Community Action Teams Evaluation Report

February 1, 2014

Florida Department of Children and Families
Substance Abuse and Mental Health Services

Contents

I. Introduction

Specific appropriation 352-A of the 2013–2014 General Appropriations Act (GAA) directed the Department of Children and Families (Department) to:

> From the funds in Specific Appropriations 352A, $675,000 in recurring funds and $4,000,000 in nonrecurring funds from the General Revenue Fund and $2,075,000 in nonrecurring funds from the Federal Grants Trust Fund are provided and shall be evenly distributed among the following mental health Community Action Teams (CATs). These teams are established as pilot projects providing comprehensive, community-based services to children aged 11 to 21 with a mental health diagnosis or co-occurring substance abuse diagnosis with accompanying characterizes such as: being at risk for out-of-home placement as demonstrated by repeated failures as less intensive levels of care; having two or more hospitalizations or repeated failures; involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or poor academic performance and/or suspensions. Children young than age 11 may be candidates if they meet two or more of the aforementioned characteristics.
>
> The department shall contract directly with the following providers to pilot Community Action Teams with nonrecurring funds:
>
> Manatee Glens – Manatee, Sarasota, Desoto Counties
> Circles of Care – Brevard County
> Life Management – Bay County
> David Lawrence Center – Collier County
> Child Guidance Center – Duval County
> Institute for Child and Family Health – Miami-Dade County
> Mental Health Care – Hillsborough County
> Personal Enrichment Mental Health Services – Pinellas County
> Peace River – Polk, Highlands, Hardee Counties
>
> The department shall contract directly with the following provider to pilot a Community Action Team with recurring funds:
>
> Lee Mental Health – Lee County
>
> The department shall develop a report that evaluates their effectiveness of CATs in meeting the goal of offering parents and caregivers of this target population a safe option for raising their child at home rather than utilizing more costly institutional placement, foster home care, or juvenile justice services. The report shall be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than February 1, 2014.[1]

This report describes the CAT programs and their status as of December 6, 2013. It provides a profile of the young people and families served including demographics, clinical characteristics, and reasons for admission. Lastly, the report provides information on the outputs and outcomes achieved by the teams.

The limited time-frame that the current CAT programs have been operational poses a challenge to the evaluation of their effectiveness. However, based on the information reported from providers, the Department concludes that the ten programs have been implemented and the people receiving services are, in general, attending school, and staying in their homes rather than residential placements.

[1] Specific Appropriation 352A, ch. 2013-040, L.O.F.

II. Background

In 2005, the Legislature funded a pilot CAT program for children, adolescents and young adults with significant mental health needs in Manatee County. The 2005-06 GAA, provided:

> This $912,500 from non-recurring general revenue funds is provided for a Children's Community Action Team (CAT TEAM) demonstration as an alternative to residential treatment for seriously emotional disturbed children. Through the CAT TEAMS, children ages 5-18 at risk of residential placement will receive intensive services from a team of psychiatrists, counselors, case-managers, and mentors who will be available seven days a week and twenty-four hours a day. The goal is to stabilize the mental illness so that they can continue to live in the community with their family. The demonstration project shall be established in Lee and Manatee counties as an extension of current crisis stabilization units for children at a cost of $50 per day per child.[2]

Manatee Glens, a non-profit behavioral health provider, implemented the pilot with the goal of providing a lower cost alternative to state funded out-of-home placement such as foster care, residential behavioral health treatment and juvenile justice incarceration by offering parents and caregivers a safe option for raising their children at home.

As it is currently implemented, CAT has not been evaluated for efficacy. It is an adaptation of Program of Assertive Community Treatment, developed by Drs. Marx, Stein, and Test, at Mendota State Hospital in Madison, WI. Also known as Assertive Community Treatment (ACT), it provided intensive services and supports to adults with severe and persistent mental illnesses transitioning from the state hospital into the community to reduce recurrent hospitalizations. To say a person is an ACT participant would mean they have been diagnosed with severe and persistent mental illness, are living in the community and their recovery is being managed by a team of clinical and support staff that follow the program guidelines of ACT. ACT has been widely implemented throughout North America and Europe.[3] There are thirty-two Florida ACT (FACT) teams serving up to 100 adults. The current FACT teams are provided in Appendix A.

Research demonstrates a variety of results as to the efficacy of ACT.[4] It is recognized as an evidenced based practice[5] (EBP) by the Substance Abuse and Mental Health Services Administration (SAMHSA).[6] Researchers note that EBP was a term first used in the 1990s, and has crystallized around the concept of the analysis of published research forming the basis for medical decision making, essentially integrating individual clinical expertise and the best external research.[7] The American Psychological Association, in a 2005 statement endorsed a modification of the approach for psychology:

> Evidence-based practice is the integration of best research evidence with clinical expertise and patient values. The purpose of evidence-based practice in psychology (EBPP) is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention.[8]

The assertive community treatment model has been the subject of more than 25 randomized controlled trials. Research has shown that this type of program is effective in reducing hospitalization, is no more expensive than traditional care, and is more satisfactory to consumers and their families than standard care.[9]

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[2] Specific Appropriation 332, ch. 2005-70, L.O.F.
[3] *See*, www.actassociation.org/actModel, site accessed December 9, 2013.
[4] T. Burns, "The rise and fall of assertive community treatment?" *International Review of Psychiatry.* April 2010; 22(2): 130-137.
[5] The Department defines evidence based practice as a practice or program that is supported by research and is standardized, replicable, and effective when used for the intended population. For the purposes of Department funding, there must be at least three independent published research journal studies for a service or program to be considered an EBP.
[6] *See*, store.samhsa.gov/shin/content//SMA08-4345/TheEvidence.pdf, site accessed December 9, 2013.
[7] *See,* J. A. Claridge et. al, *History and Development*, D. Sackett, W. Rosenborg, J. Muir-Gray, R. Haynes, and W. Richardson, *Evidence Based Medicine. What It Is, and What It Isn't,* 312 British Medical Journal, (1996).
[8] *See*, http://www.apa.org/practice/guidelines/evidence-based-statement.aspx, site accessed December 12, 2013.
[9] S.D. Phillips, B.J. Burns, E.R. Edgar, K.T. Mueser, K.W. Linkins, R.A. Rosenheck, R.E. Drake, and E.C. McDonel Herr, "Moving Assertive Community Treatment Into Standard Practice," *Psychiatric Services*. June 2001 Vol. 52 No.6. *See also*, store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345, site accessed December 9, 2013.

The original ACT model was adapted to work with people as young as age 15 to help them stay in high school and decrease their psychiatric symptoms.[10] This has been implemented in states across the country. For example, Minnesota passed legislation in 2011 to add Youth ACT to their Health Care Programs as a mental health benefit to better address this age group.[11] Our Town in Indianapolis, IN is an example of an ACT program for young adults serving 18-25 year olds with serious mental illnesses.[12] A longitudinal evaluation compared participant's progress from 2003 to 2005, and found no significant changes in quality of life and clinical functioning. However, participants improved in daily living skills,[13] improved rates of employment, and were less likely to be arrested or homeless.

According to the National Institute of Mental Health (NIMH), half of all lifetime cases of mental health disorders have begun by age 14 and three quarters have begun by age 24.[14] This means successful transition between the children and adult systems is critical. People with mental health disorders often fall through the gaps between the children and adult mental health systems during a critical time in their lives.[15] In 2003, the New Freedom Commission on Mental Health released a report entitled *Achieving the Promise: Transforming Mental Health Care in America*, which identified further gaps in the mental health system.[16] Recommendations for change were made to help people live successfully in their communities. The Commission's recommendation to fundamentally transform the mental health system through community-based services and supports that promote recovery[17] and resilience[18] sparked a nationwide effort to identify and implement best practices in the area of community behavioral health. The CAT model may be an example of such a comprehensive service approach allowing young people with mental illnesses who are at risk or out-of-home placements to remain in the community with their caregivers.

The Center for Community Support and Research at Wichita State University conducted a literature review of best practices in children's mental health that lead to good outcomes.[19] The best practices listed below were included in both the literature review and the CAT programs.

1. **Collaboration with the Child and Family**
   Parents and children are treated as partners in the assessment process, planning, delivery, and evaluation of services, and their preferences are taken seriously.
2. **Functional Outcomes**
   Services are intended to aid children to achieve success in school, live with their families, avoid delinquency and become stable and productive adults.
3. **Collaboration with Others**
   When children have multiple agencies involved, a joint assessment and service plan is implemented.
4. **Accessible Services**

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[10] *See*, www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=29040, site accessed December 8, 2013.
[11] *See*, www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_173536.pdf, site accessed December 8, 2013.
[12] J.H. McGrew & M. Danner, "Evaluation of an intensive case management program for transition age youth and its transition to assertive community treatment," *American Journal of Psychiatric Rehabilitation.* 2009; 12: 278-294.
[13] Springer defines daily living skills as a wide range of personal self-care activities across home, school, work, and community settings. Most daily living skills, like food preparation and personal hygiene, need to be performed on a regular basis to maintain a reasonable level of health and safety. *See*, www.springerreference.com/docs/html/chapterdbid/334542.html, accessed December 31, 2013.
[14] *See*, www.nih.gov/news/pr/jun2005/nimh-06.htm, site accessed December 8, 2013.
[15] *See* www.nasmhpd.org/docs/publications/docs/2005/Expand%20Transition%20Supports.pdf, Site accessed January 8, 2014.
[16] *See*, govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf, site accessed December 8, 2013.
[17] Recovery is defined by SAMHSA as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. *See*, www.samhsa.gov/newsroom/advisories/1112223420.aspx, site accessed December 20, 2013.
[18] Resilience is defined by SAMHSA as the ability to adapt well over time to life-changing situations and stressful conditions. www.samhsa.gov/children/trauma-resilience-definitions.asp, site accessed December 8, 2013.
[19] T. Gregory, D. Peltier, C. Vu, O. Dziadkowiec, E. Grant, T. Shagott, & S. Wituk, "Children's Mental Health Best Practices Literature Review," Wichita State University, Center for Community Support and Research, 2009. See, hcfgkc.org/sites/default/files/documents/hcf-wsu-children-mental-illness.pdf, site accessed December 9, 2013.

Children have access to a comprehensive array of services, sufficient to ensure that they receive the treatment they need.

5. **Best Practices**
   Services are continuously evaluated and modified when ineffective in achieving desired outcomes.
6. **Most Appropriate Setting**
   Children are provided behavioral health services in their home and community to the extent possible.
7. **Timeliness**
   Children identified in need are assessed and served promptly.
8. **Services Tailored to the Child and Family**
   Parents and children articulate their own strengths and needs, and what services they think are needed to meet their goals.
9. **Stability**
   Service plans strive to minimize multiple placements. This should take into account transitions in children's lives, including new schools, new placements, and adult services.
10. **Respect for the Child and Family's Unique Cultural Heritage**
    Services are provided in a manner that respects the cultural tradition and heritage of the child and family.
11. **Independence**
    Services include support and training for parents to meet their child's behavioral health needs and support and training for children in self- management.
12. **Connection to Natural Supports**[20]
    The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

The model contract for the CAT team was developed from the FY 2005 – 06 Manatee Glens CAT program and FACT teams. The Manatee Glens *Children's Community Action Team-CAT Team Summary of Three Year Outcomes and Findings January 1, 2010 – December 31, 2012* is provided in Appendix B. The Florida Council for Community Mental Health (Florida Council) and CAT providers formed a collaborative partnership to work with the Department to standardize and refine the implementation of the CAT programs across sites.

[20] As an example - natural support is defined in California as:
[P]ersonal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships; friendships reflecting the diversity of the neighborhood and the community; association with fellow students or employees in regular classrooms and work places; and associations developed though participation in clubs, organizations, and other civic activities. CAL. WELF. & INST. s. 4500.5 (2013).

III. The Model

The CAT programs have the following contract expectations:

- To meet benchmarks for the number of people served within 90 and 180 days and a minimum of 60 people during the contract year;
- To hire and train 50 percent of staff within 30 days and 90 percent of staff within 45 days of contract execution;
- To provide services to a family for an average of six to nine months;
- To provide services primarily in the community;
- To be available 24 hours per day, 365 days per year;
- To provide services and supports that center on the entire family and take into account their cultural background;
- To provide services as a self-contained, multi-disciplinary team consisting at minimum of the following ten staff positions:
    - (1) Team leader;
    - (2) Clinicians;
    - (.25) Psychiatrist or nurse practitioner;
    - (.5) Registered nurse or licensed practical nurse;
    - (1) Bachelor's level case managers;
    - (3) Therapeutic mentors; and
    - (1) Administrative support staff.

CAT teams in operation are similar to the ACT model discussed earlier. One of the differences between CAT and traditional mental health services is that services are provided or coordinated by a multi-disciplinary team. Additionally, services are individualized and often do not fit into the standard of medical necessity,[21] and are typically not reimbursed by Medicaid or private insurance, including services such as mentoring, tutoring, respite, and transportation. In addition, the family is treated as a unit and all family members' needs are addressed. The number of sessions and the frequency at which they are provided is set through collaboration rather than service limits. The team is available on nights, weekends, and holidays. In the event that interventions out of the scope of the team's expertise (i.e., eating disorder treatment, behavior analysis, psychological testing, etc.) are required, referrals are made to specialists, with follow up from the team. This flexibility is intended to promote a "whatever it takes" approach to assisting young people and their families to achieve their goals.

III.A. TREATMENT PROCESS

III.A.(1) Referral

Referrals for CAT services come from a variety of sources, including:

- Outpatient behavioral health treatment providers;
- Crisis stabilization units;
- Physicians;
- Child welfare providers;
- Juvenile justice or corrections;
- Psychiatric residential treatment programs;
- Parents and caretakers; and
- Schools.

[21] The American College of Medical Quality defines medical necessity as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. www.acmq.org/policies/policy8.pdf, site accessed January 8, 2014.

Participation criteria are established in proviso, and have been included in contract:

1. Young people ages 11 to 21 who have a mental health or co-occurring substance use disorder diagnosis with accompanying characteristics such as:
   1.1. Being at risk of out of home placement as demonstrated by repeated failures in lower levels of care;
   1.2. Having two or more psychiatric hospitalizations;
   1.3. Involvement with the Department of Juvenile Justice (DJJ);
   1.4. Multiple episodes involving law enforcement; or
   1.5. Poor academic performance and/or suspensions.
2. Youth younger than 11 years of age may receive CAT services if they meet two or more of the criteria above.

