specialty Care (CSC) for first episode psychosis; First Episode Psychosis (FEP) services.
- Day Treatment Services: including Day Treatment Rehabilitative (DTR) and Day Treatment Intensive (DTI) services
- 0-5 Assessment and Access Services
- Assessment & Reassessment Services - Child & Adolescent Needs & Strengths (CANS), Adult Needs and Strengths Assessment (ANSA)
- Other Specialty Services: including Eating Disorder Treatment Intensive Outpatient Programs (IOP) and outpatient programs, Transcranial Magnetic Stimulation (TMS) programs, and Supported Employment programs for Transition Age Youth (TAY)
- Eating disorder residential treatment

Eligible Locations

The County will consider applications from organizations proposing to deliver Specialty Mental Health Services (SMHS) in community-based settings that support children, youth, and nonminor dependents, including but not limited to:

- Intensive Services Foster Care (ISFC) homes — when the applicant demonstrates the capacity to meet all MediCal SMHS requirements, including clinical supervision, documentation, quality assurance, and adherence to the Core Practice Model.
- Transitional Housing Placement (THP/THPP+) programs — when the applicant proposes to deliver SMHS onsite or in conjunction with their housing program and meets all applicable MediCal and County standards.
- Other community-based program sites that can support the delivery of outpatient, Intensive Care Coordination (ICC), In-Home Behavioral Supports (IHBS), Therapeutic Behavioral Services (TBS), or related SMHS.

Designation as an ISFC or THP/THPP+ provider does not guarantee approval or contracting for SMHS. Applicants must independently demonstrate compliance with all MediCal, DHCS, and County Mental Health Plan requirements for service delivery, staffing, documentation, billing, and quality oversight.

The County reserves the right to approve, conditionally approve, or decline to contract with any applicant based on demonstrated qualifications, capacity, and alignment with system needs.

YOUTH SYSTEM METRICS

Quarterly census for the last three fiscal years:

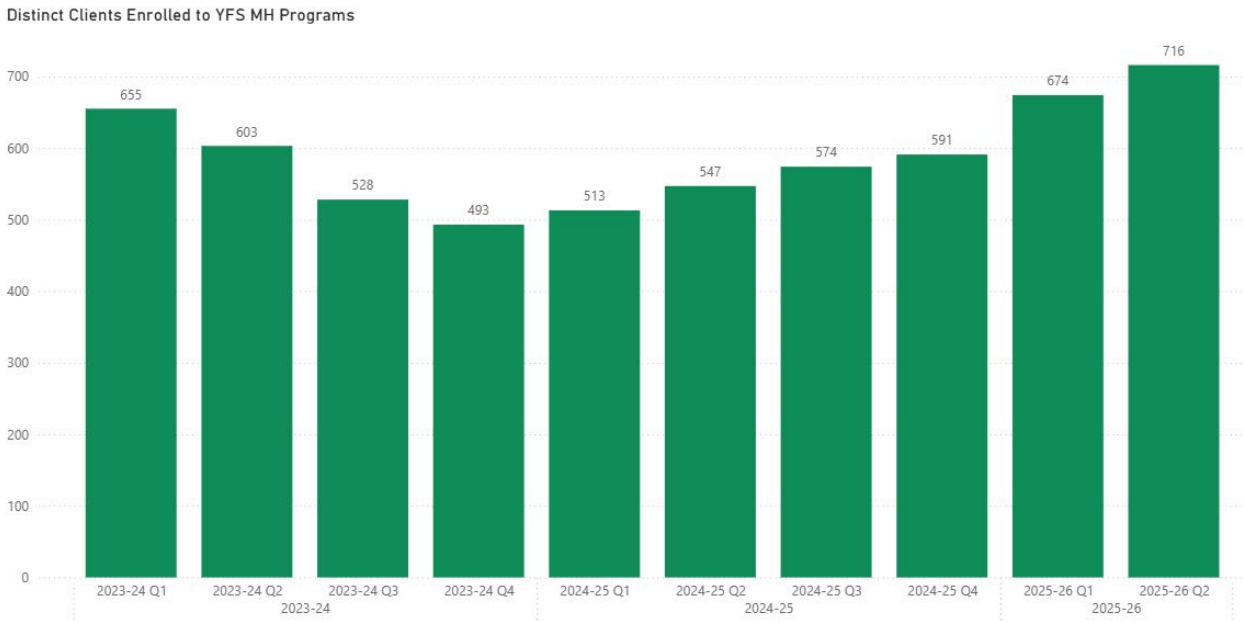

Figure 1. Quarterly Youth Specialty Mental Health Census. This chart displays the number of youth receiving Specialty Mental Health Services each quarter over the past

three fiscal years. The graph illustrates overall utilization trends across the County, showing periods of growth and decline in the number of youth served. The data is intended to demonstrate historical demand for youth behavioral health services and assist applicants in understanding service capacity needs.

Outpatient Programs quarterly census, organized by county and community-based organization, follows:

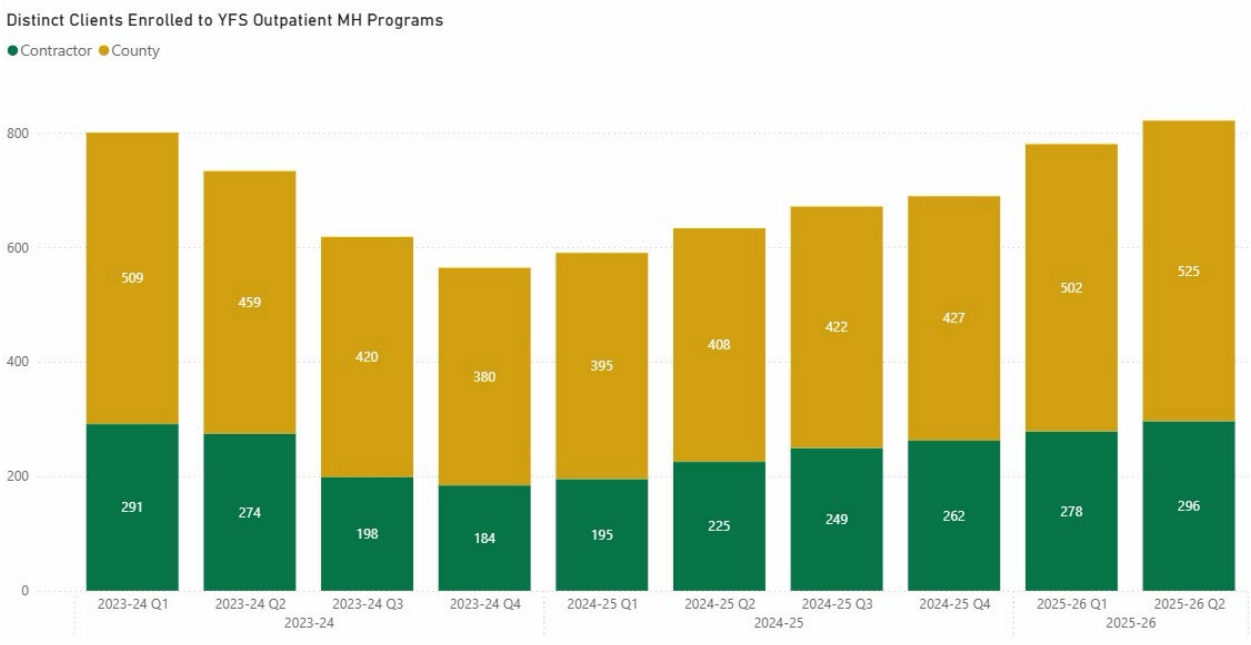

Figure 2. Quarterly Outpatient Program Census by Community-Based Organization. This graph compares the number of youth served by each contracted community-based outpatient provider over multiple quarters. The chart highlights differences in program utilization among providers and illustrates changes in service volume over time. The information is provided to demonstrate existing system capacity and identify opportunities for expanding outpatient services.

1.0 OUTPATIENT SERVICES

OUTPATIENT SERVICES OVERVIEW

Outpatient specialty mental health services are mental health treatments delivered outside of a hospital setting, designed for individuals who don't require 24/7 care. These services are typically provided in settings like doctor's offices, community clinics, schools, clients' homes, or field-based community programs. They encompass a range of treatments, including individual, family, and group therapy, medication management, and other rehabilitative services aimed at improving mental health and functional abilities. Outpatient services, particularly psychotherapy, can be delivered by community-based organizations or professionals in private practice, as a part of the county's provider network. Agencies and professionals who provide specialized services such as eating disorder treatment, services to LGBTQ+ youth, co-occurring mental health and substance abuse treatment, services in Spanish and others are needed.

