Community Action Treatment (CAT) Team for Ages 0-10
(CAT Tier 3 Variation)

Purpose: To ensure the implementation and administration of the Community Action Treatment for Ages 0-10 (CAT) Tier 3 program, the Managing Entity shall require that CAT Tier 3 Network Service Providers adhere to the service delivery and reporting requirements herein. Best practice considerations and resources are provided to support continuous improvement of the program.

Authority:

CAT Tier 3 teams provide community-based services to children ages 0-10 with a mental health or co-occurring substance abuse diagnosis with any accompanying characteristics such as being at-risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care and are assessed for an in-home program.

A. Network Service Provider Responsibilities

To ensure consistent statewide implementation and administration of this proviso project, the Network Service Providers shall:

1. Network Service Providers must adhere to the service delivery and reporting requirements described in this document.
2. Requirements to submit Appendix 1 - Persons Served and Performance Measure Report and Appendix (2) - Quarterly Supplemental Data Report in accordance with the following schedule:
    a. Appendix 1 – Monthly submission by the Network Service Provider to the Managing Entity no later than the 10th of the month following services.
    b. Appendix 2 and Appendix 3 – Quarterly submission by the Network Service Provider to the Managing Entity no later than the 10th of the month following the end of each state Fiscal Year Quarter.
3. Participation in all CAT Tier 3 program conference calls, meetings or other oversight events scheduled by the Managing Entity and/or the Department.
4. Requirements for quarterly reporting of actual expenditures, fiscal year-end financial reconciliation of actual allowable expenditures to total payments, and prompt return of any unearned funds or overpayments.

The Managing Entity shall adopt a minimum negotiated service target of children per month. The Managing Entity must request Department approval the target for a specific Network Service Provider, taking into consideration a Network Service Provider's program-specific staffing capacity, historical funding utilization, estimated community needs, or unique geographic and demographic factors of the service location. In the first year of services by a newly procured Network Service Provider, the Managing Entity may implement a phase-in period to achieve the minimum service target numbers.

B. Program Goals

CAT Tier 3 is intended to be a safe and effective alternative to out-of-home placement for children with serious behavioral health conditions. Upon successful completion, the family should have the skills and natural support system needed to maintain improvements made during services. The goals of the program are to:

1. Strengthen the family and support systems for youth to assist them to live successfully in the community;
2. Improve school, preschool, and daycare related outcomes such as attendance, grades, and grade advancement;
3. Decrease out-of-home placements;
4. Improve family and youth functioning;
5. Decrease substance use and abuse;
6. Decrease psychiatric hospitalizations;
7. Transition into age-appropriate services;
8. Increase health and wellness; and
9. Provide mentoring and peer services for both child and parent.

C. Eligibility

The Network Service Provider shall follow participation criteria for CAT Tier 3 services:

1. The child must be otherwise eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, Florida Statute, and
2. The child must be aged 0-10 with a tentative mental health diagnosis or co-occurring substance abuse diagnosis, ICD 10 Z code, and at-risk of out-of-home placement as demonstrated by repeated failures at less intensive levels of care;
3. Individuals residing in therapeutic placements such as hospitals, residential treatment centers, therapeutic group homes are not eligible to receive CAT Tier 3 services.
4. Network Service Providers may serve families who exceed the financial eligibility while applying a sliding fee scale in accordance with 394.674 Florida Statute and Ch. 65E-14.018, F.A.C., if no other option for treatment at this level is available (i.e., rural areas)

D. CAT Tier 3 Model

The CAT Tier 3 model is an integrated service delivery approach that utilizes a team of individuals to comprehensively address the needs of the young person, and their family, to include the following staff:

1. One full-time Team Leader,
2. One full-time Mental Health Clinicians,

3. One part-time Psychiatrist or Advanced Registered Nurse Practitioner (part-time),
4. One part-time Registered or Licensed Practical Nurse (part-time),
5. One full-time Case Manager,
6. One full-time Therapeutic Mentors, or certified peer specialists,
7. One full-time administrator

The Network Service Provider must have these staff as part of the team; however, the number of staff and the functions they perform may vary by team in response to local needs and as approved by the Managing Entity. CAT Tier 3 members work collaboratively to deliver the majority of behavioral health services, coordinate with other service providers when necessary, and assist the family in developing or strengthening their natural support system.

CAT Tier 3 funds are used to address the therapeutic needs of the eligible youth receiving services. However, the CAT Tier 3 model is based on a family-centered approach in which the team assists parents or caregivers to obtain services and supports, which may include providing information and education about how to obtain services and supports, and assistance with referrals.

The number of sessions and the frequency with which they are provided is set through collaboration based on the needs of the individual and family 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, qualifications, or licensure (i.e., eating disorder treatment, behavior analysis, psychological testing, substance abuse treatment, etc.) are required, referrals are made to specialists, with coordination from the individual, family and team. This flexibility in service delivery is intended to promote a "whatever it takes" approach to assisting young people and their families to achieve their goals.