Young people who have a traumatic brain injury, are in a juvenile justice commitment program, or are receiving Statewide Inpatient Psychiatric Program (SIPP) services, are not eligible for CAT services.[22]

Once a referral is reviewed and eligibility determined, the guardian is contacted and given an overview of the program. This is a family program and participation is necessary for success, which is made clear from the first conversation.

III.A.(2) Assessment

To obtain the information for a comprehensive care plan, everyone is assessed at admission, using a variety of assessment tools. A bio-psychosocial assessment is completed to determine needs in areas including education, vocation, mental health, substance use, primary health, and social connections.[23] In addition, collateral information, such as school records, mental health and substance abuse evaluations, treatment history, including level of cognitive functioning are used to develop a comprehensive understanding of the family's circumstances.

From the assessment, everyone is introduced to the "40 Developmental Assets."[24] This has been developed by the Search Institute as the building blocks for healthy development for young children to be resilient and grow up healthy, caring, and responsible. This strength based approach guides the delivery of CAT services, with the focus on recovery and wellness, rather than labels and deficits. The "40 Developmental Assets" for individuals ages 5 through 18 is provided in Appendix C.

III.A.(3) Treatment Planning

The treatment planning process serves to identify short-term objectives to build long-term stability, resiliency, family unity, and illness management. The plan describes services to be provided, outlines persons responsible for tasks, and gives timelines for completion. Everyone evaluates progress through a treatment review process, which identifies any additional needs and corrections. Throughout treatment, staff members update assessments and participants complete satisfaction surveys related to the quality and benefit of treatment.

III.A.(4) Services and Supports Provided

Services are provided in the home or other community locations convenient to the family served, and include:

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[22] This is because young people with a traumatic brain injury receive limited benefit from cognitive based mental health treatment services and require more specialized behavioral based interventions. Youth in DJJ commitment programs or SIPP are not living at home and; therefore, are not available to participate in services.

[23] A bio- psychosocial assessment is a multidisciplinary approach to assessment that includes exploration of relevant biological, psychological, social, cultural, and environmental variables for the purpose of evaluating how such variables may have contributed to the development and maintenance of a presenting problem. highered.mcgraw-hill.com/sites/0073129097/student_view0/glossary.html, site accessed, January 6, 2014

[24] *See*, www.search-institute.org/research/developmental-assets, site accessed, December 8, 2013.

- **Crisis Intervention and 24/7 On-call Coverage**
  This assists the family with crisis intervention, referrals, or supportive counseling.
- **Natural Support Network Development**
  This develops natural community supports, including extended family and friends, support groups and peer support, and religious and civic organizations.
- **Case Management**
  The case manager coordinates care with other parties such as providers, schools, or juvenile justice. They advocate on behalf of the family. They also provide access to a variety of services and supports, including but not limited to:
  - Primary health care (medical and dental);
  - Basic needs such as housing and transportation;
  - Educational services such as tutoring;
  - Vocational services such as job readiness and placement; and
  - Legal services.
- **Incidental and Emergency Funds**
  Funds are used for services and supports, outlined in their care plan. Examples of items purchased include medications, aftercare or recreational activities, and educational supplies to help them reach treatment goals and move toward greater independence.
- **Family Education**
  Families are educated on topics related to their treatment goals, including effective parenting skills and behavior management.
- **Psychiatric Services**
  A Psychiatrist or Advanced Registered Nurse Practitioner (ARNP) completes a psychiatric evaluation to determine the need for psychotherapeutic medication and for treatment recommendations. If medication is prescribed, medication management is provided to review therapeutic effects and side effects.
- **Respite**
  Staff provide short-term supervision for the young person away from the family to offer temporary relief as a planned event or to improve family stability in a time of crisis.
- **Substance Abuse and Co-occurring Services**
  Both mental health and substance abuse needs are addressed.
- **Therapeutic Mentoring**
  A mentor is assigned to serve as a role model, build a strong sense of self and assist with social, vocational and problem solving skill development.
- **Therapy**
  Staff provides and coordinates individual, group, and family therapy services. The type, frequency and location of therapy provided are based on their individual needs.
- **Transition Services**
  Staff assists the family to overcome gaps in services and supports in areas such as education, vocation, living situation, and primary health and behavioral health care when moving from the children to the adult service system.
- **Transportation**
  Staff assists with transportation to medical appointments, court hearings, or other related activities outlined in the care plan.
- **Tutoring**
  Staff assists the young person with remedial academic instruction to enhance educational performance.

III.A.(5) Discharge

The average length of time a young person is expected to receive services is six to nine months. As part of discharge planning, the team assists the family identify resources to successfully maintain progress. A young person may be discharged when:

1. They have functioned well at home and school for the past three months and the family and staff agree to terminate services;
2. Family dynamics have improved, and the family and staff agree to terminate services;
3. The parents or young person refuse to participate in services after three months despite efforts to engage them;
4. They move out of the catchment area;
5. They are admitted to a residential treatment program, a juvenile justice or criminal justice commitment program; or
6. It is determined that a different program would be more clinically beneficial to the young person.

III.B. PROGRAM GOALS

CAT is intended to be a safe and effective alternative to out-of-home placement for children with serious behavioral health issues. Upon successful completion, the family should have the skills and natural support system needed to maintain improvements made during services. The goals are to:

1. Decrease out-of-home placements;
2. Improve family and youth functioning;
3. Decrease substance use and abuse;
4. Decrease psychiatric hospitalizations;
5. Improve school related outcomes such as attendance, grades and graduation rates;
6. Increase health and wellness; and
7. Transition into age appropriate services.

III.C. FUNDING METHODOLOGY

The Department executed fixed price contracts for $675,000. The providers receive payment in monthly installments. The unit rate is based on direct staff hour and varies slightly by provider based on staffing and operation cost, ranging from $79.28 to $86.21. The unit rate includes all program expenses such as on-call time, administrative and operating costs, salaries and benefits for all staff members, and incidental funds. Incidental funds are calculated at $20,000 per year for each team to purchase items needed to support treatment, such as aftercare, recreational activities, and educational supplies.

IV. Demographic Information

To complete this report, CAT providers submitted data regarding the age, ethnicity, gender, referral sources, diagnoses and presenting problems for the young people served. This was reported from the time of contract execution through December 6, 2013. During this period, 337 young people and families have been served.

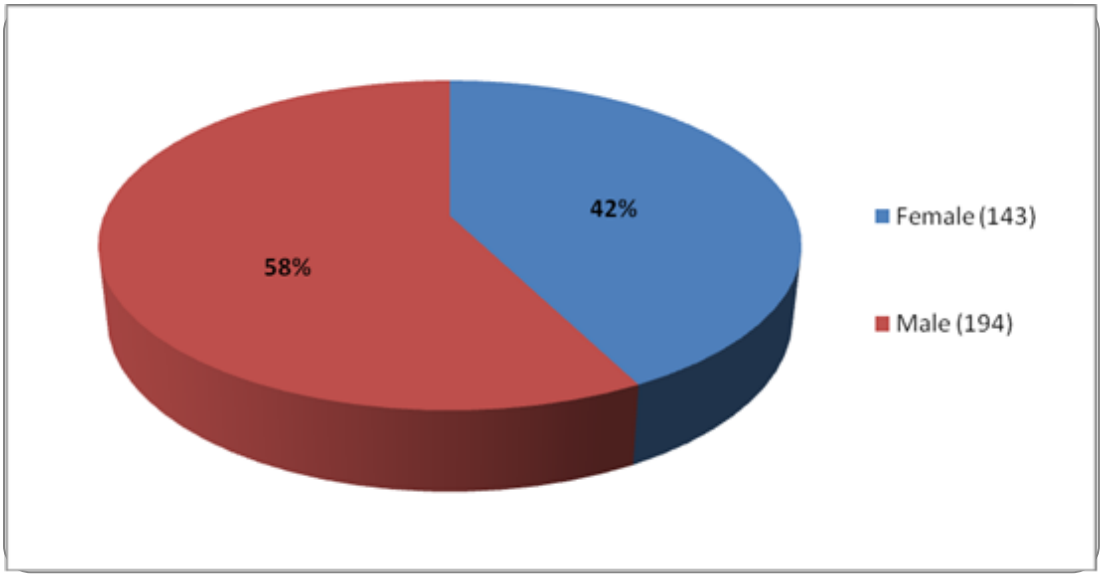
A composite of a typical CAT participant demonstrates the following characteristics:

- Male;
- Middle school aged;
- Caucasian;
- Referred by an outpatient behavioral health program;
- Presents with multiple problems at time of referral such as:
  - Defiance;[25]
  - Aggression;[26]
  - School Problems;[27]and is
- Diagnosed with a mood disorder.[28]

These young people may experience multi-system involvement with juvenile justice, mental health, special education, and child welfare due to the severity of their symptoms and behaviors. Additional conditions may also be present, such as physical health issues, intellectual disabilities, and autism-spectrum disorders.

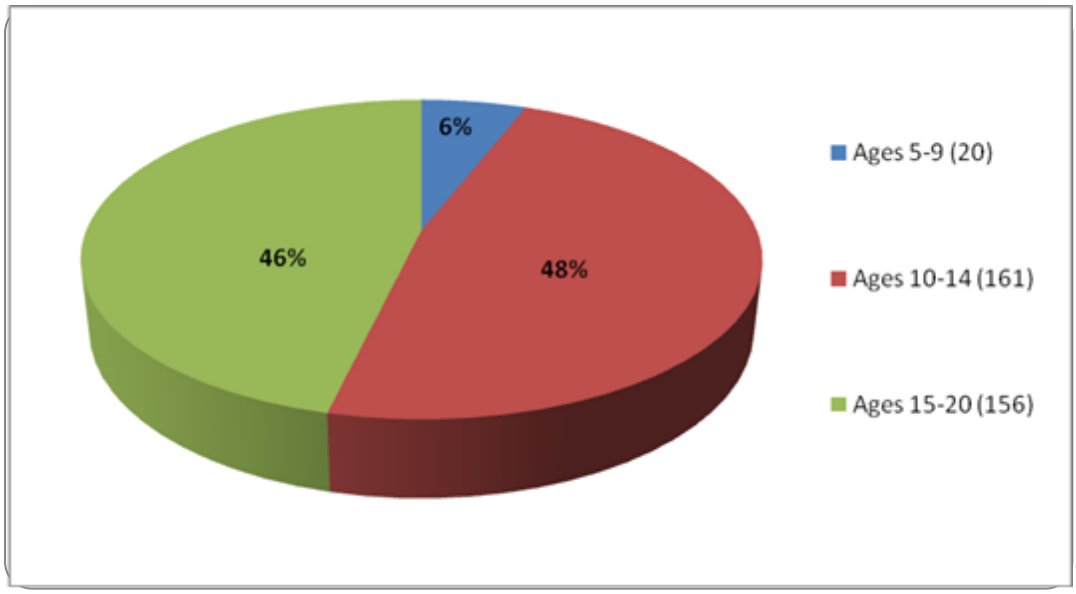
The following charts break down the age, gender and ethnicity of the people served, as well as the referral sources and the presenting problems at time of referral.

Chart 1. Gender of People Served



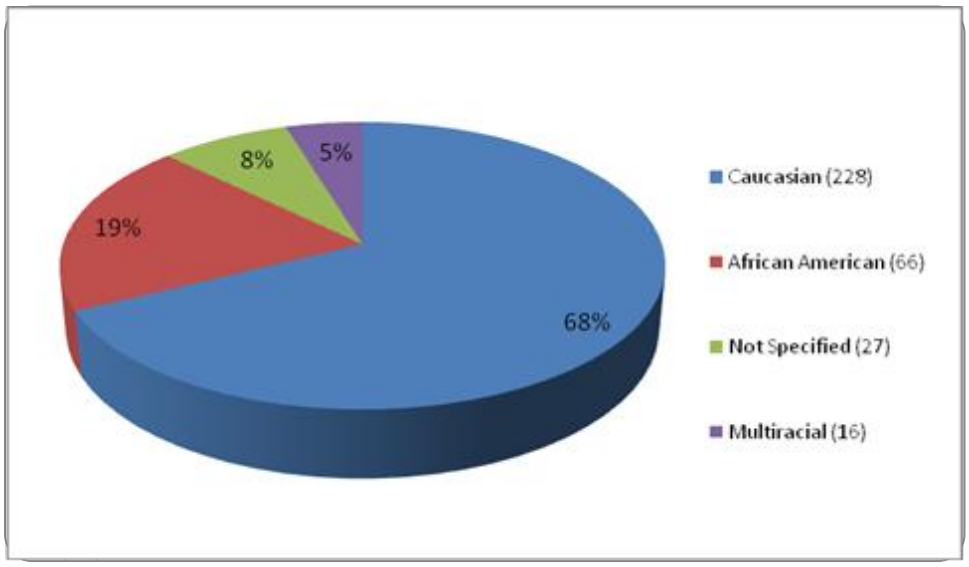
[25] Defiance includes committing crimes, not following rules or directions, and running away.
[26] Aggression includes verbal and physical aggression.
[27] School problems include truancy, poor academic performance, suspensions, and expulsions.
[28] Mood disorders include Bipolar Disorder, Depressive Disorder NOS, Mood Disorder NOS, Dysthymia, and Major Depressive Disorder.