Key aspects of outpatient specialty mental health services include:

LOCATION

Services are delivered in non-hospital settings like clinics, community programs, homes, schools, or supported housing programs (TAY population only).

TREATMENT TYPES

This may include therapy (individual, group, family), medication management, case management, rehabilitative and crisis support. Examples of services include assessment, treatment planning, therapy, medication support, crisis intervention, psychosocial rehabilitation, and targeted case management.

TARGET POPULATION

These services are for children and youth with high-moderate to severe levels of need, ages 0-21 years, and Transition Age Youth (TAY) ages 18 – 25, with diagnosed mental health conditions, including but not limited to, depression, anxiety, bipolar disorder, and psychotic disorders. Child and youth services necessarily address the family as well.

GOAL

The aim is to reduce symptoms, improve functioning, and support individuals in managing their mental health conditions, often to avoid hospitalization, out-of-home placements, arrests & incarceration.

REHABILITATIVE FOCUS

Services are designed to restore or improve a youth's ability to perform skills they previously had, correct or ameliorate a youth's mental health condition, even if the condition is not fully cured, or maintain a youth's mental health condition, compensate for a mental health problem, prevent it from worsening or prevent the development of additional mental health problems.

COLLABORATION

Outpatient services typically involve collaboration with other professionals, such as primary care physicians, housing services providers, eligibility specialists, teachers & education specialists, and legal advocates.

1.1 OUTPATIENT MODERATE INTENSITY (NON-FSP)

Programs at the high-moderate, non-FSP level of care provide an array of services to children, youth, and their families identified as needing a service constellation that is less than that provided by an FSP.

TARGET POPULATION

Children, youth with at least one behavioral health need, and two functional needs or 1 functional need and 1 risk factor.

Behavioral Health Needs	Functional Needs	Risk Factors
• Psychosis • Impulsivity/ Hyperactivity • Depression • Anxiety • Oppositional • Conduct • Anger Control • Adjustment to Trauma • Eating Disturbance	• Family Functioning • Living Situation • Social Functioning • Decision-Making • Independent Living Skills for TAY • School Behavior • School Attendance • Sexual Development	• Suicide Risk • Non-Suicidal Self-Injurious Behavior • Other Self-Harm (recklessness) • Danger to Others • Sexual Aggression • Delinquent Behavior • Runaway • Intentional misbehavior

SERVICE LIST

- Rehabilitative Mental Health Services (community and/or home-based)
- Outpatient Therapy and Mental Health Services (assessment and plan development)
- Targeted Case Management Services to assist clients with connecting to:
    - Specialized Educational Services
    - Medical/Physical Health services
    - Financial support services (TAY)
    - Housing programs and resources (TAY)
    - Transportation supports
- Medication Support

SERVICE DOSAGE

Service frequency expectations per client include a minimum of 1 hour of service every two weeks, and a maximum of up to 3 hours per week. Typically, clients would receive therapy or other rehabilitative services 2-4x per month and case-management 1-2x per month.
The anticipated caseload size per provider at this program level is 30 clients, with a maximum program census of 250-270 total clients.

1.2 OUTPATIENT - HIGH INTENSITY

High Intensity Outpatient programs provide increased client contact outside of a therapeutic office setting. Some services are “self-contained,” providing a single well-defined service, such as Therapeutic Behavioral Services (TBS) and In-Home Behavioral Supports (IHBS). Others provide a broader mix of services ranging from behavioral support, psychotherapy and case management, such as Intensive Care Coordination (ICC) and Full Service Partnerships (FSP). High intensity services are included in a child or youth’s recommended service array when they have multiple and more severe psychological, emotional or behavioral deficits that threaten

their ability to maintain a healthy developmental trajectory and function in standard community settings, such as school and their families.

1.2.1 OUTPATIENT HIGH INTENSITY (FSP LEVEL SUPPORT)

Full Service Partnership (FSP) programs deliver recovery-oriented, comprehensive services targeted at children and youth experiencing significant emotional, psychological, or behavioral challenges that interfere with their wellbeing. FSP programs were designed to serve children, youth, and their families in their homes and community rather than in residential treatment settings, locked psychiatric hospitals, juvenile halls and other non-family, institutional settings By engaging children, youth, and families in their own care and providing services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, and enhance outcomes.

The name – Full Service Partnership – reflects the goal of developing a partnership between the child, youth and their family being served and the service provider, and offering a full array of services, through a "whatever it takes" approach to meeting needs – or Full Service. FSPs are core investments of the Mental Health Services Act and the Behavioral Health Services Act and a key element of California's continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness. Programs at the high-intensity FSP level of care provide an array of ancillary services to children, youth, and families participating in County FSP programs.

TARGET POPULATION

Children and youth with at least two behavioral health needs, two functional needs, and two risk factors.

Behavioral Health Needs	Functional Needs	Risk Factors
• Psychosis • Impulsivity/ Hyperactivity • Depression • Anxiety • Oppositional • Conduct • Anger Control • Adjustment to Trauma • Eating Disturbance	• Family Functioning • Living Situation • Social Functioning • Decision-Making • Independent Living Skills for TAY • School Behavior • School Attendance • Sexual Development	• Suicide Risk • Non-Suicidal Self-Injurious Behavior • Other Self-Harm (recklessness) • Danger to Others • Sexual Aggression • Delinquent Behavior • Runaway • Intentional misbehavior

SERVICE LIST

- Rehabilitative Mental Health Services (community and/or home-based)
- Outpatient Therapy and Mental Health Services (assessment and plan development)

- Targeted Case Management Services to assist clients with connecting to:
    - Specialized Educational Services
    - Medical/Physical Health services
    - Financial support services
    - Housing programs and resources (TAY)
    - Transportation support
- Medication Support

SERVICE DOSAGE

Service frequency expectations per client include a minimum of 1 hour of service per week, and a maximum of up to 4 hours per week. Typically, clients would receive therapy or other rehabilitative services 1x per week and case-management 2x per month.
The anticipated caseload size per provider at this program level is 20 clients, with a maximum program census of 80-100 total clients.

1.2.2 THERAPEUTIC BEHAVIORAL SERVICES (TBS)

TBS is an intensive, individualized, short-term outpatient treatment intervention for beneficiaries up to age 21 with full scope Medi-Cal. Individuals receiving this service have serious emotional disturbances, are experiencing stressful transitions or life crises, and need additional short-term, specific support services to achieve outcomes specified in their client plans.

If the child or youth is living at home, a TBS staff person can work one-to-one with the child or youth to reduce severe behavior problems to try to keep the child or youth from needing a higher level of care.

If the child or youth is placed outside of their home living in a group home or a short-term residential therapeutic program for children, adolescents, and young people with very serious emotional problems, a TBS staff person can work with the child or youth so they may be able to move to a lower level of care, such as a foster home or back home. TBS helps families, caregivers, or guardians learn new ways of addressing problem behavior and ways of increasing the kinds of behavior that will allow the child or youth to be successful. The child or youth, the TBS staff person, and the family, caregiver, or guardian work together as a team to address problematic behaviors for a short period, until the child or youth no longer needs TBS.

TARGET POPULATION

TBS is designed to serve Medi-Cal beneficiaries below age 21 who:

- Are placed in a Rate Classification Level (RCL) facility of 12 or above or a locked treatment facility for the treatment of mental health needs;
- Are being considered for placement in these facilities; or
- Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.

The Medi-Cal beneficiary eligibility criteria for TBS follows:

A. The child/youth is receiving other specialty mental health services; and
B. The clinical judgment of the mental health provider indicates that it is highly likely that without the additional short-term support of TBS:
    1) The child/youth will need to be placed out-of-home, or into a higher level of residential care, including acute care, because of the child/youth's behaviors or symptoms which jeopardize continued placement in the current living situation/facility; "acute care" includes acute psychiatric hospital inpatient services, psychiatric health facility services, and crisis residential treatment services

or;

    2) The child/youth needs this additional support to transition to a home or foster home or lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS is needed to stabilize the child/youth in the new environment. The MHP or its provider must document the basis for the expectation that the behavior or symptoms will change.

SERVICE DOSAGE

TBS is individualized to meet the unique needs of the child or youth served; however, the standard dosage of services is 60-90 min sessions 2x weekly, for 60-180 days.

1.2.3 INTENSIVE CARE COORDINATION (ICC)

Intensive Care Coordination is a targeted case management service that provides assessment, care planning, and coordination of services for MediCal beneficiaries under age 21 who are eligible for the full scope of MediCal and meet medical necessity criteria for Specialty Mental Health Services (SMHS). ICC ensures that children and youth with complex needs receive integrated, timely, and effective services across child serving systems.

ICC includes four core service components:

- Assessment — identifying strengths, needs, risks, and service requirements.
- Service planning and implementation — developing and coordinating the Client Plan with the Child and Family Team (CFT).
- Monitoring and adapting — reviewing progress, adjusting interventions, and ensuring services remain aligned with needs.
- Transition planning — supporting movement to lower levels of care or natural supports.

ICC is delivered according to the Integrated Core Practice Model (ICPM) and is facilitated through the Child and Family Team (CFT). The CFT brings together:

- Formal supports (care coordinator, mental health providers, child serving agency staff)
- Natural supports (family, friends, community members, cultural supports)
- Other key individuals involved in the child or youth's care

Together, the CFT develops, implements, and monitors the Client Plan to support the child's goals and stability.

The ICC Coordinator is responsible for ensuring that services are:

- Strength-based, individualized, and culturally responsive
- Guided by the needs and preferences of the child and family
- Coordinated across providers and systems
- Accessible and delivered in a timely manner
- Supportive of caregivers in meeting the child's behavioral health needs
- Aligned through the CFT, including establishing and maintaining the team
- Organized across systems to help the child remain in their home and community whenever possible

TARGET POPULATION

ICC serves children and youth whose mental health condition requires coordinated, multi-agency treatment and support to ensure stability and success in their home, school, and community environments. This population typically includes children and youth who:

- Have moderate to high service intensity needs
- Require multiple services or supports across systems such as child welfare, education, developmental services, or juvenile justice
- Need structured care coordination to prevent placement disruption, hospitalization, or escalation to higher levels of care

SERVICE LIST

Intensive Care Coordination

SERVICE DOSAGE

ICC Service Dosage is individualized and determined through the Child and Family Team (CFT). Dosage reflects the level of coordination needed to support the child or youth's goals and may include:

- Frequency of care coordination contacts
- Regular CFT meetings based on need and system involvement
- Increased coordination during periods of transition or instability
- Ongoing communication with providers, caregivers, and natural supports
- Adjustments in intensity as the child stabilizes or needs increase

Dosage is needs-driven, not schedule-driven, and must be documented in the Client Plan and reviewed regularly by the CFT.

1.2.4 IN-HOME BEHAVIORAL SUPPORTS

Intensive Home Based Services (IHBS) are individualized, strength-based behavioral interventions designed to reduce mental health symptoms that interfere with a child or youth's

functioning. IHBS focuses on helping the child build the skills needed to function successfully in the home and community, while also strengthening the family's capacity to support the child's stability and progress.

IHBS is delivered within the Integrated Core Practice Model (ICPM) and coordinated through the Child and Family Team (CFT). IHBS activities are aligned with the child and family's overall service plan and may include assessment, treatment planning, therapy, rehabilitation, and contact with significant support persons or other collaterals when their involvement directly supports the child's treatment goals.

IHBS is available to Medi-Cal beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet access criteria for Specialty Mental Health Services (SMHS).

TARGET POPULATION

Children and youth whose mental health disorders, including externalizing behavioral disorders—places them at risk of losing their home placement or disrupt their ability to remain safely and successfully in their home environment.

This population includes children and youth who:

- Benefit from skills building and behavioral support delivered in their natural environment.
- Require moderate to high-intensity services to maintain stability in the home or community.
- Need structured behavioral interventions to prevent escalation, placement disruption, or functional decline.

SERVICE LIST

In-home Behavioral Health Services (IHBS)

SERVICE DOSAGE

Service dosage is individualized and determined by the Child and Family Team (CFT) based on clinical need, functional impairment, safety considerations, and the intensity of support required to achieve treatment goals. Dosage typically reflects the level of intervention needed to stabilize behaviors, support caregivers, and promote skill development in the home and community.

1.2.5 CHILD & FAMILY TEAM (CFT) FACILITATION

Consistent with the California Integrated Core Practice Model (ICPM) Sonoma County utilizes Child and Family Teams (CFT) for youth enrolled in FSP, or receiving ICC or IHBS. A CFT is a group of individuals that includes the child/youth, family members, professionals, natural community supports and other individuals identified by the family who are invested in the child/youth and family's success. The individuals on the CFT work together to identify each family member's strengths and needs based on relevant life domains, to develop a child/youth and family-centered case plan.

An important CFT component are CFT meetings, led by specially trained CFT facilitators. The role of the facilitator is to help identify needed contacts, build consensus within the team around collaborative plans, actively support the agenda, and ensure that the child, youth, and family voice and choice are heard throughout the entire teaming process.

CFT facilitators must complete a recognized CFT Facilitation training and be certified to administer the Child & Adolescent Needs & Strengths (CANS).

TARGET POPULATION

See FSP, ICC and IHBS population descriptions.

SERVICE LIST

CFT/MDT Services

SERVICE DOSAGE

CFT meetings occur every 90 days.

1.3 SUPPORTED HOUSING PROGRAM LEVEL (FIELD OR EMBEDDED)

Supported housing programs that offer specialty mental health services provide a combination of housing and intensive support for Transition Age Youth (TAY) individuals with severe mental health needs who may also be experiencing or at risk of homelessness. These programs prioritize TAY with the most complex needs and aim to promote long-term housing stability and recovery.

Key aspects of supported housing programs with specialty services include:

HOUSING

The core of these programs is providing or supporting stable, affordable housing options. This can range from permanent supportive housing (with on-site services) to transitional housing (providing temporary housing while individuals work toward permanent solutions).

SPECIALTY SUPPORTIVE SERVICES

These programs offer a range of services tailored to the specific needs of individuals with severe mental health conditions, to support their success in housing stability. These services may include:

- Medication monitoring: Assisting individuals in developing the skills to self-manage their medication routines, including setting reminders and performing medication check observations.
- Individual and group psychosocial rehabilitation: Providing skill-building and counseling support to address mental health symptoms which may disrupt housing stability and promote coping skills for long-term success.

- Case management: Connecting individuals with necessary resources to support successful housing stability.
- Crisis intervention: Providing immediate support during mental health crises.
- Supportive employment services: Helping individuals find and maintain employment, which in turn supports long-term stability.

LOW-BARRIER ACCESS

Many supported housing programs prioritize individuals with complex needs and utilize low-barrier tenant selection practices, meaning they focus on support individuals regardless of their history or current circumstances.

TARGET POPULATION

TAY with at least one behavioral health need and four functional needs (or 3 functional needs and 1 risk factor).

Behavioral Health Needs	Functional Needs	Risk Factors
• Psychosis • Impulse Control • Depression • Anxiety • Interpersonal Problems • Adjustment to Trauma • Eating Disturbance	• Physical/Medical • Employment • Social Functioning • Independent Living Skills • Residential Stability • Basic Activities of Daily Living • Decision Making	• Danger to Self • Self-Injurious Behavior • Other Self-Harm • Exploitation

SERVICE DOSAGE

Service frequency expectations at this level of care involve daily checks on clients in housing. Typically, a minimum of 3 hours per client per week, and a maximum of up to 7-10 hours per week. Typically, clients receive psychosocial rehabilitation services and medication monitoring 5-7x per week, and in some cases, twice daily checks. Group services offered on-site are also typical of this level of care.

The anticipated caseload size per provider at this program level is 10 clients, with a maximum program census of 20-30 total clients.

2.0 EVIDENCE-BASED INTENSIVE OUTPATIENT SERVICES

EVIDENCE-BASED INTENSIVE OUTPATIENT SERVICES OVERVIEW

BH Connect includes requirements that county mental health plans provide a set of evidence-based practices as treatment services. Under EPSDT Medi-Cal, services county mental health plans must offer, to qualified beneficiaries meeting medical necessity, now include: High Fidelity Wraparound (HFW), Functional family Therapy (FFT), Multi-Systemic Therapy (MST) and Parent Child Interaction Therapy (PCIT). Providers must implement these practices with the

support of Centers of Excellence (COE) established by DHCS and attain certification, a process that ensures programs are provided with high levels of model adherence.

HFW is also a required Full Service Partnership Program (FSP) within the Behavioral Health Services Act (BHSA).

2.1 HIGH FIDELITY WRAPAROUND

HFW is a team-based, family-centered service for children and youth living with serious mental health or behavioral challenges. HFW is an intervention designed to help the youth stay at home with their families/caregivers, in school, and in the community. HFW is also designed to help the youth's family, caregivers, and natural supports understand the youth's needs and learn how to support them in navigating complex mental health and/or behavioral challenges. HFW is not a prescribed set of services but instead organizes a collaborative planning process that brings together the youth and family/caregivers, natural supports, and involved providers to develop and carry out an individualized plan.