Chart 2. Age of Young People Served



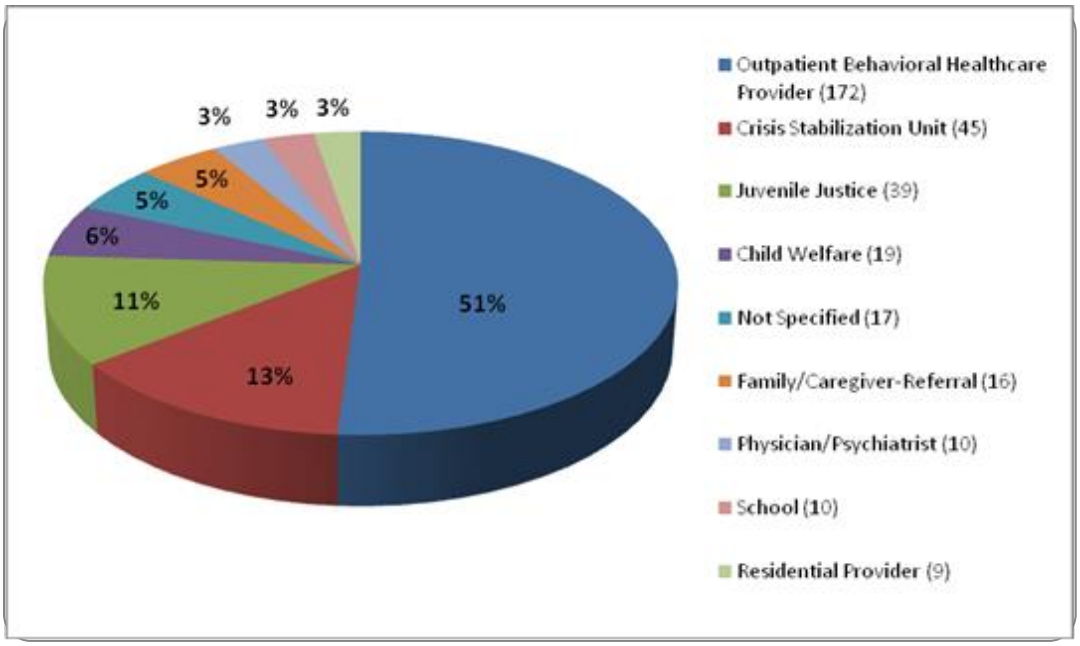
- The predominant age for CAT services is 11 through 21 years of age; however, children younger than 11 may be served if they meet the two or more of the eligibility criteria.

Chart 3. Race of Young People Served



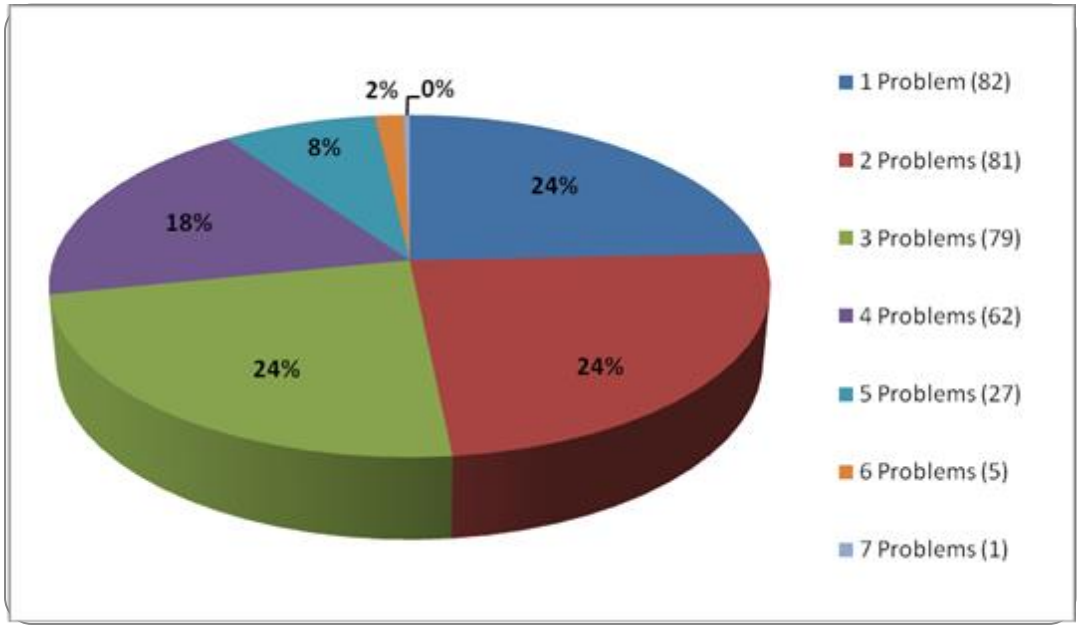
- Chart 3 shows the majority of young people served are Caucasian, accounting for 68 percent of service recipients.
- The “not specified” category includes young people for which a race was not given by the provider.
- Ethnicity is not included in the report due to inconsistent reporting by providers.

Chart 4. Referral Source



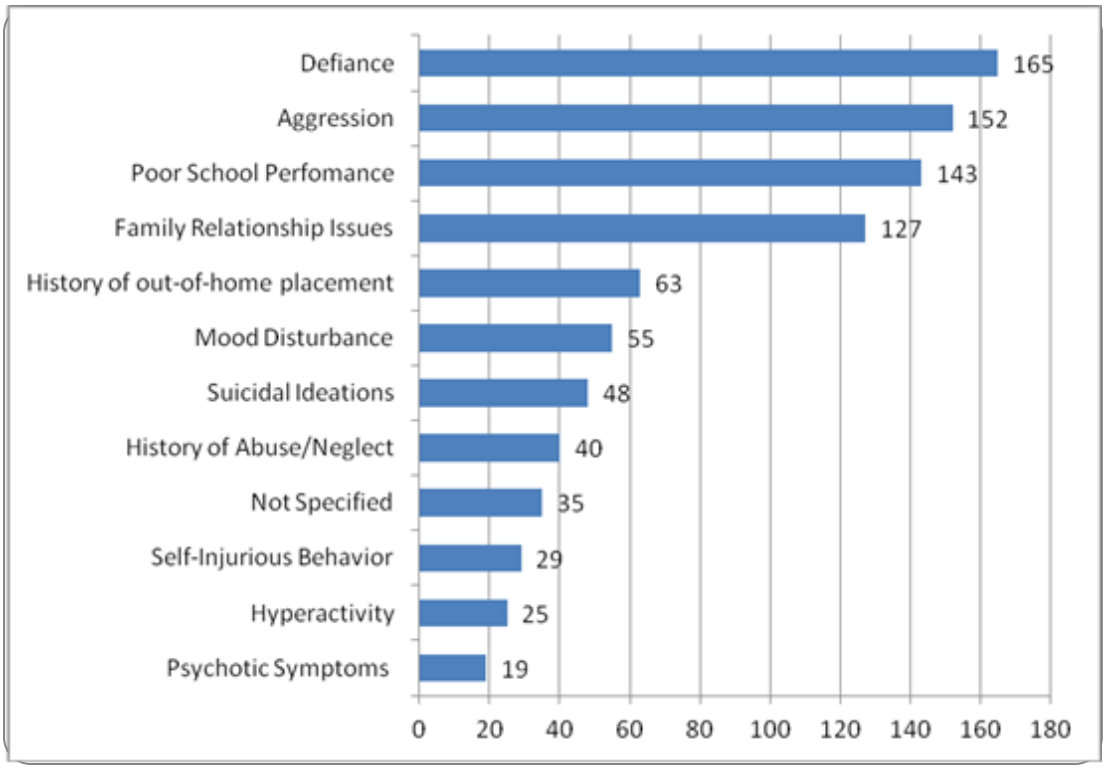
- Chart 4 shows the primary referral sources are outpatient behavioral health providers.
- The “not specified” category includes referral sources described by the provider without sufficient detail to categorize.

Chart 5. Number of Presenting Problems



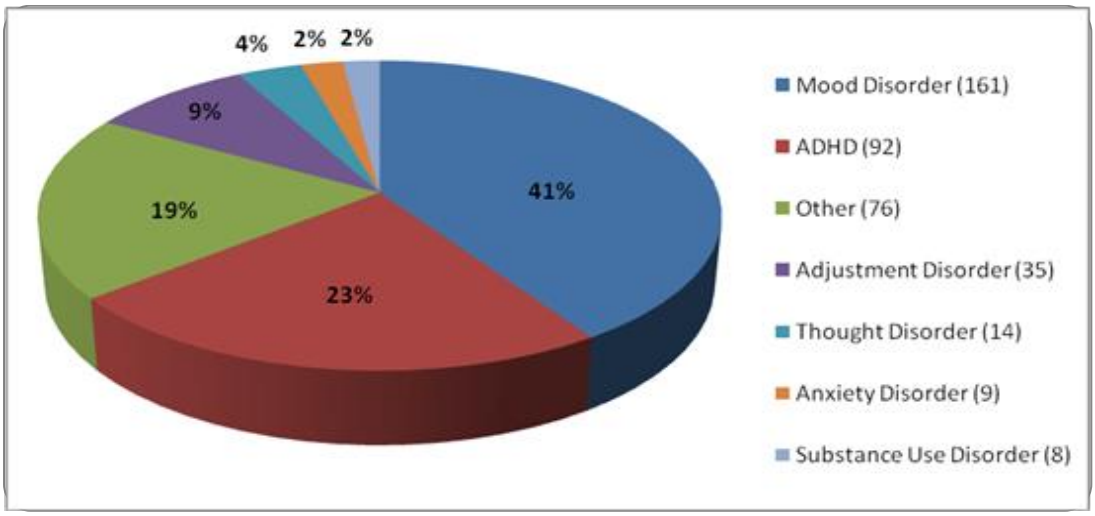
- Charts 5 shows that 75 percent of young people served had two or more presenting problems.
- It should be noted that the number of young people with multiple presenting problems may not be an accurate representation, due to inconsistent reporting.

Chart 6. Presenting Problem



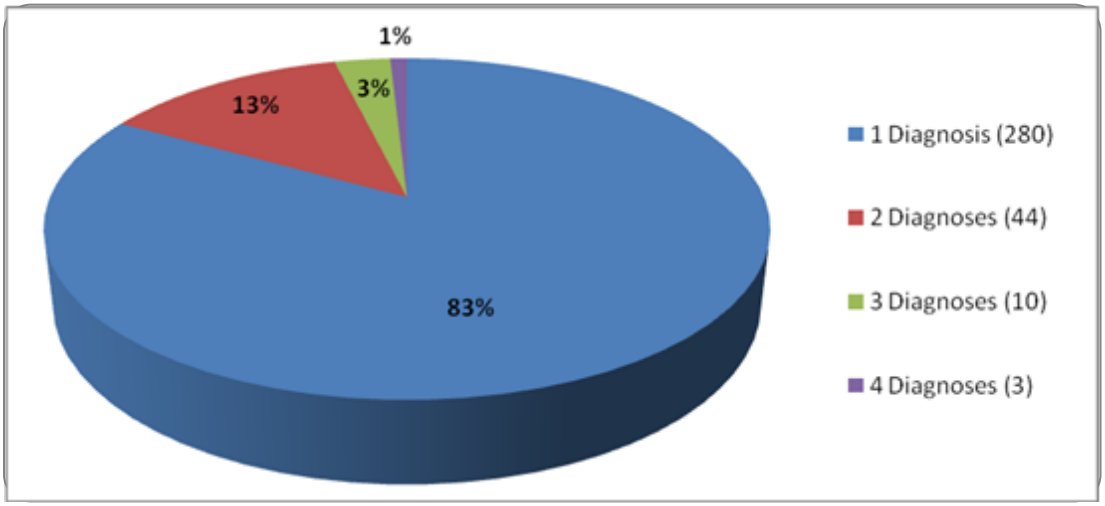
- Chart 6 shows the frequency of presenting problems identified at the time of admission. As noted in Chart 5, they may enter the program with multiple presenting problems.
- The “not specified” category includes young people for whom a presenting problem was not specified or was too vague to categorize, such as “multiple hospitalizations’ or “at risk of residential placement.”

Chart 7. Behavioral Health Diagnoses



- Chart 7 shows the behavioral health diagnoses reported at admission. The total number of diagnoses exceeds the total number of young people served due to multiple diagnoses per person in some instances.
- The diagnoses are organized into major diagnostic categories with mood disorders ranking as the most common.
- The "other" category includes diagnoses not captured in the major categories, such as impulse control disorder, oppositional defiant disorder, intermittent explosive disorder, disruptive behavior disorder, conduct disorder, and pervasive developmental disorders.

Chart 8. Number of Reported Behavioral Health Diagnoses per Young Person



- Chart 8 shows the number of diagnoses reported for each young person served.
- It should be noted that the number of young people with one diagnosis may not be an accurate representation, due to inconsistent reporting.

V. CAT Providers

In terms of geography, there is at least one CAT provider in five of the six Department regions, with the Southeast Region being the exception. With the exception of Manatee Glens, all providers are new. It should be noted that any delay between contract execution and initiation of services is a result of provider start-up activities, such as obtaining a location, hiring and training staff and developing referrals sources. An overview of each provider and the populations they serve is provided here.

V.A. CHILD GUIDANCE CENTER

Child Guidance Center is a private, non-profit agency located in Jacksonville, Florida, offering a full array of community based behavioral health care for children and their families including outpatient services, day care consultation, infant mental health/high risk newborn services, school based services, case management, and mobile crisis services. The Child Guidance Center has been providing behavioral health services for nearly 60 years and is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) International.

1. The CAT catchment area includes Duval County.
2. The CAT contract was executed on 7/19/2013, and services began 8/1/2013.
3. As of 12/06/2013, a total of 31 young people and their families have received CAT services.

V.B. CIRCLES OF CARE

Circles of Care is a non-profit community based corporation located in Melbourne, Florida, with satellite locations throughout Brevard County. The agency provides behavioral health care programs to adults and children including inpatient, residential, outpatient, in-home, on-site, professional consultation and public information/education services. Circles of Care was founded in 1963 and is accredited by The Joint Commission.

1. The CAT catchment area includes Brevard County.
2. The CAT contract was executed on 7/31/2013, and services began 8/1/2013.
3. As of 12/06/2013, a total of 31 young people and their families have received CAT services.

V.C. DAVID LAWRENCE CENTER

David Lawrence Center is a non-profit behavioral health provider located in Naples, Florida, with eight satellite locations in Collier County. The David Lawrence Center provides inpatient, outpatient, residential and community based prevention and treatment services for children and adults who experience mental health, emotional, psychological and substance abuse challenges. David Lawrence Center was founded in 1986 and is accredited by the Joint Commission.

1. The CAT catchment area includes Collier County.
2. The CAT contract was executed on 7/26/2013, and services began 8/22/2013.
3. As of 12/06/2013, a total of 25 young people and their families have received CAT services.