Beginning July 2026, DHCS is implementing HFW both as a statewide bundled service under Medi-Cal and as a county requirement under the Behavioral Health Services Act (BHSA). (https://www.dhcs.ca.gov/Documents/HFW-Policy-Manual.pdf) (California Department of Health Care Services, 2026). More information is available in the DHCS publication "High Fidelity Wraparound (HFW) Concept Paper (https://www.dhcs.ca.gov/Documents/Medi-Cal-HFW-Concept-Paper.pdf) (Services, 2025)

TARGET POPULATION

HFW is available to children and youth 0-21 yrs old, as an EPSDT service. These children and youth have complex emotional, behavioral and mental health challenges that threaten their ability to remain in, or return to, their family and home setting. These children and youth are assessed to have high intensity service needs, and would typically include children and youth with at least two behavioral health needs, two functional needs, and two risk factors.

Behavioral Health Needs	Functional Needs	Risk Factors
• Psychosis • Impulsivity/ Hyperactivity • Depression • Anxiety • Oppositional • Conduct • Anger Control • Adjustment to Trauma Eating Disturbance	• Family Functioning • Living Situation • Social Functioning • Decision-Making • Independent Living Skills for TAY • School Behavior • School Attendance • Sexual Development	• Suicide Risk • Non-Suicidal Self-Injurious Behavior • Other Self-Harm (recklessness) • Danger to Others • Sexual Aggression • Delinquent Behavior • Runaway • Intentional misbehavior

SERVICE LIST

- HFW Bundled Rate
- HFW clients may also receive SMHS not included in the HFW bundled rate of services. In some cases, the HFW provider may provide these additional services to support coordination of care. These services may include:
    - Outpatient Therapy and Mental Health Services
    - Medication Support Services
    - TBS or IHBS

SERVICE DOSAGE

See The California Wraparound Standards and DHCS HFW documents previously cited for more detailed information about service dosage.
(https://ucdavis.app.box.com/s/94aybj8t75e1i6ye0wpnktpmbzpk7qtq)

2.2 FUNCTIONAL FAMILY THERAPY (FFT)

FFT is a service for children and youth who are at risk of developing, or who are already experiencing, moderate to severe behavioral or emotional challenges, such as conduct disorder, violent acting-out, substance use, at-risk youth who experience challenges with externalizing behaviors (e.g., physical aggression, oppositional behavior, substance use) that require the engagement of the youth or family members' support system. FFT focuses on reducing adolescent behavioral problems, conduct disorder, substance use and recidivism, and improving parenting behaviors. A critical component of FFT is involvement of the family, caregivers, foster family or other key home-based influences.
(https://bhcoe.dhcs.ca.gov/ebp/functional-family-therapy-fft/) (Services, Website - Behavioral Health Center of Excellence: FFT LLC , 2026)

See the DHCS designated Center of Excellence website for additional information regarding FFT:

- https://bhcoe.dhcs.ca.gov/ebp/functional-family-therapy-fft/

TARGET POPULATION

FFT is designed to serve children and youth ages 11 yrs to 18 yrs, or of an appropriate developmental age to receive the service. These children and youth must be at risk of or have moderate to severe behavioral or emotional challenges, such as conduct disorder, violent acting-out, substance use disorder (SUD), or delinquency. The following are primary indicators of appropriateness for FFT:

Behavioral Health Needs	Functional Needs	Risk Factors
• Oppositional • Conduct • Anger Control	• Family Functioning • Living Situation • School Behavior	• Danger to Others • Sexual Aggression • Delinquent Behavior • Runaway • Intentional misbehavior

Youth who may not be appropriate for FFT include:

- Youth residing in inpatient, residential, or congregate living settings.
- Youth with current acute psychosis or who present with severe psychiatric illness.
- Youth who have no psychosocial system that constitutes family.
- Youth 9 to 10 years of age or below (as primary referral) or 19 years and over.

SERVICE LIST

FFT providers will bill standard Medi-Cal SMHS. There is no bundled or augmented rate for FFT. SMHS eligible for billing for FFT services include but are not limited to:

- Rehabilitative Mental Health Services (community and/or home-based)
- Outpatient Therapy and Mental Health Services
- Targeted Case Management Services to assist clients with connecting to:
    - Specialized Educational Services
    - Medical/Physical Health services
    - Financial support services
    - Housing programs and resources (TAY)
    - Transportation support
- Crisis Services

SERVICE DOSAGE

FFT is offered on average through 12 to 14 therapy sessions generally spread over a three-to-five-month period. FFT is a five-phase family therapy model:

- Engagement
- Motivation
- Relational assessment
- Behavior change
- Generalization

2.3 MULTI-SYSTEMIC THERAPY (MST)

MST is a family- and community-based treatment that uses therapy sessions to address emerging high-risk behaviors including criminogenic behavior, anti-social activities, substance use, and other behaviors that may lead to juvenile justice involvement or out-of-home placement.

Through MST, caregivers learn skills to independently address difficulties in raising children and adolescents as well as skills to cope with other family, peer, and neighborhood problems.

MST emphasizes cultural responsiveness and the centering of home and community settings, as well as partnership with law enforcement and the juvenile justice system. (https://bhcoe.dhcs.ca.gov/ebp/multisystemic-therapy-mst/)

TARGET POPULATION

Youth at risk of severe system consequences within their family, school, or community due to serious externalizing, anti-social, and/or challenging behaviors.

The following are indicators that MST may be medically necessary and appropriate:

- The youth is aged 12 to 17 or of an appropriate developmental age to receive the service; and
- The youth exhibits serious externalizing, anti-social, aggressive, and/or criminogenic behaviors that may place the child or youth at risk of out-of-home placement and
- The youth resides in a family, community or home-like setting that is conducive to a family-focused treatment model

Behavioral Health Needs	Functional Needs	Risk Factors
• Oppositional • Conduct • Anger Control	• Family Functioning • Living Situation • School Behavior	• Danger to Others • Sexual Aggression • Delinquent Behavior • Runaway • Intentional misbehavior

MST may not be appropriate for:

- Youth living independently.
- Sex offending in the absence of other anti-social behavior.
- Youth with moderate to severe autism.
- Actively homicidal, suicidal, or psychotic.
- Youth whose psychiatric problems are the primary reason leading to referral or youth who have severe and serious psychiatric problems.

SERVICE LIST

MST is billed as a bundled rate.

SERVICE DOSAGE

Therapists have small caseloads and are on-call 24/7—providing services in the home at times convenient to the family. The average length of treatment is between 3 and 5 months.

2.4 PARENT-CHILD INTERACTION THERAPY (PCIT)

PCIT is a specialized behavior management intervention for children and their caregivers. Through PCIT, a therapist provides caregivers in-the-moment coaching via a wireless headset while they engage in therapeutic play with their child, helping caregivers apply the most effective strategies with their child.

PCIT is focused on decreasing child behavior challenges (e.g., aggression, noncompliance, and tantrums), increasing positive parent behaviors (e.g., therapeutic play, effective prompts), and improving the caregiver-child relationship through structured interactions.

Through PCIT, a parent or caregiver wears a headset while playing with their child in a special playroom. A therapist watches from another room or on video and coaches the parent or caregiver through the headset. The therapist helps the parent or caregiver learn how to encourage healthy behavior and improve their relationship with their child. PCIT helps children who have difficult behaviors and helps their parents/caregivers learn new ways to handle them. These behaviors might include getting angry or not following rules. (https://bhcoe.dhcs.ca.gov/ebp/parent-child-interaction-therapy-pcit/)

TARGET POPULATION

Young children with oppositional or defiant behavior, aggression, frequent or severe tantrums, or symptoms related to child behavioral health conditions such as attention-deficit/hyperactivity disorder (ADHD), anxiety, or trauma.

The following are indicators that PCIT may be medically necessary and appropriate:

- The child is aged 2 to 7 or of an appropriate developmental age to receive the service; and
- The child exhibits dysregulation or behavior challenges that may be helped by PCIT; and
- The child resides with their caregiver (including but not limited to foster parents, kinship carers, and non-residential caregivers [e.g., non-custodial parents] who shares caregiving responsibilities of the child) and not within a residential facility.

Behavioral Health Needs	Functional Needs	Risk Factors
• Oppositional • Conduct (mild-moderate level, early childhood) • Anger Control • Impulsivity/Hyperactivity (when disruptive) • Anxiety • Adjustment to Trauma	• Family Functioning • Living Situation • Social Functioning • School Behavior	• Intentional Misbehavior • Danger to Others (mild-moderate aggression in young children)

May not be appropriate for:

- Children under two years old or over seven years old.
- Parents with severe untreated mental illness or active substance use disorders that significantly impair their ability to participate.
- Families with ongoing safety concerns, such as child abuse or domestic violence, where safety is not yet stabilized.

SERVICE LIST

PCIT providers will bill standard Medi-Cal SMHS. There is no bundled or augmented rate for PCIT. PCIT can be billed under family therapy or individual psychotherapy codes. SMHS eligible for billing for PCIT services include but are not limited to:

- Rehabilitative Mental Health Services (community and/or home-based)
- Outpatient Therapy and Mental Health Services
- Targeted Case Management Services to assist clients with connecting to:
    - Specialized Educational Services
    - Medical/Physical Health services
    - Transportation supports
- Crisis Services

SERVICE DOSAGE

Standard program components include:

- Weekly, hour-long sessions over approximately 14 to 20 weeks.
- Family therapy.
- Family education and support.
- Live coaching of caregivers.
- Assessment-driven clinical decision-making.

3.0 DAY TREATMENT SERVICES

DAY TREATMENT OVERVIEW

Specialty mental health day treatment, also known as partial hospitalization or intensive outpatient programs, provides intensive support and treatment for children and youth with moderate to severe mental health conditions. These programs offer structured therapy and rehabilitation services for at least 3 hours a day, for half-day programs, and full day programs exceeding 4 hours per day, but less than 24 hours, as an alternative to inpatient hospitalization or more restrictive placements.

Key aspects of day treatment specialty mental health service include:

STRUCTURED ENVIRONMENT

Day treatment involves a structured schedule with therapeutic activities, individual and group therapy, and skills training, typically lasting several hours per day.

INTENSIVE TREATMENT

This level of care is suitable for individuals who need more intensive support than traditional outpatient services but do not require 24-hour inpatient care.

MULTI-DISCIPLINARY APPROACH

Day treatment programs often involve a team of mental health professionals, including therapists, psychiatrists, and other specialists, offering a range of services.

REHABILITATION AND THERAPY

Services focus on improving, maintaining, or restoring daily living and social skills, as well as reducing mental health symptoms.

ALTERNATIVE TO HOSPITALIZATION

Day treatment can be used as an alternative to hospitalization or to prevent the need for more restrictive care, or as a step-down from hospitalization to facilitate successful transition to the community.

COMMUNITY INTEGRATION

Day treatment programs are typically offered in community settings, allowing children and youth to maintain connections with their families and communities. The aim is to help children and youth maintain or regain their ability to live and function within the community.

3.1 DAY TREATMENT REHABILITATIVE PROGRAM LEVEL

Day Treatment Rehabilitation (DTR) is a structured program which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of developmentally appropriate functioning consistent with the principles of learning and development. Intensive Outpatient Programs (IOP) are considered to be equivalent to Day Treatment Rehabilitation level of care.

SERVICE COMPONENTS

DTR Programs contain the following required service components:

- Therapeutic Milieu
- Skill-Building Groups
- Adjunctive Therapies
- Collateral Contact
- Mental Health Crisis Protocol
- Written Weekly Schedule

THERAPEUTIC MILIEU

This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with developmentally appropriate opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that

focus on teaching self-management skills that children and youth may use to develop appropriately to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

PROCESS GROUPS

These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with their problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.

SKILL-BUILDING GROUPS

In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.

ADJUNCTIVE THERAPIES

These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression but rather be able utilize the modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs.

MENTAL HEALTH CRISIS PROTOCOL

There shall be an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.

WRITTEN WEEKLY SCHEDULE

A weekly detailed schedule shall be available to beneficiaries and as appropriate to their families, caregivers or significant support persons. The schedule will identify when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.

STAFFING REQUIREMENTS

The allowable staffing credentials for DTR include:

- Physicians
- Psychologists or related waivered/registered professionals.
- Licensed Clinical Social Workers or related waivered/registered professionals.
- Marriage, Family and Child Counselors or related waivered/registered professionals.
- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists

The required staffing ratio is 1:10. Persons who are not solely used to provide Day Treatment services may be utilized according to program need but shall not be included as part of the above ratio.

STAFF ACTIVITIES

Staff may be required to spend time on day treatment activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, caregiver contacts). At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation.

STAFF IN MULTIPLE PROGRAMS

The program may use day treatment staff who are also staff with other responsibilities (e.g., staff of a group home, staff of a residential program, staff of another mental health treatment program). The program shall document the scope of responsibilities for these staff and the specific times in which day rehabilitation activities are being performed exclusive of other activities.

STAFFING IN PROGRAMS SERVING MORE THAN 12 CLIENTS

For DTR programs serving more than 12 clients, two of the staff must have a non-OT (Occupational Therapist) credential.

DOCUMENTATION REQUIREMENTS

Providers shall complete a daily progress note for services that are billed on a daily basis, and a separate progress note for collateral contact.

DAILY NOTE

The daily progress note shall include:

- Type of service rendered
- Sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s)

- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
- The date that the service was provided
- Duration of the service, including travel and documentation time
- Location of the beneficiary at the time of service
- Printed name, signature or the service provider, and date of signature
- Next steps, including planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other providers and any update to the problem list

COLLATERAL CONTACT

Providers shall document at least one contact per month with a family member, caregiver or other significant support person identified by an adult beneficiary. This contact occurs outside hours of operation and outside the therapeutic program for day treatment.

- This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.)
- The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration

PROBLEM LIST

The provider(s) responsible for the member's care shall create and maintain a problem list. The problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

The problem list shall include the following:

- Diagnosis/es identified by a provider acting within their scope of practice, if any
- Current International Classification of Diseases (ICD) Clinical Modification (CM) codes
- Problems identified by a provider acting within their scope of practice, if any
- Problems identified by the member and/or significant support person, if any
- The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved

BILLING REQUIREMENTS

A half-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

A full day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

CONTINUOUS HOURS OF OPERATION

The requirement for continuous hours of operation does not preclude short breaks between activities. A lunch or dinner break may also be appropriate depending on the program's schedule. These breaks do not count toward the total hours of operation of the day program for purposes of determining minimum hours of service.

3.2 DAY TREATMENT INTENSIVE PROGRAM LEVEL

Day Treatment Intensive (DTI) is a structured, multi-disciplinary program which provides services to a distinct group of individuals. Day treatment intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the beneficiary in living within a community setting. Partial Hospital Programs (PHP) are considered to be equivalent to Day Treatment Intensive level of care.

SERVICE COMPONENTS

DTI Programs contain the following required service components:

- Therapeutic Milieu
- Skill-Building Groups
- Adjunctive Therapies
- Collateral Contact
- Mental Health Crisis Protocol
- Written Weekly Schedule
- Psychotherapy

THERAPEUTIC MILIEU

This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with developmentally appropriate opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that children and youth may use to develop appropriately to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

PROCESS GROUPS

These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with their problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems.

SKILL-BUILDING GROUPS

In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.

ADJUNCTIVE THERAPIES

These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression but rather be able utilize the modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs.

PSYCHOTHERAPY

Day Treatment Intensive shall additionally include Psychotherapy.

MENTAL HEALTH CRISIS PROTOCOL

There shall be an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.

WRITTEN WEEKLY SCHEDULE

A weekly detailed schedule shall be available to beneficiaries and as appropriate to their families, caregivers or significant support persons. The schedule will identify when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.

STAFFING REQUIREMENTS

The allowable staffing credentials for DTI include:

- Physicians
- Psychologists or related waivered/registered professionals.
- Licensed Clinical Social Workers or related waivered/registered professionals.
- Marriage, Family and Child Counselors or related waivered/registered professionals.
- Registered Nurses
- Licensed Vocational Nurses

- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists

The required staffing ratio is 1:8 and must include at least one staff person whose scope of practice includes psychotherapy. Persons who are not solely used to provide Day Treatment services may be utilized according to program need but shall not be included as part of the above ratio.

STAFF ACTIVITIES

Staff may be required to spend time on day treatment activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, caregiver contacts). At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation.

STAFF IN MULTIPLE PROGRAMS

The program may use day treatment staff who are also staff with other responsibilities (e.g., staff of a group home, staff of a residential program, staff of another mental health treatment program). The program shall document the scope of responsibilities for these staff and the specific times in which day treatment intensive activities are being performed exclusive of other activities.