V.D. INSTITUTE FOR CHILD & FAMILY HEALTH (ICFH)

ICFH is a private, non-profit organization located in Miami, Florida, providing health, behavioral health, educational and prevention services to children, adolescents and families in Miami-Dade County. The organization has provided services for 60 years and is accredited by the Council on Accreditation (COA).

1. The CAT catchment area includes Miami-Dade County.
2. The CAT contract was executed on 7/26/2013, and services began 8/27/2013.
3. As of 12/06/2013, a total of 30 young people and their families have received CAT services.

V.E. LIFE MANAGEMENT CENTER

Life Management Center is a non-profit organization located in Panama City, Florida, that provides behavioral health and family counseling services to children, adolescents and adults in Bay, Calhoun, Gulf, Holmes, Jackson, and Washington counties. Life Management Center has been in operation since 1954 and is accredited by CARF International.

1. The CAT catchment area includes Bay County.
2. The CAT contract was executed on 7/29/2013, and services began 7/29/2013.
3. As of 12/06/2013, a total of 32 young people and their families have received CAT services.

V.F. MANATEE GLENS

Manatee Glens was founded as a non-profit organization in 1955 and is located in Bradenton, Florida. Manatee Glens specializes in mental health and addictions and provides an array of inpatient, residential, intensive outpatient and counseling services for children, adults and elders. The organization is accredited by The Joint Commission and was funded by the 2005 legislature to implement the first CAT model in Florida.

1. The CAT Team catchment area includes Manatee, Sarasota and DeSoto Counties.
2. The CAT Team contract was executed on 7/26/2013, and services began 7/29/2013.
3. As of 12/06/2013, a total of 33 young people and their families have received CAT services.

V.G. GRACEPOINT (FORMALLY MENTAL HEALTH CARE)

Gracepoint was founded in Tampa, Florida in 1942 as the Child Guidance Center serving children in the Tampa area. Gracepoint has since expanded services to adults and provides an array of programs and behavioral health services to individuals in Hillsborough and Pasco Counties. Gracepoint is accredited by the Joint Commission.

1. The CAT catchment area includes Hillsborough County.
2. The CAT contract was executed on 7/26/2013, and services began 8/19/2013.
3. As of 12/06/2013, a total of 31 young people and their families have received CAT services.

V.H. PEACE RIVER CENTER

Peace River Center is a private, non-profit community mental health organization located in Bartow, Florida serving Polk, Highland and Hardee Counties. The agency provides an array of services and programs including crisis stabilization, outpatient counseling, psychiatric/medical services, adult residential treatment, case management, substance abuse services, domestic violence and rape recovery programs, and a 24-hour crisis hotline. The Peace River Center has been providing services for over 62 years and is accredited by The Joint Commission.

1. The CAT catchment area includes Polk, Highlands, and Hardee Counties.
2. The CAT contract was executed on 8/1/2013, and services began 9/27//2013.
3. As of 12/06/2013, a total of 33 young people and their families have received CAT services.

V.I. PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES (PEMHS)

PEMHS is a private, non-profit behavioral health care organization located in Pinellas County, Florida. Programs include a 24-hour suicide prevention hotline, emergency screening and crisis

intervention services, inpatient services for adults and children, residential services for children and community based programs. PEMHS has been providing services since 1981 and is accredited by the Joint Commission.

1. The CAT catchment area includes Pinellas County.
2. The CAT contract was executed on 7/26/2013, and services began 8/19/13.
3. As of 12/06/2013, a total of 31 young people and their families have received CAT services.

V.J. SALUSCARE (FORMALLY LEE MENTAL HEALTH)

SalusCare was incorporated in 2013 after two Southwest Florida healthcare providers, Lee Mental Health and Southwest Florida Addiction Services, merged into one new not-for-profit healthcare organization with seven locations throughout Lee County. SalusCare serves individuals with mental health and substance use issues, providing intake, outpatient and residential services. SalusCare is accredited by CARF International.

1. The CAT catchment area includes Lee County.
2. The CAT contract was executed on 8/20/2013, and services began on 7/11/2013.
3. As of 12/06/2013, a total of 60 young people and their families have received CAT services. SalusCare contracted with the Department for a CAT program made up of 11 staff members, allowing them to serve more young people.

VI. Performance Indicators

Output and outcome performance measures included in provider contracts were selected in partnership with the providers, the Florida Council and the Department. The output measures address basic start-up activities required by teams for program implementation within a specified time period. The outcome measures address the intended impact of services for an individual served by the CAT program.

As stated in the CAT contract, the Department will require the CAT team providers to develop a corrective action plan outlining how they will address a deficient contract requirement if they fail to meet a required performance target for 30 calendar days. If the provider fails to remedy the situation within 60 calendar

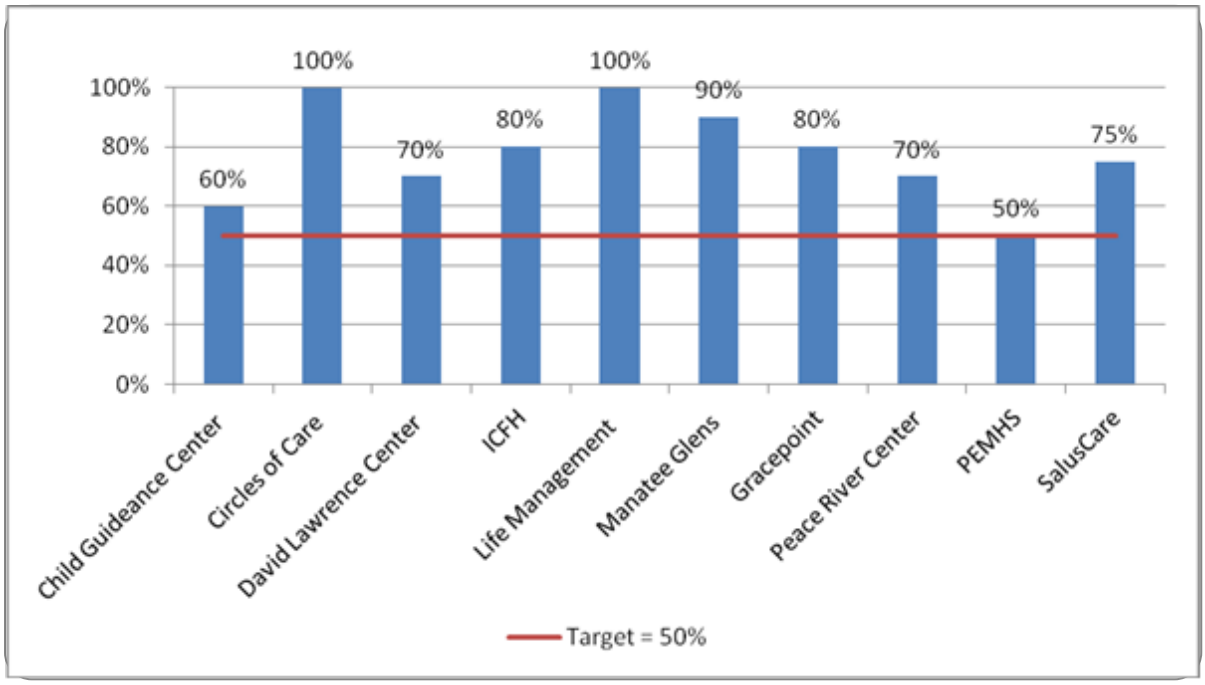
days, the Department will apply financial consequences pursuant to subsection 287.058(1)(h), F. S., and section 21 of the Standard Contract.

VI.A. OUTPUTS

CAT providers submitted output data from the time of contract execution through December 6, 2013.

1. **A minimum of 50 percent of staff shall be hired and trained within thirty (30) days of contract execution.**

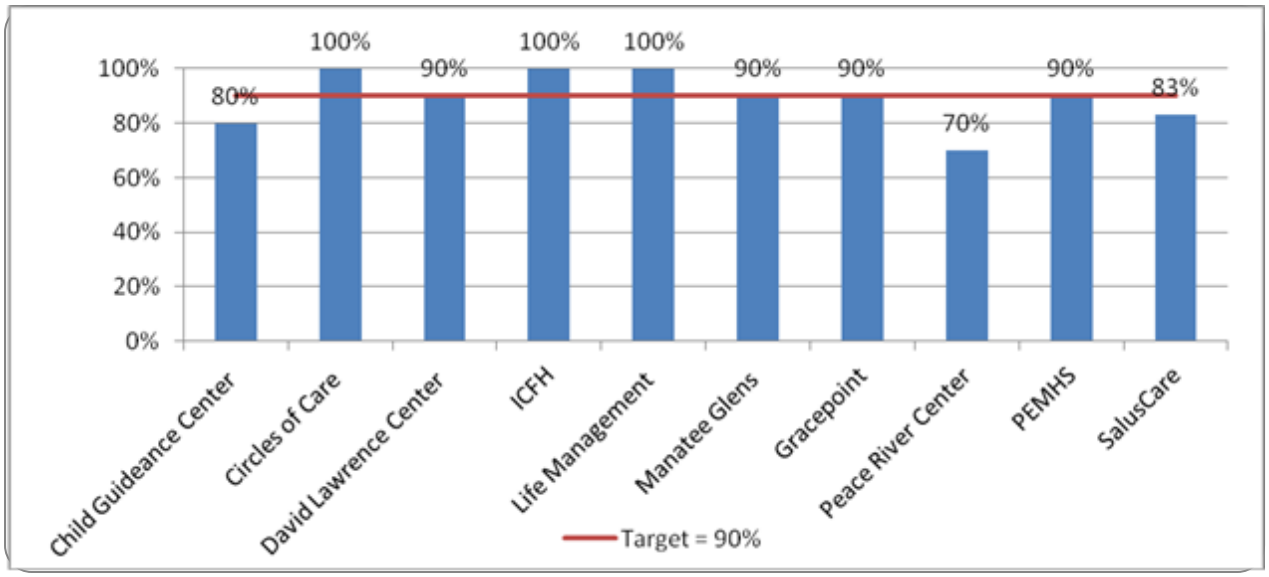
Chart 9. Staff Hired and Trained within 30 Days, as a percentage



- Summary: All ten providers hired and trained at least 50 percent (5) of the total CAT staff members required (10) within 30 days of contract execution.
- Methodology: The number of staff hired and trained within 30 days of contract execution divided by the total number of staff to be hired shall be ≥ 50 percent. The total number of staff required is a minimum of 10, with the exception of SalusCare that contracted for a minimum of 12.
- Frequency of Reporting: 30 days after of contract execution.

2. **A minimum of 90 percent of staff shall be hired and trained within forty-five (45) days of contract execution.**

Chart 10. Staff Hired and Trained within 45 Days, as a percentage



- Summary: Seven of ten providers hired and trained at least 90 percent of CAT staff members within 45 days of contract execution.
- Methodology: The number of staff hired and trained within 45 days of contract execution divided by the total number of staff to be hired shall be ≥ 90 percent.
- Frequency of Reporting: 45 days after contract execution.

3. A minimum of twenty (20) young people will be enrolled within ninety (90) calendar days of contract execution.

Table 11. Number of Young People Enrolled in 90 Days

- Summary: Eight of ten providers enrolled a minimum of 20 young people within 90 days of contract execution.
- Methodology: The number of young people enrolled within ninety (90) calendar days of contract execution shall be ≥ 20.
- Frequency of Reporting: Once at approximately 90 days.

4. **A minimum of forty (40) young people will be enrolled within one hundred and eighty (180) calendar days of contract execution.**

- Summary: This has not been calculated as yet; therefore, no graph is provided for this performance measure.
- Methodology: The number of young people enrolled within 180 calendar days of contract execution shall be ≥ 40.
- Frequency of Reporting: At the end of the contract year.

5. **A minimum of sixty (60) targeted individuals will be served during the contract year.**

- Summary: This has not been calculated as yet; therefore, no graph is provided for this performance measure.
- Methodology: The number of young people enrolled at the end of the contract year shall be ≥ 60.
- Frequency of Reporting: At the end of the contract year.

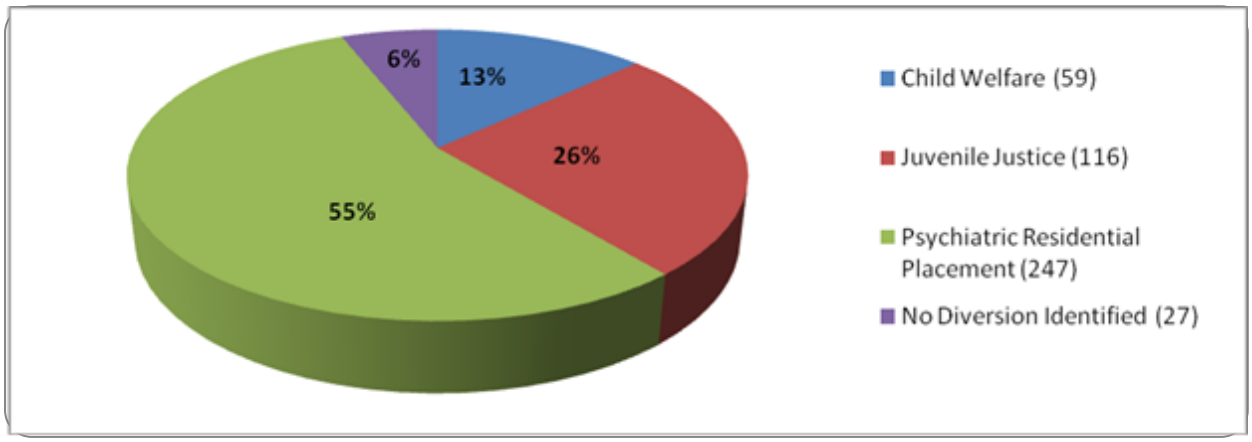
VI.B. OUTCOMES

These outcomes are based on performance measures from the original 2005 pilot CAT team contract and are reported from September 1, 2013 through December 6, 2013. By contract, they include:

- Diversion from out of home placement;
- Level of cognitive and behavioral functioning;
- School attendance;
- Days in the community; and
- Level of parental stress.