STAFFING IN PROGRAMS SERVING MORE THAN 12 CLIENTS

For DTI programs serving more than 12 clients, two of the staff must have a non-MHRS (Mental Health Rehabilitation Specialist) credential.

DOCUMENTATION REQUIREMENTS

Providers shall complete a daily progress note for services that are billed on a daily basis, and a separate progress note for collateral contact.

DAILY NOTE

The daily progress note shall include:

- Type of service rendered
- Sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s)
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
- The date that the service was provided
- Duration of the service, including travel and documentation time
- Location of the beneficiary at the time of service
- Printed name, signature or the service provider, and date of signature

- Next steps, including planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other providers and any update to the problem list

COLLATERAL CONTACT

Providers shall document at least one contact per month with a family member, caregiver or other significant support person identified by an adult beneficiary. This contact occurs outside hours of operation and outside the therapeutic program for day treatment.

- This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.)
- The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration

PROBLEM LIST

The provider(s) responsible for the member's care shall create and maintain a problem list. The problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

The problem list shall include the following:

- Diagnosis/es identified by a provider acting within their scope of practice, if any
- Current International Classification of Diseases (ICD) Clinical Modification (CM) codes
- Problems identified by a provider acting within their scope of practice, if any
- Problems identified by the member and/or significant support person, if any
- The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved

BILLING REQUIREMENTS

A half-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

A full day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

CONTINUOUS HOURS OF OPERATION

The requirement for continuous hours of operation does not preclude short breaks between activities. A lunch or dinner break may also be appropriate depending on the program's schedule. These breaks do not count toward the total hours of operation of the day program for purposes of determining minimum hours of service.

4.0 FOSTER CARE

FOSTER CARE SERVICES OVERVIEW

Therapeutic Foster Care represents an out-of-home placement treatment setting supported by the Behavioral Health Division. Therapeutic Foster Care is administered by county Departments of Social Services to provide 24-hour substitute care for children who cannot safely live with their biological parents, or other family members, due to abuse, neglect or exploitation. Mental Health services provide additional treatment support for children and youth in these settings. Therapeutic Foster care services supported by Medi-Cal are designed to address mental health and behavioral needs that interfere with a child or youth's ability to live in foster care, with family or in other foster care alternatives.

INTENSIVE TREATMENT

Foster parents who serve this population have specialized training and therapeutic services support that enable them to meet the child's and youth's needs in a family setting.

FOCUS ON SKILL DEVELOPMENT

Therapeutic Foster Care helps children and youth develop skills and the ability to regulate emotions in a manner that enable them to live and succeed in family and community settings.

TRANSITION TO COMMUNITY LIVING

The ultimate goal of foster care is to enable the child or youth to live with their families and integrate successfully into the community, often with ongoing support through outpatient services.

LEVELS OF CARE

Therapeutic Foster Care represents a distinct level of care in the service continuum, and can vary in duration.

4.1 THERAPEUTIC FOSTER CARE (TFC)

Therapeutic Foster Care is a short-term, intensive, trauma-informed Specialty Mental Health Service (SMHS) delivered in a family setting by specially trained and closely supervised TFC parents. TFC provides individualized mental health interventions—primarily plan development, rehabilitation, and collateral services—to children and youth with complex emotional and behavioral needs who require frequent, structured therapeutic support in the home.

TFC is a homebased alternative to higher levels of care, including group homes and Short-Term Residential Therapeutic Programs (STRTPs), and is available under the EPSDT benefit for MediCal beneficiaries under age 21 who meet medical necessity criteria.

The TFC parent is a core member of the treatment team and provides trauma-informed, medically necessary interventions throughout the day in coordination with the child's mental health providers.

TARGET POPULATION

TFC is intended for children and youth who:

- Have complex emotional and behavioral needs requiring intensive, frequent therapeutic support in a family environment
- Are Medi-Cal eligible and meet medical necessity criteria for SMHS
- Have an established Child and Family Team (CFT) guiding treatment planning
- May or may not be involved with child welfare or probation
- Require TFC in addition to ICC and other medically necessary SMHS

Behavioral Health Needs	Functional Needs	Risk Factors
• Disruptive Behavior • Impulse Control • Depression • Anxiety • Adjustment to Trauma-PTSD • Psychosis • Interpersonal Problems	• Physical/Medical • Employment • Social Functioning • School Functioning • Independent Living Skills for TAY • Residential Stability • Basic Activities of Daily Living as developmentally appropriate • Emotional regulation	• Suicide Risk • Non-Suicidal Self-Injurious Behavior • Other Self-Harm (recklessness) • Danger to Others • Sexual Aggression • Delinquent Behavior • Runaway • Intentional misbehavior

SERVICE LIST

- Therapeutic Foster Care
- Children and youth served in a TFC home, must receive one other Specialty Mental Health Service (SMHS), and may be eligible for other SMHS.

SERVICE DOSAGE

TFC is a 24/7 service.

5.0 EARLY INTERVENTION SERVICES

Early intervention services are designed to recognize and treat symptoms of mental illness as they emerge.

5.1 COORDINATED SPECIALTY CARE (CSC) FOR FIRST EPISODE PSYCHOSIS (FEP)

CSC is a community-based service designed for members experiencing first episode psychosis (FEP). By providing timely and integrated support during the critical initial stages of psychosis, CSC reduces the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, involvement with the criminal justice system, substance use, and homelessness.

CSC is a comprehensive, team-based service in which multidisciplinary teams provide a wide range of individualized supports to members exhibiting initial signs of psychosis CSC promotes recovery by providing timely and integrated support during the critical initial stages of psychosis to help members cope with the symptoms of their mental health condition and to function and remain integrated in the community.

CSC includes a wide range of individualized supports that are provided by a multidisciplinary team of licensed and non-licensed mental health practitioners.

Participating in CSC has been shown to reduce the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, criminal justice system involvement, substance use, and homelessness, and result in improved psychopathology and overall quality of life.

Citation https://www.dhcs.ca.gov/CalAIM/Pages/Adult-Evidence-Based-Practices.aspx

TARGET POPULATION

CSC is appropriate for individuals who are experiencing initial signs of psychosis or attenuated psychosis symptoms, including individuals that have:

- Exhibited onset of psychotic symptoms within the past five years.
- Exhibited attenuated psychosis symptoms that meet criteria for clinical high-risk syndrome.
- Are ages 12 through 40 years.
- May be appropriate for individuals outside of the target age population as determined by clinician.

CSC may not be appropriate for:

- Individuals whose psychotic-like experiences are better attributed to an intellectual/developmental disability (I/DD) or secondary to physical health condition (e.g., traumatic brain injury, delirium, dementia).
- Individuals who experience substance-induced psychosis; however, if a member presents symptoms of psychosis induced primarily by a substance use disorder (SUD), a clinician may recommend CSC if they determine the comprehensive CSC model is appropriate to support the member's recovery.

SERVICE LIST

- Outpatient Therapy and Mental Health Services
- In-home Behavioral Health Services (IHBS)
- Targeted Case Management Services
- Peer Support
- Medication Support
- Crisis Intervention Services

SERVICE DOSAGE

Individuals may receive CSC for FEP services for 1 – 3 years. Early on services are high intensity involving the individual, care team and family. Services include case management, medication management, psychotherapy, psychoeducation for the individual and family, and others.

5.2 0-5 SCREENING, ASSESSMENT AND REFERRAL SERVICES

This service with screen and assess children ages 0-5 yrs for the need for mental health services. When a need is identified, the provider will refer to MHP mental health services.

TARGET POPULATION

Children, age 0-5 yrs, demonstrating mental health and/or behavioral disorders.

SERVICE LIST

- Assessment
- Plan Development
- Targeted Case Management
- Crisis response

SERVICE DOSAGE

Children and their families will receive services for up to 30 days.

6.0 SPECIALTY PROGRAMS

6.1 TRANSCRANIAL MAGNETIC STIMULATION (TMS) PROGRAMS

Transcranial Magnetic Stimulation (TMS) is an FDA-approved, non-invasive treatment for Major Depressive Disorder and Obsessive-Compulsive Disorder (OCD). It uses magnetic pulses to stimulate specific regions of the brain associated with mood regulation and behavior, particularly the prefrontal cortex. TMS is a safe and well-tolerated option for individuals who have not responded to traditional treatments such as medication or psychotherapy. The therapy involves a series of sessions, typically lasting 20-40 minutes each, over several weeks, with no need for anesthesia or recovery time, allowing patients to resume daily activities immediately after treatment. Its proven efficacy and minimal side effects make TMS a valuable addition to mental health care.

SERVICE DESCRIPTION

Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment includes:

- Initial cortical mapping and motor threshold determination
- Initial delivery and management of TMS
- Subsequent motor threshold re-determination
- Subsequent delivery and management of TMS

TARGET POPULATION

Transcranial magnetic stimulation (TMS) is a non-invasive neuromodulation therapy used for treatment-resistant major depressive disorder (MDD) and obsessive-compulsive disorder (OCD).

REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (RTMS) FOR DEPRESSION

The National Network of Depression Centers and the American Psychiatric Association recommend rTMS for patients with MDD who have not responded to at least two antidepressant medications. rTMS typically involves daily sessions over 4-6 weeks, with each session lasting approximately 30-40 minutes. The standard protocol involves high-frequency (10 Hz) stimulation of the left dorsolateral prefrontal cortex (DLPFC).

DEEP TRANSCRANIAL MAGNETIC STIMULATION (DTMS) FOR OCD

dTMS targets deeper brain regions, such as the medial prefrontal cortex and anterior cingulate cortex, which are implicated in OCD.

ELIGIBILITY CRITERIA

Clients must meet the following criteria for referral to TMS Programs:

- A confirmed diagnosis of severe Major Depressive Disorder (MDD) or recurrent episode, or Obsessive Compulsive Disorder (OCD), as defined by the current DSM.
- One or more of the following:
    - Resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to 2 trials of psychopharmacologic agents in the current depressive episode from at least 2 different agent classes.
    - Inability to tolerate psychopharmacologic agents as evidenced by 2 trials of psychopharmacologic agents from at least 2 different agent classes, with distinct side effects.
    - History of response to TMS in a previous depressive episode.
    - If client is currently receiving ECT, TMS may be considered reasonable and necessary as a less invasive treatment option.
- A trial of an evidence-based psychotherapy known to be effective in the treatment of MDD or OCD of an adequate frequency and duration without significant improvement in depressive or OCD symptoms as documented by standardized rating scales that reliably measure depressive/OCD symptoms.

Clients with any of the following contraindications would not be eligible for referral to TMS Programs:

- Metal in, near, or around the head (30 centimeters from top of head), such as:
    - Metal plates/pins/screws
    - Aneurysm clip/coil/stent

    - Carotid or cerebral stents
    - Bullet or metal fragments
- Have the following devices:
    - Pacemaker
    - Implanted cardioverter defibrillator (ICD)
    - Vagus nerve stimulator (VNS)
    - Deep brain stimulator
- Diagnosis of Schizophrenia
- Client is pregnant
- History of:
    - Seizure or stroke (active seizure or stroke within the past six months)
    - Recent head trauma (within the last six months)
    - Aneurysm (lifetime history)
- Current substance or alcohol use

6.2 EATING DISORDER TREATMENT – INTENSIVE OUTPATIENT LEVEL (EDO IOP)

EDO IOP is considered equivalent to the Day Treatment Rehabilitative Program level, with an Eating Disorder Treatment Specialty. Please review the DTR section above for an overview of requirements.

IOP (Intensive Outpatient Programs) are structured mental health treatment programs that offer more intensive care than regular outpatient therapy but differ in intensity and time commitment from residential programs. IOP typically involves 3-5 days of programming for around 3-4 hours per day while working with outpatient providers. This allows clients to maintain their daily routines such as work or school. It focuses on providing support and strategies for managing symptoms while clients live at home.

IOP is typically provided by a team of licensed psychologists, therapists, clinicians, dietitians and psychiatrists. IOP may be provided in-person, or through telehealth modalities.

PROGRAM ELEMENTS

EDO IOP Programs provide daily group therapy sessions (both process and skills-based groups), weekly individual therapy, and weekly individual sessions with a dietician. Each individual is assigned to a multi-disciplinary team who creates an individualized eating disorder treatment plan and provides medical and psychiatric oversight. Typically, one supported meal and snack is provided during each IOP session.

EDO IOP Programs include adjunctive therapies to promote recovery, such as weekly experiential therapies including restaurant outings, grocery shopping, and cooking groups. They may also provide individual sessions with exercise physiologists, if cleared by the treatment team.

GROUP COMPONENT (PROCESS AND SKILLS-BASED GROUPS)

EDO IOP group schedules and curriculum are grounded in evidence-based practices, including Cognitive Behavioral Therapy and Dialectical Behavior Therapy.

The following are examples of groups provided in EDO IOP programs:

- Movement in moderation psycho-education group
- Joyful movement and exercise groups
- Art therapy groups
- Body Image groups
- Relationship Skills groups
- Stress Management skills groups
- Life Skills groups
- Medical Integrated Care psychoeducation groups
- Peer Support groups

COLLATERAL CONTACT

Included in many programs are family sessions and a family group without clients to provide psychoeducation and build effective support strategies.

TELEMEDICINE EDO IOP

EDO IOP can be adapted for telehealth modalities. In this format, individuals typically participate in group sessions 3 times per week (for a minimum of 9 hours of group work), plus individual therapy and dietitian sessions. Telehealth allows for flexible time options for IOP programming, which may provide options for those who work or attend school during the day.

With video conferencing, staff are able to work with clients as they engage in daily activities. For example, a therapist may work with a client while they are grocery shopping or clothing shopping to address anxiety issues, or a dietitian may join a client at a restaurant or on a trip when food choices are limited. The nutrition program can be adapted to provide weekly meal support where clients eat a meal online once a week.

BEST PRACTICES

Effective EDO IOP Programs consider the following best practices:

- Utilizing a non-diet approach with individualized nutritional programming
- Providing personalized treatment within real life settings
- Providing medical oversight
- Retaining staff who are specialists in Anorexia Nervosa, Bulimia Nervosa, Binge Eating and other eating disorders treatment; staff are typically masters-level, with 5 years' experience treating eating disorders
- Offering support groups for continuing aftercare
- Utilizing adjunctive therapies, such as meditation, experiential therapies, body image support & wellness activities

- Integrating trauma treatment to address co-occurring PTSD in eating disorders
- Involving family and support persons
- Providing comprehensive discharge planning to support long-term recovery

TARGET POPULATION

A client could be appropriate for IOP if:

- They are medically and psychiatrically stable
- They need less structured meal support
- They are able to function in some aspects of their daily life
- They need minimal accountability regarding their urges and behaviors
- They could benefit from more individual sessions and groups than provided in outpatient therapy

TREATMENT DURATION

The length of the program is based on several factors, including the client's specific recovery needs, the severity of the eating disorder, the client's progress in treatment, and the program's structure. For some individuals, treatment might be shorter in duration, while others could extend to several months, depending on their progress and treatment goals.

6.3 EATING DISORDER TREATMENT – PARTIAL HOSPITALIZATION PROGRAM LEVEL (EDO PHP)

EDO PHP is considered equivalent to the Day Treatment Intensive Program level, with an Eating Disorder Treatment Specialty. Please review the DTI section above for an overview of requirements.

PHP (Partial Hospitalization Programs) are structured mental health treatment programs that offer more intensive care than regular outpatient therapy but differ in intensity and time commitment from Residential Treatment. PHP is more intensive than IOP, running from 5-6 days per week for 6 or more hours per day. It provides a higher level of care, but clients return home at the end of the day. PHP is designed for individuals who need significant support but do not require 24-hour supervision.

PROGRAM ELEMENTS

EDO PHP Programs provide multiple daily group sessions, two individual therapy sessions per week, as well as weekly sessions with a dietitian and medical team. Each individual is assigned to a multi-disciplinary team who creates an individualized eating disorder treatment plan and provides medical and psychiatric oversight. Typically, one supervised meal and two snacks are provided during each PHP session.

EDO PHP Programs include adjunctive therapies to promote recovery, such as weekly experiential therapies including restaurant outings, grocery shopping, and cooking groups. They may also provide individual sessions with exercise physiologists, if cleared by the treatment team.

GROUP COMPONENT (PROCESS AND SKILLS-BASED GROUPS)

EDO PHP group schedules and curriculum are grounded in evidence-based practices, including Cognitive Behavioral Therapy and Dialectical Behavior Therapy.
The following are examples of groups provided in EDO PHP programs:

- Movement in moderation psycho-education group
- Joyful movement and exercise groups
- Art therapy groups
- Body Image groups
- Relationship Skills groups
- Stress Management skills groups
- Life Skills groups
- Medical Integrated Care psychoeducation groups
- Peer Support groups

COLLATERAL CONTACT

Included in many programs are family sessions and a family group without clients to provide psychoeducation and build effective support strategies.