6. **A minimum of 65 percent of enrolled young people will be diverted from placement into child welfare, juvenile or criminal justice, or residential care.**

Table 12. Percent of Young People Diverted



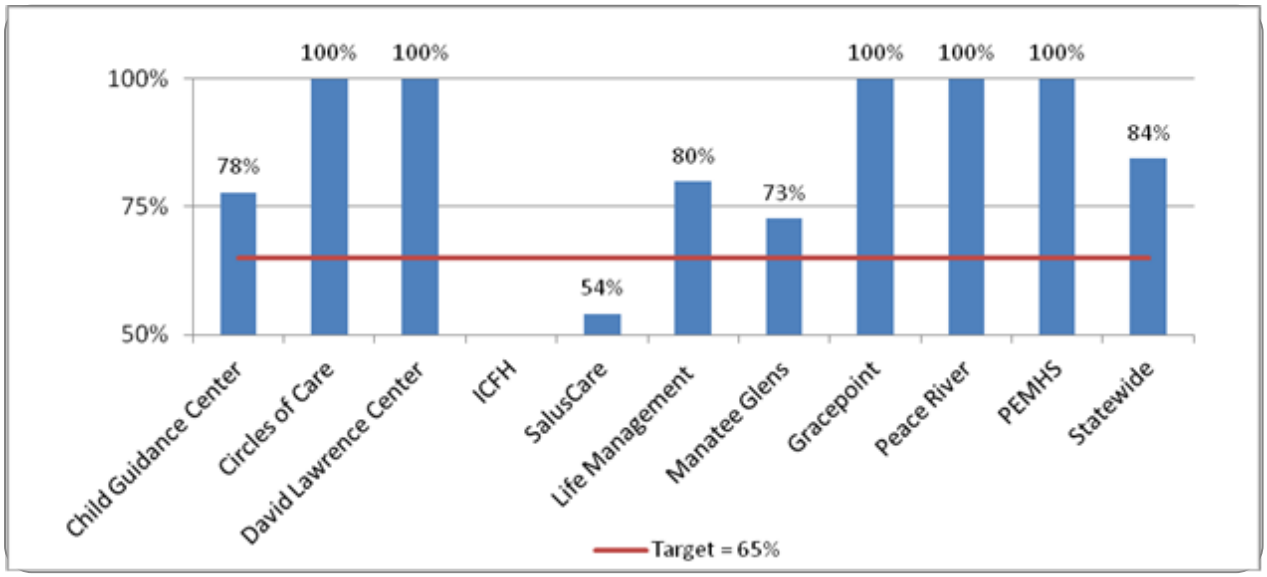
- Summary: Statewide, 94 percent of people referred were identified by providers as being diverted from out-of home placements at time of admission. The total number diverted exceeds the total number of young people served due to diversions from multiple placements per person. In the time examined, 14 of 337 or 4 percent of young people served were placed into out-of-home care as follows:

- Five were incarcerated through juvenile justice;
- One was removed from the home and placed in a child welfare placement;
- Five were placed in residential psychiatric treatment programs;
- Two were incarcerated through juvenile justice and placed in psychiatric treatment programs; and
- One was removed from the home through child welfare and placed in a psychiatric treatment program.

- Methodology: The total number of young people diverted from child welfare, juvenile or criminal justice, or residential care divided by the total number of young people served who were deemed at risk of out-of-home placement at time of referral shall be ≥ 65 percent.
- Frequency of Reporting: At intake and quarterly thereafter.

7. A minimum of 65 percent of enrolled young people will improve their level of functioning as measured by CFARS if under 18, or FARS if 18 or older.

Chart 13. Functional Improvement, as a percentage

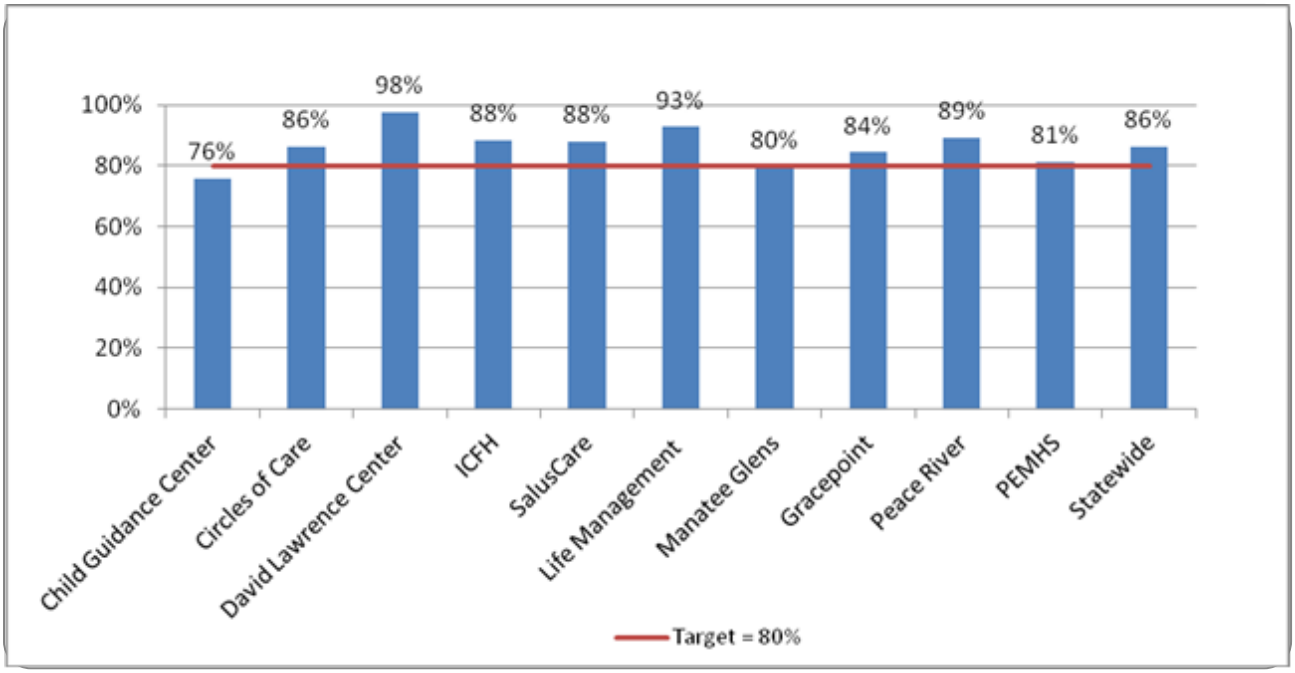


- Summary: Functional improvement was determined by comparing a young person's CFARS or FARS scores at admission and at three month after admission.[29] Young people served less than three months are not included in this chart. Eight of ten providers exceeded the target. One provider did not meet the target while another, ICFH, served only two young people longer than three months and did not submit quarterly CFARS scores. Statewide, 84 percent of young people served improved their level of functioning.
- Methodology: The total number of enrolled young people who improved their level of functioning as measured by the Child Functional Assessment Rating Scale (CFARS) if under age 18 or the Functional Assessment Rating Scale (FARS) if age 18 or older divided by the total number of enrollees shall be ≥ 65 percent.
- Frequency of Reporting: At intake and quarterly thereafter.

8. Enrolled young people will attend a minimum of 80 percent school days.

[29] The Children's Functional Assessment Rating Scale (CFARS) and the Functional Assessment Rating Scale (FARS) were developed by the Florida Mental Health Institute, University of South Florida in partnership with the department to assess the effectiveness of state contracted mental health services for adults and to gather functional assessment information for multiple domains. *See*, calmhsa.org/wp-content/uploads/2013/06/cfarsmanual.pdf, site accessed January 8, 2014.

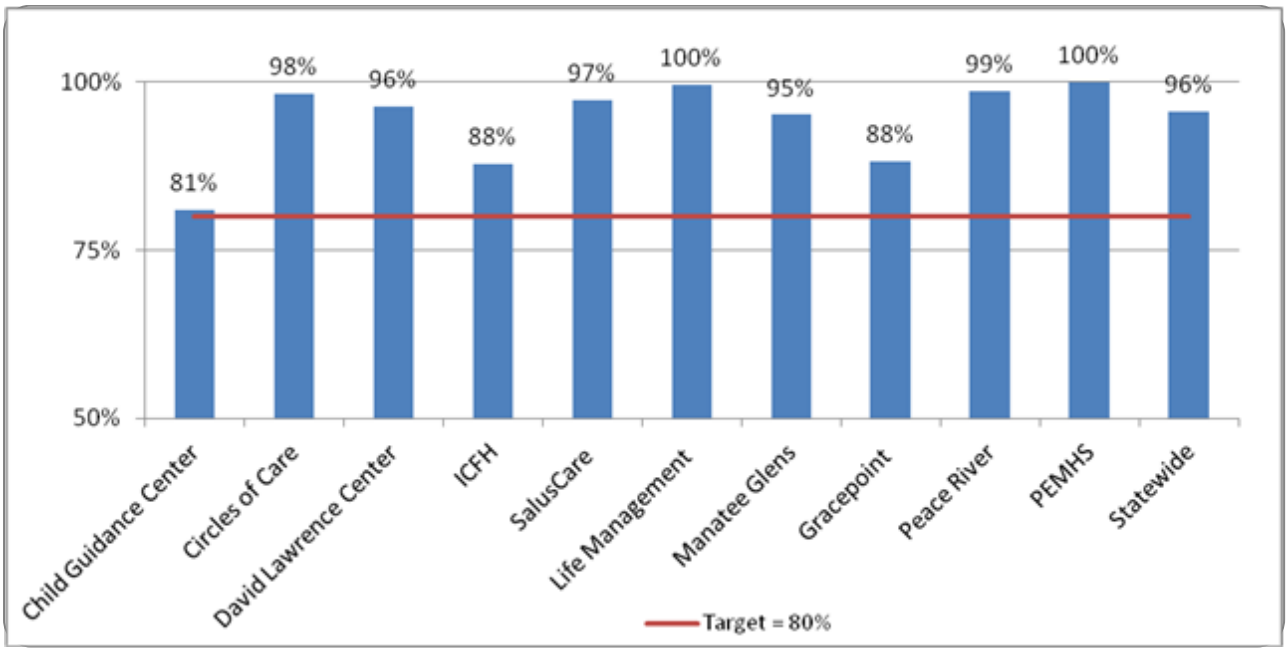
Chart 14. Days in School, as a percentage



- Summary: This measure includes all young people age 15 and under and those age 16 and over who are participating in a school program. Nine of ten providers met or exceeded this target. Statewide, young people attended 86 percent of school days.
- Methodology: The total number of school days attended by enrolled young people divided by the total number of school days available shall be ≥ 80 percent.
- Frequency of Reporting: Monthly

9. Enrolled young people older than school age will spend a minimum of 80 percent of the days in the community.

Chart 15. Days in the Community, as a percentage



- Summary: Reporting for this measure was required for young people aged 16 and older. However, a number of providers also reported on young people served aged 15 and younger. All data reported was included in the graph above. Ten of ten providers exceeded this target. Statewide, young people served spent an average of ninety-six percent of days in the community.
- Methodology: The total number of days enrolled young people spent in the community (i.e., not in a psychiatric hospital, juvenile detention center, residential treatment facility, or on runaway) divided by the total number of days available during that month shall be ≥ 80 percent.
- Frequency of Reporting: Monthly

10. A minimum of 65 percent of enrolled young people will improve their level of functioning as measured by the PSI™-4 (Parenting Stress Index™, Fourth Edition) for youth age 12 and under.

- Summary: This measure is calculated by comparing the PSI admission and 90 day scores. The performance on this measure was not included due to the low number of PSIs completed and scores reported by CAT providers.
- Methodology: The total number of enrolled young people age 12 and under who improved their level of functioning as measured by the PSI™-4 (Parenting Stress Index™, Fourth Edition) for children age 12 and under divided by the total number of enrollees age 12 and under shall be ≥ 65 percent.
- Frequency of Reporting: At intake and quarterly thereafter.

11. A minimum of 65 percent of enrolled young people and their families will improve their level of functioning as measured by the SIPA™ (Stress Index for Parents of Adolescents™) for youth age 13 and older.

- Summary: This measure is calculated by comparing the SIPA admission and 90 day scores. The performance on this measure was not included due to the low number of SIPAs completed and scores reported by CAT providers
- Methodology: The total number of enrolled young people age 13 and older who improved their level of functioning as measured by the SIPA™ (Stress Index for Parents of Adolescents™) for youth age 13 and older divided by total number of enrollees age 13 and older shall be ≥ 65 percent.
- Frequency of Reporting: At intake and quarterly thereafter.

VI.C. COST COMPARISON

The primary goal is to divert people from out-of-home placement. Out-of-home-care programs for juvenile justice, child welfare and residential mental health treatment have different associated costs, lengths of service; and do not include publically funded services families may be receiving. The most relevant cost comparison can be made between residential mental health treatment and CAT programs.

Given the limited operation of the CAT teams, the following projection as to cost is made:

- CAT

  The cost of each CAT team is $675,000 per year, and are contracted to serve a minimum of 60 young people and their families.

  From this, the average cost for one CAT treatment episode per young person is estimated to be $11,250.

- SIPP

  The cost of the Medicaid funded Statewide Inpatient Psychiatric Program (SIPP) is $408 per day with an average length of treatment of 180 days, per the Agency for Health Care Administration.

  From this, the average cost for one mental health residential treatment episode is estimated to be $73,440.

VII. Conclusion

Given the limited timeframe that the CAT teams have been in operation, is it not possible to provide an unequivocal conclusion as to the efficacy of the CAT model. However, providers have been deployed quickly to implement services and meet the 90-day enrollment target. Based on outcome data to date, it appears that young people with severe emotional disturbance served by the CAT teams are staying in school and in their community.

Next Steps

The Department will continue to partner with the Florida Council for Community Mental Health, CAT providers to refine the CAT programs. The following have been identified for improvement:

- Monitor and streamline implementation across providers to ensure fidelity to the basic principles and framework;
- Develop a CAT practice manual that addresses major components of the CAT model;
- Revise performance measures to address educational, vocational options, quality of life, and satisfaction with services;
- Develop youth and family specific performance measures that better capture both short and long term impact on family functioning;
- Research and implement the most up to date clinical practices in the areas of screening, assessment and treatment, as appropriate;
- Identify and leverage community resources that promote resiliency, positive youth development and self-advocacy, such as Peer Specialists and Vocational Rehabilitation; and
- Coordinate with the Agency for Health Care Administration to identify opportunities to bill for and expand the CAT services and supports under Medicaid Managed Care.

Appendix A Florida Assertive Community Treatment (FACT) Teams

	Name of Provider	County(ies) Served
1	Mental Health Resource Center	Alachua
2	Life Management Center	Bay

	Name of Provider	County(ies) Served
3	Mental Health Resource Center	Brevard
4	Henderson Behavioral Health	Broward
5	Coastal Behavioral Healthcare	Charlotte
6	Mental Health Resource Center	Collier
7	Mental Health Resource Center	Duval, Clay, and Nassau (North)
8	Mental Health Resource Center	Duval, Clay, and Nassau (South)
9	Lakeview Center	Escambia and Santa Rosa
10	Peace River Center	Hardee and half of Polk
11	Mental Health Resource Center	Highlands and half of Polk
12	Mental Health Resource Center	Hillsborough
13	Northside Mental Health	Hillsborough
14	Suncoast Center	Hillsborough and Pinellas
15	LifeStream Behavioral Center	Lake, Sumter, Hernando, Citrus, and Marion
16	Coastal Behavioral Healthcare	Lee (North)
17	Coastal Behavioral Healthcare	Lee (South)
18	Apalachee Center	Leon
19	Manatee Glens	Manatee
20	Mental Health Resource Center	Martin, Okeechobee, and St. Lucie
21	Citrus Health Network	Miami-Dade
22	Citrus Health Network	Miami-Dade
23	Fellowship House	Miami-Dade
24	Lakeside Behavioral Healthcare	Orange
25	Mental Health Resource Center	Osceola

	Name of Provider	County(ies) Served
26	Henderson Behavioral Health	Palm Beach
27	BayCare Health System	Pasco
28	Boley Centers for Behavioral Health Care	Pinellas
29	Mental Health Resource Center	Pinellas
30	Coastal Behavioral Healthcare	Sarasota and Desoto
31	New Horizons of the Treasure Coast	St. Lucie and Indian River
32	Stewart Marchman Act Behavioral Healthcare	Volusia, Flagler, Putnam, and St. Johns

DISCLAIMER:

Please note that Appendix B is a reproduction of an outcome report completed by Manatee Glens, for Community Action Team (CAT) services provided from January 1, 2010, through December 31, 2012. The comments and conclusions expressed in Appendix B should be attributed to the authors of the report, and as such should not be construed as those of the Department.

Appendix B Manatee Glens CAT Team Outcome Report

Mental Health & Addictions
Specialty Hospital and Outpatient Practice
MANATEE GLENS

Children's Community Action Team-CAT Team

Summary Three Year Outcomes and Findings

January 1, 2010-December 31, 2012

Mary Ruiz, MBA

Melissa Larkin-Skinner, LHMC

Introduction

In 2005 the Florida Legislature launched a behavioral healthcare pilot for youth in Manatee County known as the **Community Action Team** or **CAT Team** with the following goals:

Goal 1: Offer parents and caregivers of seriously, emotionally disturbed youth a safe option for raising their son or daughter at home.

Goal 2: Provide a lower cost alternative to state-funded care such as foster homes, residential treatment or juvenile justice.

The **CAT Team** bridges the gap between home and institutional care by providing families a "hospital without walls" including such features as:

- Counselors on 24 hour call
- Availability of daily services in home or school
- One integrated team of experts addressing multiple problems
- Coaching for effective parenting of special needs
- Family support including counseling, respite, mentoring and social services including expense for incidentals

The **CAT Team** is not a "program" but a service that is unique in "wrapping around" the individual circumstances of each family and the needs of every member in the family. This whole family approach deals with all challenges that

might confront the child or the home environment. At the end of six months of **CAT Team** services, the majority of families are able to successfully manage the concerns that brought them to the **CAT Team.**

This summary evaluation was conducted at Manatee Glens, a nonprofit specialty hospital and outpatient practice in Bradenton, Florida. The purpose of the evaluation was to assesses outcomes for the three-year time period from January 2010 to December 2012 when **CAT Team** services were enhanced to address co-occurring alcohol and drug abuse issues along with mental health concerns.

Summary Findings

Goal 1: Offer parents and caregivers of seriously, emotionally disturbed youth a safe option for raising their son or daughter at home

Performance Outcome Measure

Goal: Serve 75 cases and 300 family members per year

Result: Served 81 cases and 332 family members per year

From January 1, 2010 through December 31, 2012, a total of 244 cases and 995 family members were served over three years. The **CAT Team** exceeded the outcome for annual numbers served with an average of 81 cases admitted per year and an average of 332 family members served annually. Most of these cases (76%) fell between the ages of 11 to 17. The majority of family members represent siblings impacted by the behavioral difficulties demonstrated by their brother or sister.

CAT Team January 1, 2010 to December 31, 2012

Age at Admission	Number of Admissions
4 years	2
5 years	6
6 years	6
7 years	12

8 years	11
9 years	10
10 years	11
11 years	23
12 years	28
13 years	33
14 years	24
15 years	26
16 years	32
17 years	20
Total Admissions	**244**

Performance Outcome Measure

Goal: Serve 65% of cases with multiple diagnoses

Result: Served 69% of cases with multiple diagnoses

The **CAT Team** is required to treat the most serious of childhood disorders including schizophrenia, bipolar disorder, post-traumatic stress syndrome, substance abuse and mood disorders. It must also routinely handle complex cases with multiple major diagnoses. Below is a summary of diagnoses for the 244 admissions from January 1, 2010 to December 31, 2012.

CAT Team January 1, 2010 to December 31, 2012

Diagnosis	**Number of Clients**	**Percent of Total**
Two Major Diagnoses	169	69%
Three Major Diagnoses	53	37%
Psychotic Disorder/Schizophrenia	16	7%
Bipolar	37	15%
Post-Traumatic Stress	36	15%
Substance Abuse	58	24%

Performance Outcome Measure

Goal: Readmission rate less than 15%

Result: Readmission rate of 4%

Despite the severity and complexity of cases, the **CAT Team** must successfully transition children and their families to less intensive levels of care within less than a year. In the three years from January 1, 2010 to December 31, 2012, the total three-year readmission rate was 4% of total cases. While length of stay varied from three months to just over a year, most cases transitioned in six months or less.

CAT Team January 1, 2010 to December 31, 2012

Readmissions to CAT by Case	**Readmissions**
One Readmission	8
Two Readmissions	1
Three Readmissions	0
Total Readmissions	**10**

Goal 2: Provide a lower cost alternative to state-funded foster homes, residential treatment or juvenile justice.

Performance Outcome Measure

Goal: Divert 85% at risk of foster care, residential or juvenile justice

Result: Diverted 93.7% foster care, 87.5% residential, 74.2% juvenile justice

Because the youth's behavior poses a threat to the safety of the child, home or community, most cases (66%) admitted to the **CAT Team** from January 1, 2010 to December 31, 2012 were at risk of residential placement. Families themselves are also in jeopardy. Of the total cases admitted during this three year period, more

than a third (39%) was at risk of entering the foster care system. Public safety concerns resulted in 25% of cases at risk of incarceration in the juvenile justice system.

The **CAT Team** was most successful in diverting cases from foster care at 93.7%. Diversion from residential placement also exceeded the expected outcome at 87.5%. Diversion from juvenile justice achieved 74.2% which was below the expected outcome of 85%. Many cases were at risk of multiple system admissions with the most typical overlap occurring between foster care and residential treatment.

CAT Team January 1, 2010 to December 31, 2012

At Risk of Admission	Number of Clients	Number Admitted	Diversion Rate
Residential Placement	160	20	87.5%
Foster Care	95	6	93.7%
Juvenile Justice/Detention	62	16	74.2%

The majority of referrals to the **CAT Team** came from the following sources in order of frequency:

- Crisis or outpatient behavioral health services
- Child welfare or child protective services
- Parents and Schools
- Residential (Family Services Planning Team)
- Department of Juvenile Justice

Performance Outcome Measure

Goal: Expenses below daily rate of $100

Result: Expenses at daily rate of $67.43

During the three-year period from January 1, 2010 to December 31, 2012, the CAT Team provided 250 days of service to an average caseload of 47. Average annual operating costs were $792,388 for a daily cost of $67.43 excluding one-time capital and minor durable expenses for computers, desks, vehicles, phones and equipment of about $62,000.

A break-even analysis requires that only 9 of the 244 admissions to the CAT Team need be diverted from a residential treatment stay of six months at $350 a day to offset the entire cost of all families served.

Case Studies

Tom *The seventeen year old was impulsive. His increasing aggression toward his mother and classmates began to alarm his adoptive parents. Tom was grounded at home and suspended from school. Nothing worked. CAT Team helped Tom reestablish self-control. Counseling provided pressure relief, insight into triggers for anger and agreement on ground rules at home. Medication provided Tom enough relief from his symptoms to begin to self-manage his impulsivity and aggression. One-on-one time with the CAT Team mentor helped Tom get back on top of his game at school. Tom's father wrote in gratitude about his son "he is fun to be around and we all laugh together."*

Trina *Her mood swings were severe even for a sixteen year old girl. Trina just couldn't stand herself. She began cutting her arms in secret and openly defying her mother by sexually acting out. The CAT Team psychiatrist was able to stabilize her moods but the damage had been done with Trina's family relationships and her school work. Counselors helped Trina think about consequences before choosing actions and work on positive communication. She is meeting her goal of a 3.0 GPA in school. Trina's mother says, "I am glad to have my daughter back."*

Sandy *The grandparents of this ten- year-old girl knew they were in way over their heads. They finally sought out residential treatment because Sandy was explosive and aggressive without warning. Her poor social skills meant she was always bullied at school. So Sandy refused to go to school and her grades fell. CAT Team went in the home to help the grandparents build structure and consistency. Counselors addressed Sandy's self-esteem and offered ways she could be assertive without being aggressive. Sandy found out about how to cope with the stress of school so she could make friends and get her grades up. Grandmother told the CAT counselor, "We know we can raise our granddaughter at home with us now."*

From Parents

"You would really do this for me?"

"I must be dreaming this is too good to be true."

"It makes me feel like we are not alone."

"I appreciate your help; you have put my mind at ease."

"I am so glad to have you guys on my side."

Recommendations

1. Make CAT Team a permanent strategy in Florida's behavioral health system for youth and young adults. Florida families are too often left "home alone" with seriously emotionally disturbed youth and young adults without adequate support to handle the challenge. Out of desperation, families seek residential placement or even foster care or juvenile justice to keep their children and their families safe.

While families wait for help, Florida's communities risk losing public safety. This three-year summary evaluation concludes that the CAT Team can fill this gap in care for Florida families with great acceptance by families and lower cost for Florida tax payers. Every child should have every chance to be raised at home. No Florida community should have to fear its own children. With only a 4% readmission rate for this difficult population, the CAT Team proves it can answer the call.

2. Add 30 CAT Teams at $20.25 million throughout the state tied to child or adult public receiving facilities. There are 30 full FACT Teams in Florida for adults. A like number of CAT Teams will offer the same level of service for youth and young adults. Tying CAT Team services to crisis centers provides a seamless transition from the crisis center to intensive in home services of the CAT Team. Rural counties are best served as an adjunct to an urban team with an appropriate reduction in required caseload to allow for time and distance of a larger geographic area. The model budget of $675,000 cannot be scaled down as the staffing plan is the minimum required to provide 24 hour coverage. It can be scaled up to provide care for more cases. For example the budget could be doubled to serve 80 cases at a time or 165 a year. CAT Teams are a good investment for the state as they have a proven, positive impact

on diversion from foster care, residential treatment and juvenile justice offering a bend in the cost curve for the expansion of these deep end services. CAT Team services are reimbursed at a daily rate of $67.50 vs. $350 for residential care.

3. Update the model for today's challenges. Expand age to 21 for CAT services and admit children under 11 if they meet test of severity of illness. Require co-occurring substance abuse and trauma and care management of medical issues. Young adults up to age 21 years need to be provided transitional care in the youth system before they enter the adult system. Young adults with serious emotional disturbance have unique challenges in this stage of life.

CAT Teams have proven they can address a broad range of ages from four years old to eighteen. Therefore CAT Teams should be allowed to admit young adults up to 21 years old. A new state funding category would be required. While the majority (76%) of youth in this three year study is eleven or older, the flexibility to admit younger children based on the severity of their illness is important to avoid more significant problems later in life.

Given there is a significant rate of co-occurring substance abuse(26%) and trauma, Cat Teams should be required to treat substance abuse as an integrated part of their services. Further CAT Teams should integrate care management of medical issues into their services.

4. Implement and monitor proven outcomes. Performance outcomes measures developed in this study for volumes of service, severity of cases, readmission, diversion and cost containment promote accountability for contracted services. It is recommended that these outcomes be applied to future CAT Team contracted services.

5. Allow cost-based grants for first six months of start-up to cover one-time capital and equipment costs and enrollment

ramp up. It is recommended that the first six months of CAT Team operation be on a cost-based grant allowing for hiring and training of staff, purchase of one time equipment including furnishings, computers, phones and automobiles and phase in of cases over time to full caseload. This approach will assure a smooth transition for the CAT Team with a well-prepared clinical staff and adequate start up resources. Start-up capital costs are about $62,000.

Appendix A

Clinical Program Description

The Community Action Team (CAT Team) is a self-contained integrated multi-disciplinary team providing comprehensive, intensive community based treatment to families with children and youth at risk of out-of-home placement due to a mental health disorder. It includes oversight of the primary care needs of the children served.

The CAT Team provides family-centered, culturally competent services focused around the strengths and needs of each child and his/her family with a goal of supporting and sustaining the child in his/her family system and in the community. Medical staff provides psychiatric care, basic health status checks and works with the family to maintain medical records and linkages to community health care practitioners. The whole family is embraced in care and family commitment and participation is essential and expected. The CAT Team assists the family in developing a natural support network, improve interactions with the school system, and develop and use other community resources and supports.

Rationale: Mental disorders are the most prevalent illnesses affecting young people and are the largest single category to contribute to both mental and physical long-term societal costs. More than two-thirds of mental illnesses onset before 25 years of age, and these disorders are mostly chronic with substantial negative impact on multiple personal, interpersonal, social and physical health domains. Early identification and intervention can decrease both short- and long-term morbidity and may substantially improve both physical and mental health outcomes.