BEST PRACTICES

Effective EDO PHP Programs consider the following best practices:

- Utilizing a non-diet approach with individualized nutritional programming
- Providing personalized treatment within real life settings
- Providing medical and psychiatric oversight
- Retaining staff who are specialists in Anorexia Nervosa, Bulimia Nervosa, Binge Eating and other eating disorders treatment; staff are typically masters-level, with 5 years' experience treating eating disorders
- Offering family support groups
- Utilizing adjunctive therapies, such as meditation, experiential therapies, body image support & wellness activities
- Integrating trauma treatment to address co-occurring PTSD in eating disorders
- Providing comprehensive discharge planning to support long-term recovery

TARGET POPULATION

A client could be appropriate for PHP if:

- They are medically and psychiatrically stable
- They need structured meal support for the majority of their meals
- They have some insight that their eating disorder is adversely affecting their daily life
- They need accountability regarding their urges and behaviors
- They could benefit from daily group therapy and multiple individual sessions throughout the week

TREATMENT DURATION

The length of the program is based on several factors, including the client's specific recovery needs, the severity of the eating disorder, the client's progress in treatment, and the program's structure. For some individuals, treatment might be shorter in duration, while others could extend to several months, depending on their progress and treatment goals.

6.4 EATING DISORDER TREATMENT – RESIDENTIAL LEVEL (EDO RES)

Please review the Residential Treatment program requirements in the Residential Treatment Level section above.

EDO Residential Treatment provides 24/7 care in a home-like environment, integrating therapy-based treatment interventions with those that are experiential, allowing clients to have exposure to real life issues and challenges, while still receiving the care and support of their treatment team.

EDO Residential treatment is provided by a team of care professionals, including doctors, psychiatrists, nurses, dietitians, therapists, and mental health counselors. Together, they create a comprehensive treatment plan to guide clients on their path to recovery while staying in a home-like treatment setting.

PROGRAM ELEMENTS

EDO Residential Treatment includes group interventions, individual sessions, medical support, nutritional support, and adjunctive therapies.

MEDICAL SUPPORT

Clients are seen at least once a week by a physician or nurse practitioner for standard assessments to track and support treatment outcomes. Many eating disorders can cause health complications that require specialized treatment, like anemia, heart failure, or malnutrition, which the program medical team can evaluate and monitor during treatment. Additionally, clients are seen at least weekly by a Psychiatrist. 24/7 nursing staff are also typical of this level of care.

INDIVIDUAL AND GROUP COUNSELING

Master's-level or higher therapists provide individual therapy 3 times per week and small group therapy 7 days a week.

The following are types of groups and treatment activities that may be offered in residential settings:

- Individual therapy (three sessions a week)
- Family therapy
- Detoxification Services
- Medication management
- Medical care
- Expressive arts group
- Solution-focused group

- Connected recovery group
- Attachment repair group
- Acceptance and commitment therapy group (ACT)
- Self-empowerment group
- Rational somatic therapy group
- Self-empowered body image group
- Dialectical behavior therapy group (DBT)
- Cognitive behavioral therapy group (CBT)
- Yoga
- Guided meditation/soothing stretch
- Exposure therapy
- Community meetings

COLLATERAL CONTACT

Family and support persons are integrated into care. Programs provide coaching, therapeutic support, and educational resources for loved ones as they assist in recovery.

NUTRITIONAL SUPPORT

Clients meet with registered dieticians one-on-one for nutritional education and meal support. Supervised meals and snacks are provided in program. Nutritional support typically includes:

- Nutritional counseling session (one session a week)
- Nutrition education
- Restaurant outings with dietitian
- Challenge food outings with dietitian
- Group dinner planning

TARGET POPULATION

EDO Residential Treatment is appropriate for individuals who require 24-hour supervision and care, but not inpatient medical care.

TREATMENT DURATION

The length of stay in residential programs varies based on several factors, but a typical stay is around 6 weeks.

SYSTEM MONITORING METRICS

DHS-BHD utilizes metrics across several domains to assess quality and patient outcomes. System metrics are grouped into measures of efficiency and measures of effectiveness. Specifically:

- Effort Quantity (How much did we do?)
- Effort Quality (How well did we do it?)
- Effect (Are clients better off?)

EXPECTED PROCESS METRICS FOR ALL SERVICE CATEGORIES

The Department is committed to tracking meaningful outcomes and working with CBOs to ensure that high quality services are delivered effectively and efficiently. The primary system outcomes of interest for this RFA include:

- Access to Services: The County is committed to providing services in such a way as to reflect and honor the social and cultural characteristics of the community and focuses on organizational efforts to reduce barriers to service utilization. No client should be turned away from services due to lack of system capacity.
- Timeliness: Youths identified as eligible for a potential service should be offered a service appointment with an appropriate provider within 10 business days.
- Clinical Outcome Improvements: Clients should show improvements on the Child and Adolescent Needs and Strengths (CANS) and/or other outcome measurement tools CBOs may utilize.
- Functional Improvements: The County aims to provide clients with the services, skills, and supports necessary to obtain and maintain stable housing, engage community connections, and avoid hospital or other facility placements unless absolutely necessary.

The County is eager to work with service providers to identify additional outcomes and metrics to measure over the duration of these contracts that could help ensure that clients are receiving the services and supports they need.

TYPICAL PROGRAM OUTCOME METRICS

The following chart outlines expected program monitoring metrics by level of care.

Level of Care	Effort Quantity	Effort Quality	Effect
Outpatient Non-FSP	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Timeliness to services Language capacity Program retention	Average actionable items on CANS Functional improvement rates Hospital admission rates
Outpatient High Intensity Services (FSP, TBS, ICC, IHBS)	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Timeliness to services Language capacity Program retention	Average actionable items on CANS Functional improvement rates Hospital admission rates Utilization of crisis services Justice Involvement rates
Evidence-based Intensive Outpatient Programs	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Timeliness to services Language capacity Program retention ACT model fidelity	Average actionable items on CANS Functional improvement rates Hospital admission rates Utilization of crisis services Justice-involvement rates

Level of Care	Effort Quantity	Effort Quality	Effect
Day Treatment	Total client volume Average program census Average length of stay Program utilization rate	Client to staff ratio Language capacity Program retention	Functional improvement rates Hospital admission rates Utilization of crisis services
Foster Care & Residential Treatment	Total client volume Average program census Average length of stay Program utilization rate	Client to staff ratio Language capacity Program retention	Disposition to lower level of care Hospital admission rates Hospital re-admission rates post-discharge
Early Intervention Services	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Timeliness to services Language capacity Program retention	Average actionable items on CANS Functional improvement rates Hospital admission rates

REIMBURSEMENT RATES

Contract rates are set as a percentage of the County rates. Historically DHS has paid between 65-80% of the DHCS published rates, depending on several factors outlined below. DHS rate range methodology is comprised of the following steps. Annually an analysis of the most recent fiscal year of Medi-Cal approved claim data is conducted to determine the Reimbursement Percentage of Federal Financial Participation (FFP) and State Grant Funds (SGF) the County receives relative to the amount claimed in order to establish a Sustainable Percentage of the County rates which can be passed through to Contracted providers.

Rates will be negotiated individually with each contracted agency

- Negotiated rates must be approved by the Director and Chief Finance Officer

During rate setting negotiations, special consideration is given for:

- Level of care
- The impact of travel/field-based services
- Specialty focus within a program (e.g., dual-diagnosis or eating disorders)
- The programs impact on continuity of care

For a full listing of County rates, utilize the Fee Schedule link in the Reference section below.

LICENSING AND CERTIFICATION REQUIREMENTS

All programs awarded contracts will need to complete a Medi-Cal site certification through DHS-BHD. Additionally, residential programs must be licensed through the California Department of Social Services. Current licensure and certification preferred at time of application.

REFERENCES

STATE OF CALIFORNIA SERVICE ACTIVITY DEFINITIONS AND REFERENCES

1. 2025-2026 Specialty Mental Health Services Table - https://www.dhcs.ca.gov/services/MH/Documents/Specialty-Mental-Health-Service-Table-25-26.xlsx
2. Mental Health Plan Agreement - https://www.dhcs.ca.gov/Documents/Sonoma-4260-2220139.pdf
3. BHIN 23-068: Documentation Requirements for all Specialty Mental Health Services - https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (DHCS) SPECIALTY MENTAL HEALTH SERVICES REIMBURSEMENT RATES

1. Fee Schedules by Fiscal Year - https://www.dhcs.ca.gov/services/MH/Pages/Fiscal-Year-2025-26-Medi-Cal-Behavioral-Health-Fee-Schedules-FY25-26.aspx