Mental health teams have long been the foundation for mental health services provided to children and youth. Changes in professional practices, the emergence of evidence-based care, the importance of integrating mental health and primary health care delivery provides even newer challenges to providing quality mental health care. The CAT Team provides a proven framework to address mental health and physical health care needs where 'traditional' mental health service interventions have not worked.

Target Population: Children ages 11 to 21 years with a mental health diagnosis or co-occurring substance abuse diagnosis, at-risk of out-home placement for whom traditional services have not been adequate as demonstrated by repeated failures at less intensive levels of care, 2 or more hospitalization or repeated failures, involvement with DJJ or multiple episodes involving law enforcement, or poor academic performance and/or suspensions. Also in the target group are adolescents/young adults aging out of the child welfare system or adolescents aging out of the children's system with high treatment needs as demonstrated above as part of their transition into the adult system of care. Children younger than 11 can be accepted into the program if they meet 2 or more of the criteria above.

Staffing/Minimum Qualifications: The CAT Team capable of serving 40 children/young adults consists of: 1) Team Leader who is a licensed mental health professional; 2) 1 licensed or licensed-eligible mental

health/substance abuse professionals; 3) 1 non-licensed master's level mental health/substance abuse professionals; 4)1 bachelor's case manager 5) 3 mentors/paraprofessionals; 6) .25 psychiatrist and or .50 ARNP and .5 RN or LPN ; 7) 1 administrative/support staff. Mentoring staff have the ability to assist with educational and vocational skill development as well as other non-clinical activities. The staffing model needs to allow for some flexibility to allow staff to provide the array of services that best meets the needs of the individuals/families. For example it may be more useful to have more psychiatric time or more nursing time or more mentoring.

Service Capacity: 40 children and their families; annual caseload from 75-80.

Length of Stay: Average length of stay per family/child is 6 months although length of stay is determined on a case by case basis.

Services: CAT Team services are provided in the community. Specific services are based on the child and family's strengths and needs. Services provided by the team and/or coordinated by the team include:

- Psychiatric (evaluation and medication management)
- Case Management
- Therapy (individual, group, family)
- Crisis response 24/7
- Community resource coordination including medical/dental
- Transportation (within specific guidelines)
- Educational system advocacy, coordination, tutoring
- Legal system advocacy and coordination
- Substance abuse/co-occurring services
- Parenting skills/Family education/Network Development
- Vocational/Educational Skills
- Therapeutic mentoring, including respite care up to 4 hours
- Coordination of other mainstream behavioral health treatment and support services
- Behavioral management and social skill development

Expected Effects:

- School related outcomes such as improved attendance, grades and graduation rates
- Decrease in out-of-home placements
- Improved family/child functioning
- Decrease in substance use/abuse
- Decrease in psychiatric hospitalizations
- Transition into age appropriate services
- Increase in health and wellness

Discharge Criteria:

1. 21 years old and transitioned to adult treatment services if appropriate
2. Child has functioned well at home and school (or employment if age appropriate) for 6 months
3. Family and team mutually agree to terminate services
4. Parent and/or child refuses to participate after 3 months despite best efforts of team to engage family
5. One year unless a reassessment determines continuation would be of value
6. Family moves

7. The child is placed in foster care, residential care, DJJ facility /or prison
8. The team determines that a different program would be more clinically appropriate

Appendix B
Budget and Staffing Model

Budget Model Narrative

An integrated team of 8.75 Full Time Equivalents representing six different behavioral health disciplines is required to provide services to 40 cases at a time for 250 days a year with 24 hour call, frequent or daily contact, in-home or in-community care, and coordination with schools, child welfare and other agencies.

- **Clinical Director**
- **Psychiatrist/Advanced Registered Nurse Practitioner**
- **Registered or Licensed Nurse**
- **Master's Therapists**
- **Bachelor's Case Manager**
- **Mentors**
- **Support Staff (Records, Reports, Schedules, Reception)**

Other expenses include transportation and family support. Family support expenses while a minor part of the budget play a major part in the **CAT Team** success. Examples of family support expense might be the continuation of activities offered by schools during the summer time, lock boxes for kitchen knives or other dangerous household objects or emergency purchases for health or safety.

Total cost per team is $675,000 a year serving 75-80 cases a year at a cost of $67.50 per day for 250 days a year. One time capital expenses of $62,000 provide for computers, furnishings, vehicles, phones and other start-up costs. These can be addressed in a six-month start up contract

that is cost-based to cover these one-time expenses and ramp up of staffing ahead of accepting cases.

Budget Model

POSITION	FTE	ANNUAL SALARY	RATE	ALLOCATED SALARY
Psychiatrist/ARNP	0.25	195,000	93.75	$ 48,750
RN/LPN	0.5	54,080	26.00	27,040
Team Leader/Lic Clinician	1	44,500	21.39	44,500
Licensed Clinician	1	40,560	19.50	40,560
Masters Level Clinician	1	35,360	17.00	35,360
Bachelor's Case Manager	1	32,552	15.65	32,552
Mentor's	3	29,494	14.18	88,483
Admin Assist	1	27,560	13.25	27,560
Total Salary Expense	8.75			$ 344,805
Benefits/Call (24%)				$ 82,072
Subtotal Staffing Expense				$ 426,877
Direct Operating Expense				$ 225,623
Family Incidentals				$ 22,500
Total Expense				$ 675,000

Appendix C Diagnoses

CAT Team January 1, 2010 to December 31, 2012

Principle Diagnosis	Number of Clients
Adjustment Disorder	3
Alcohol Abuse	1
Anxiety Disorder	4
Attention Deficit/Hyperactivity Disorder	73
Bipolar Disorder	30
Cannabis Abuse	15
Conduct Disorder	3
Depression	18
Disruptive Behavior Disorder	5
Impulse Control Disorder	6
Intermittent Explosive Disorder	3
Mood Disorder	49
Obsessive Compulsive Disorder	1
Opioid Dependence	1
Oppositional Defiant Disorder	10
Polysubstance Dependence	1
Post-traumatic Stress Disorder	14
Psychotic Disorder/Schizophrenia	7
Total	**244**

CAT Team January 1, 2010 to December 31, 2012

Secondary Diagnosis	Number of Clients
Adjustment Disorder	2
Alcohol Abuse	1
Anxiety Disorder	8
Asperger's Disorder	4
Attention Deficit/Hyperactivity Disorder	34
Bipolar Disorder	5
Cannabis Abuse	22
Conduct Disorder	1
Depression	5
Disruptive Behavior Disorder	4
Impulse Control Disorder	2
Mood Disorder	31
Opioid Dependence	1
Oppositional Defiant Disorder	13
Polysubstance Dependence	7
Post-traumatic Stress Disorder	20
Reactive Attachment Disorder	3
Psychotic Disorder/Schizophrenia	6
Total with at least two diagnoses	**169**

CAT Team January 1, 2010 to December 31, 2012

Tertiary Diagnosis	Number of Clients
Alcohol Abuse	1
Amphetamine Abuse	1
Anxiety Disorder	7
Asperger's Disorder	1
Attention Deficit Hyperactivity Disorder	12
Bipolar Disorder	2
Cannabis Abuse	6
Conduct Disorder	2
Depression	2
Disruptive Behavior Disorder	1
Impulse Control Disorder	1
Mood Disorder	8
Oppositional Defiant Disorder	3
Polysubstance Dependence	1
Post-traumatic Stress Disorder	2
Psychotic Disorder/Schizophrenia	3
Total with at least three diagnoses	**53**

Appendix D

Manatee Glens

Manatee Glens

Manatee Glens is a nonprofit organization specializing in mental health and addictions so that health and wellness is possible for every family. It was founded in 1955. Manatee Glens specialty hospital and outpatient practice is headquartered in Bradenton on the west coast of Florida. The agency provides care to more than 15,000 persons a year including 4,200 children and teens. Manatee Glens also offers child welfare services focused on family safety and reunification or adoption. Staff of 450 doctors, nurses, counselors and case workers serves one out of every thirty families in our region. Manatee Glens partners with local hospitals, physicians and law enforcement to accept referrals for more than $16 million in charity care a year.

Manatee Glens is able to offer this extraordinary level of service to the community through grants and donations from federal, state and local government as well as foundation and community donations. Our average cost per patient served is less than $2,200 a year. Seventy percent of our inpatients rate Manatee Glens' care as excellent far exceeding average national customer service levels (HCAPS). We achieve these cost efficiencies and high customer satisfaction through compassionate care, community partnerships, disciplined business practice, high productivity and innovation. Manatee Glens has a statewide and national reputation for state of the art care.

Mary Ruiz MBA and Melissa Larkin-Skinner LMHC

Ms. Ruiz is a senior behavioral healthcare executive with 25 years of experience in hospital administration, managed care systems, marketing and business development. For the past 16 years she has been President and CEO of Manatee Glens expanding annual services under her leadership from $12 million to $27 million.

Ms. Larkin-Skinner is a senior clinical manager with 15 years of experience in crisis and trauma services, child welfare, intensive outpatient and inpatient services. Currently she is Vice President of Inpatient and Residential Services responsible for a 78-bed campus offering mental health and addictions care for children and adults.

VIII. Appendix C 40 Developmental Assets

Search INSTITUTE

40 Developmental Assets® for Children Grades K–3 (ages 5-9)

Search Institute® has identified the following building blocks of healthy development—known as **Developmental Assets®**—that help young people grow up healthy, caring, and responsible.

External Assets

Support

1. **Family Support**—Family continues to be a consistent provider of love and support for the child's unique physical and emotional needs.
2. **Positive Family Communication**—Parent(s) and child communicate openly, respectfully, and frequently, with child receiving praise for her or his efforts and accomplishments.
3. **Other Adult Relationships**—Child receives support from adults other than her or his parent(s), with the child sometimes experiencing relationships with a nonparent adult.
4. **Caring Neighborhood**—Parent(s) and child experience friendly neighbors who affirm and support the child's growth and sense of belonging.
5. **Caring School Climate**—Child experiences warm, welcoming relationships with teachers, caregivers, and peers at school.
6. **Parent Involvement in Schooling**—Parent(s) talk about the importance of education and are actively involved in the child's school success.

Empowerment

7. **Community Values Children**—Children are welcomed and included throughout community life.
8. **Children as Resources**—Child contributes to family decisions and has opportunities to participate in positive community events.
9. **Service to Others**—Child has opportunities to serve in the community with adult support and approval.
10. **Safety**—Parents and community adults ensure the child's safety while keeping in mind her or his increasing independence.

Boundaries & Expectations

11. **Family Boundaries**—The family maintains supervision of the child, has reasonable guidelines for behavior, and always knows where the child is.
12. **School Boundaries**—Schools have clear, consistent rules and consequences and use a positive approach to discipline.
13. **Neighborhood Boundaries**—Neighbors and friends' parents help monitor the child's behavior and provide feedback to the parent(s).
14. **Adult Role Models**—Parent(s) and other adults model positive, responsible behavior and encourage the child to follow these examples.
15. **Positive Peer Influence**—Parent(s) monitor the child's friends and encourage spending time with those who set good examples.
16. **High Expectations**—Parent(s), teachers, and other influential adults encourage the child to do her or his best in all tasks and celebrate their successes.

Constructive Use of Time

17. **Creative Activities**—Child participates weekly in music, dance, or other form of artistic expression outside of school.
18. **Child Programs**—Child participates weekly in at least one sport, club, or organization within the school or community.
19. **Religious Community**—Child participates in age-appropriate religious activities and caring relationships that nurture her or his spiritual development.
20. **Time at Home**—Child spends time at home playing and doing positive activities with the family.

Internal Assets

Commitment to Learning

21. **Achievement Motivation**—Child is encouraged to remain curious and demonstrates an interest in doing well at school.
22. **Learning Engagement**—Child is enthused about learning and enjoys going to school.
23. **Homework**—With appropriate parental support, child completes assigned homework.
24. **Bonding to School**—Child is encouraged to have and feels a sense of belonging at school.
25. **Reading for Pleasure**—Child listens to and/or reads books outside of school daily.

Positive Values

26. **Caring**—Parent(s) help child grow in empathy, understanding, and helping others.
27. **Equality and Social Justice**—Parent(s) encourage child to be concerned about rules and being fair to everyone.
28. **Integrity**—Parent(s) help child develop her or his own sense of right and wrong behavior.
29. **Honesty**—Parent(s) encourage child's development in recognizing and telling the truth.
30. **Responsibility**—Parent(s) encourage child to accept and take responsibility for her or his actions at school and at home.
31. **Self-Regulation**—Parents encourage child's growth in regulating her or his own emotions and behaviors and in understanding the importance of healthy habits and choices.

Social Competencies

32. **Planning and Decision Making**—Parent(s) help child think through and plan school and play activities.
33. **Interpersonal Competence**—Child seeks to build friendships and is learning about self-control.
34. **Cultural Competence**—Child continues to learn about her or his own cultural identity and is encouraged to interact positively with children of different racial, ethnic, and cultural backgrounds.
35. **Resistance Skills**—Child is learning to recognize risky or dangerous situations and is able to seek help from trusted adults.
36. **Peaceful Conflict Resolution**—Child continues learning to resolve conflicts without hitting, throwing a tantrum, or using hurtful language.

Positive Identity

37. **Personal Power**—Child has a growing sense of having influence over some of the things that happen in her or his life.
38. **Self-Esteem**—Child likes herself or himself and feels valued by others.
39. **Sense of Purpose**—Child welcomes new experiences and imagines what he or she might do or be in the future.
40. **Positive View of Personal Future**—Child has a growing curiosity about the world and finding her or his place in it.

Search INSTITUTE

40 Developmental Assets® for Middle Childhood (ages 8-12)

Search Institute® has identified the following building blocks of healthy development—known as **Developmental Assets®**—that help young people grow up healthy, caring, and responsible.

External Assets

Support

1. **Family support**—Family life provides high levels of love and support.
2. **Positive family communication**—Parent(s) and child communicate positively. Child feels comfortable seeking advice and counsel from parent(s).
3. **Other adult relationships**—Child receives support from adults other than her or his parent(s).
4. **Caring neighborhood**—Child experiences caring neighbors.
5. **Caring school climate**—Relationships with teachers and peers provide a caring, encouraging environment.
6. **Parent involvement in schooling**—Parent(s) are actively involved in helping the child succeed in school.

Empowerment

7. **Community values youth**—Child feels valued and appreciated by adults in the community.
8. **Children as resources**—Child is included in decisions at home and in the community.
9. **Service to others**—Child has opportunities to help others in the community.
10. **Safety**—Child feels safe at home, at school, and in his or her neighborhood.

Boundaries & Expectations

11. **Family boundaries**—Family has clear and consistent rules and consequences and monitors the child's whereabouts.
12. **School Boundaries**—School provides clear rules and consequences.
13. **Neighborhood boundaries**—Neighbors take responsibility for monitoring the child's behavior.
14. **Adult role models**—Parent(s) and other adults in the child's family, as well as nonfamily adults, model positive, responsible behavior.
15. **Positive peer influence**—Child's closest friends model positive, responsible behavior.
16. **High expectations**—Parent(s) and teachers expect the child to do her or his best at school and in other activities.

Constructive Use of Time

17. **Creative activities**—Child participates in music, art, drama, or creative writing two or more times per week.
18. **Child programs**—Child participates two or more times per week in cocurricular school activities or structured community programs for children..
19. **Religious community**—Child attends religious programs or services one or more times per week.
20. **Time at home**—Child spends some time most days both in high-quality interaction with parents and doing things at home other than watching TV or playing video games.

Internal Assets

Commitment to Learning

21. **Achievement Motivation**—Child is motivated and strives to do well in school.
22. **Learning Engagement**—Child is responsive, attentive, and actively engaged in learning at school and enjoys participating in learning activities outside of school.
23. **Homework**—Child usually hands in homework on time.
24. **Bonding to school**—Child cares about teachers and other adults at school.
25. **Reading for Pleasure**—Child enjoys and engages in reading for fun most days of the week.

Positive Values

26. **Caring**—Parent(s) tell the child it is important to help other people.
27. **Equality and social justice**—Parent(s) tell the child it is important to speak up for equal rights for all people.
28. **Integrity**—Parent(s) tell the child it is important to stand up for one's beliefs.
29. **Honesty**—Parent(s) tell the child it is important to tell the truth.
30. **Responsibility**—Parent(s) tell the child it is important to accept personal responsibility for behavior.
31. **Healthy Lifestyle**—Parent(s) tell the child it is important to have good health habits and an understanding of healthy sexuality.

Social Competencies

32. **Planning and decision making**—Child thinks about decisions and is usually happy with results of her or his decisions.
33. **Interpersonal Competence**—Child cares about and is affected by other people's feelings, enjoys making friends, and, when frustrated or angry, tries to calm her- or himself.
34. **Cultural Competence**—Child knows and is comfortable with people of different racial, ethnic, and cultural backgrounds and with her or his own cultural identity.
35. **Resistance skills**—Child can stay away from people who are likely to get her or him in trouble and is able to say no to doing wrong or dangerous things.
36. **Peaceful conflict resolution**—Child seeks to resolve conflict nonviolently.

Positive Identity

37. **Personal power**—Child feels he or she has some influence over things that happen in her or his life.
38. **Self-esteem**—Child likes and is proud to be the person that he or she is.
39. **Sense of purpose**—Child sometimes thinks about what life means and whether there is a purpose for her or his life.
40. **Positive view of personal future**—Child is optimistic about her or his personal future.

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40. **Positive view of personal future**—Child is optimistic about her or his personal future.

IX. Appendix D Stories from the Field

Several families and providers shared heartwarming accounts describing the positive impact of the Community Action Team (CAT) programs on the quality of their lives. Following are examples told from the perspective of parents, clinicians, and agency administrators.[30]

Child Guidance Center - From the Nurse:

"One mother told me that she had no hope previously that her son would do any better, but now she is happy because "M. (therapist) and K. (mentor) are so good" with her son and he listens to them, and he is now doing better.

I have also had parents thank me for talking to them about their child's medications and helping them to understand the medication better. Most of the parents tell me how much our staff is helping them and that they feel more hopeful for their child working with the CAT team.

And one mother said she was worried about her son's overuse of his inhaler and she was glad a medical person told him too about the dangers and it gave her the courage to stand up to him. The mother then told the Psychiatrist, who talked to the son about it."

Child Guidance Center – M., LCSW, Clinician

"*On the day my client (a 16 year old female) was released from the Youth Crisis Center, the Community Action Team completed the initial intake for CAT as the mother was very concerned about her daughter coming home. At the onset, the mother did not believe that her daughter should be home and the daughter had no desire to be home. This young teen was consistently taking off from home, would not listen to mom and was easily irritated. The relationship between mom and daughter was toxic in that they each managed to trigger each other negatively. Mom spent the first three weeks making calls to our team requesting to have her daughter removed from her home. Mom insisted that there was no way she would allow her daughter to continue to act out in her home. This was fine with her daughter who wanted out of her mother's life and believed that mother's family was too occupied with this teenager's life.*

The mentor, C., would arrive to the school only to find that the young lady was not at school. This young lady was getting into fights with other female peers in the community and on her school bus. Our targeted case manager, T., spent time attempting to assist with getting services for this family and trying to enroll this teen in an alternative school. This young ladies oldest sister cringed at the thought of having this young lady home. Her youngest sister, during visits to home was very serious minded and would not smile. The phone calls almost daily resonated of how we needed to get this young lady out of her mother's home. During the psychiatric appointment with the mother, daughter and Dr. Y., this young lady quickly became irritated by mother who was upset about her daughter's behaviors. This young lady got up from her chair and slammed the door on her way out. Her trust in me, as her therapist, was minimal. All she wanted was to go live with her father's family. She believed that this is where she would find love.

With time this family is now on the way to healing. T. reports that during one visit in the home the mother

[30] The letters and statements were provided to the Department by the providers. All names of CAT program participants are removed to protect the privacy of the families served.

was able to remain calm and quiet even though her daughter was quite disrespectful and yelling. Additionally, C. reports that she has noticed that the daughter is not running off but is working on talking problems through. During our session this past Friday when both T. and I were present, I asked mother and daughter what improvements they believe have occurred since the Community Action Team began working with this family. This young lady said, "it got me to connect better with momma". Mother said that her daughter is riding the school bus and attending school more often. Mother said "I don't feed into her crap". Mother also said that her daughter's anger issues are better, she comes in the house when told and she is now getting enough sleep.

This has been a team effort with the nurse and psychiatrist playing a significant role as well. It is a delight to see the mother and daughter talking and in agreement with the issues need to be addressed. The older sister is now riding the bus home with her sister and they are talking more. The little sister will come in the room during session with smiles and joking as she is shoed back to her room. This young lady sat through an entire session with me and was able to admit that this is the family that loves her and not her father's. Mother has not made calls to remove her daughter from the home in over three weeks. Although there will need to be more improvements in the home I can honestly say it is nice to hear the laughter that has been exchanged for the constant yelling that once plagued this home."

Gracepoint – L., CAT Program Participant

"I can't begin to tell y'all how awesome this program is. My 14-year-old adopted foster daughter is mentally ill and spent six months in residential treatment. This is a group of people who have my back. Yes, they talk to my daughter. And, they talk to me! They give me tips, she sees a psychiatrist every three weeks instead of every three months to monitor her meds. Since the CAT Team started working with us, my daughter has not had a violent outbreak!"

Gracepoint – B., Chief Operating Officer

"Nearly one year after the Newtown shootings, we know one of the worst things you can hear when a child has issues is there is a two month wait. In CAT there's no wait for services—a CAT family begins services within 48 hours. We can spend six to nine months making sure the changes and improvements are longer lasting. We accept youth who are 11-21. There was not much out in the community in the way of deep end services for these children prior to the Community Action Team's creation. We work with community based care, the courts, DJJ, the school district, our children's crisis center along with other community providers struggling to address the needs of children like these. "

Gracepoint – B. & C., CAT Program Participants

"*The CAT Team is the first behavioral health service that actually happened just like they said. C.'s case manager was at our house the day he was released from a residential program*," recalled B.

B.'s estranged 15-year-old lived with his dad in another state. He was traumatized and started self-medicating his mental illness with drugs and alcohol. When he moved home, the substance abuse continued. "*It took one year in and out of programs and being shuffled around before he got help,*" B. said.

That help came through an advocate with Disability Rights Florida. She helped B. and C. navigate the system and qualify for the special residential placement.

"*When I found out he was going to be released, I was afraid he wouldn't get follow up for three months.*" That had happened before. The advocate with Disability Rights Florida helped qualify them for the Gracepoint CAT Team.

C. likes the team and enjoys his therapy time because he relates to his therapist. At the beginning of the school year, C. tested at seventh grade level. The CAT Case Manager went with B. when she enrolled C. in a charter school that allows him to work online at the school and have teachers available. He is attending school and studying. The back talk and disrespect is getting under control, too. He retreats to his room. C. and his mom are working with his therapist and mentor on ways they can get together during these times.

"*A typical morning now is I say something about his room being a mess," B. said. "The other day I started in again, and he just busted out laughing. He said, 'Mom! Do you remember what we used to fight about?' I busted out laughing, too! I totally get that these are our problems now. We're closer to normal*."

Personal Enrichment through Mental Health Services – L. & Li., CAT Program Participants

"I found out about the Community Action Team from Li.'s school social worker. CAT is extraordinary. I'd never heard of anything so comprehensive. It's a dream come true. Everybody should have access to this type of care," L. said.

Li. was born with significant nerve damage to his shoulder and spent years with physical therapists. He compensated. His mother thought was a normally active 5-year-old. Then, his kindergarten teacher urged L. to have Li. tested. The diagnosis was ADD.

"He always wanted to go to college, to take AP classes," L. recalled. By seventh grade, he was self-aware and refused to take more medications. *"We couldn't find something that worked well, so he went off the meds. It was really stressful."*

So stressful, Li. considered drinking Drano this year. His school social worker hospitalized him using the Baker Act. When he was stable, Li. and his mother started with the Pinellas CAT Team. His CAT team members sent the same message: "You're in charge. You can change or stop your meds at any time."

Li. has changed his medication regime a few times trying to gain more focus during evening homework time. He had Facebook friends, but zero personal friends. He's working on that. His mom admits there is no magic bullet.

"Coping with daily life is incredibly exhausting for my son. When the meds work, I can see it's amazing. He's a different person. I can have a conversation with him. He gets things done and organizes himself. Before, he couldn't see himself older than 18. It was inconceivable to him that he could drive, go to college or have a job. Before, there were zero self-aware observations. Yesterday he wanted to talk about his day!" L. said.

"As a single parent, asking advice is like dropping a message in a bottle in the ocean. No one answers. The CAT Team comes to my home. I have someone who I can talk to. They know where I'm coming from," L. said. "*Before the CAT Team there was nothing to support hard working people who occasionally fall on bad times. There was no real safety net when we needed a helping hand during a tough stage. Now I feel spoiled."*

L. is practicing stepping away a little bit. Li. is learning compassion and is in the driver's seat.

Manatee Glens – R., CAT Program Participant

To Whom It May Concern, December 4, 2013

My name is R.; I am a single parent of a mental health special needs teenage daughter.
I adopted my daughter K. when she was 3 yrs. old. She was 5 yrs. old when we started treatments for her mental health issues. It was always been a hassle to keep all of K.'s support staff updated working together schools, doctors, councilors, therapists etc.

K. had a massive break down April-2012 and had to spend 6 months in a stabilization unit then 6 months in a group home.

K. has now been home since May of 2013 and we had to find all new doctors, councilors and support staff again.

When I contacted Manatee Glens for services again I was expecting the same type of hassles of communication I had experienced before. Then I was introduced to the Cat Team Program and what they can offer us.

I think this is the best program to help my daughter and our family in the ongoing treatments K. needs in her understanding and adapting to experience a normal everyday life.

The fact that 1 phone number allows us to contact our doctors, nurses, councilors and TCM is only the beginning of the available support that this program offers to us. The team has weekly meeting to discuss K.'s updates. Including the feedback that they get from K.'s school and myself is great in understanding K.'s everyday needs for they change every day.

Then the personal touch the staff gives us is a great support structure too for there is nothing more important to us than our children.

We have only been with this program for 6 months right now and I already know that the communication issues of keeping everyone on the same page is a better experience than ever before. I look forward to the continuing support that this program gives us in our everyday lives dealing with mental health issues.

Regards
R.

Manatee Glens – S., Independent Living Supervisor, The Safe Children Coalition

"I would like to extend my appreciation for the Manatee Glens CAT team. They have been instrumental in helping our agency preserve families and reunify children with their parents while providing in home support that extends far beyond therapeutic. It is evident that the children that they work with are able to form a bond of trust with the team and can rely on them to provide a safe haven for them to discuss the issues that are affecting their behaviors. I have witnessed the lengths that the team goes to in advocating for these children and providing support to the family and help change behaviors and processes in the home to provide a more stable and structured environment. The CAT team is an extremely valuable resource!"

Circles of Care CAT Program – A., CAT Participant

To Whom It May Concern,

How has the COC program helped me and my family? To put this bluntly and to the point, the team has done what me and my husband could not or did not do with teaching our son life skills.

K. has showed Ar. that no matter what problems in life come his way that he can overcome them, and this has given Ar. self confidence. That is priceless! Self confidence. We as adults take that for granted. To me that is a life skill. Another thing K. has shown him is that there is more than one way to skin a cat. Not a real cat! Problem solving, which takes patience, knowledge and persistence, structure, all that and it's due to this program. It has saved our family. I am so grateful for this program.

E. has also done some pretty amazing things for our family, with Ar. He has taught Ar. that it's okay to feel and express himself. Again a life skill.

The whole team has their part and I know it would not work if one element was gone. They take off a lot of pressure with the kids and they are helping not only the kids, but me and my husband as well, how to talk and deal with the kids and things that come up. I know this letter is not going to justify my thoughts and gratitude that I have for this program and the people that just don't do a job. This is their passion, and me and my family have been blessed to be touched by this program.

I am going to leave with this. With my son's charge, he has all the cards stacked against him. This program is like our ace in the hole.

Thank you,

A.