E. Coordination With Other Key Entities

It is important for Network Service Providers to address the provision of services and supports from a comprehensive approach, which includes coordination with other key entities providing services and supports to the individual receiving services. In collaboration with and based on the preferences of the individual receiving services and their parent/legal guardian (if applicable). Network Service Providers should identify and coordinate efforts with other key entities as part of their case management function, which include but are not limited to primary health care, child welfare, juvenile justice, corrections, and special education. In addition, Network Service Providers should make all efforts to include natural support systems of the individual and community connections in service delivery.

With special considerations to the 0-5 age group, it is important to establish direct communication and coordination with the Early Learning Coalition. This collaboration will ensure caregivers are provided expedited linkage to childcare services.

If the individual receiving services is a minor served by child welfare, members of their treatment team shall include their child welfare Case Manager and guardian ad litem (if assigned). If and how the parent will be included in treatment should be determined in coordination with the dependency case manager, based on individual circumstances. Network Service Providers shall document efforts to identify and coordinate with the other key entities in the case notes.

If the Network Service Provider identifies a child (0-12 months) involved with the Plan of Safe Care / Substance Exposed Newborn Program, a staffing of the client should be completed to avoid duplication of services.

F. Screening and Assessment

Within 45 days of an individual's admission to services, the Network Service Provider shall complete the North Carolina Family Assessment Scale for General Services and Reunification® (NCFAS-G+R) as the required initial assessment to assist in identifying areas of focus in treatment. The NCFAS-G+R and Plans of Care (Initial and Master) must be completed for all individuals served, to include those transferred from another program within the same agency.

Network Service Providers are encouraged to use a variety of reliable and valid screening and assessment tools in addition to the NCFAS-G+R as part of the assessment process, with focus on screening for co-occurring mental health and substance use disorder. Additionally, Network Service Providers are encouraged to gather collateral information in coordination with the individual served, their family and other system partners, to include such things 4 as: school records; mental health and substance abuse evaluations and treatment history; and level of cognitive functioning to develop a comprehensive understanding of the young person's and their family's circumstances.

As with best practice approaches such as Systems of Care, Transition to Independence and Wraparound, the screening and assessment process should focus on identifying competencies and resources to be leveraged as well as needs across multiple life domains, such as education, vocation, mental health, substance use, primary health, and social connections. Please visit http://www.socflorida.com/wraparound.shtml for guidance on the Florida Wraparound model.

G. Initial Plan of Care

Within 30 days of an individual's admission to services, the Network Service Provider shall complete an Initial Plan of Care to guide the provision of services. Services and supports are established in the Initial Plan of Care, which provides sufficient time to complete the NCFAS-G+R within the first 45 days. Review of the Initial Plan of Care is required to ensure that information gathered during the first 60 days is considered and that a Master Plan of Care is developed to articulate the provision of services and supports longer-term. The Network Service Provider must document that the Initial Plan of Care was reviewed with the individual being served and his or her parent or guardian and request that they sign the plan at the time of review. At a minimum, the Initial Plan of Care shall:

1. Be developed with the participation of the individual receiving services and his or her family, including caregivers and guardians;
2. Specify the CAT Tier 3 services and supports to be provided, to include a focus on engagement, stabilization, and a safety planning if needed; and
3. Include a brief initial discharge planning discussion, to include the general goals to be accomplished prior to discharge.

H. Master Plan of Care

Within 60 days after admission, the Network Service Provider shall review the Initial Plan of Care and update it as needed to include the NCFAS-G+R initial assessment and other information gathered since admission. The Network Service Provider will implement the updated Initial Plan of Care as the Master Plan of Care. The Network Service Provide may adopt an unrevised Initial Plan of Care if it meets the requirements of the Master Plan of Care and includes the initial NCFAS-G+R assessment. At minimum the Master Plan of Care shall:

1. Be strength-based and built on the individual's assets and resources;
2. Be individualized and developmentally appropriate to age and functioning level;
3. Address needs in various life domains, as appropriate;
4. Integrate substance abuse and mental health treatment when indicated;
5. Specify measurable treatment goals and target dates for services and supports;
6. Specify team members responsible for completion of each treatment goal; and
7. Include a discharge plan and identify mechanisms for providing resources and tools for successful transition from services.

At minimum, the Network Service Provider shall review and revise the Master Plan of Care every three months thereafter until discharge, or more frequently as needed to address changes in circumstances impacting treatment and discharge planning. In each review, the Network Service Provider shall include active participation by the individual receiving services, and his or her family, caregivers, guardians, and other key entities serving the individual and natural supports, as appropriate.

I. Treatment Planning Process

The treatment planning process serves to identify short-term objectives to build long-term stability, resilience, family unity and to promote wellness and illness management. A comprehensive, team-based approach is increasingly seen as the preferred mechanism for creating and monitoring treatment plans and is consistent with the CAT Tier 3 program.

There is evidence that outcomes improve when youth and families participate actively in treatment and their involvement is essential at every phase of the treatment process, including assessment, treatment planning, implementation, and monitoring and outcome evaluation.1 Working as a team, the young person, family, natural supports, and professionals can effectively support individualized, strength-based, and culturally competent treatment.

Network Service Providers shall focus on engagement of the young person and their family as a critical first step in the treatment process, as well as the promotion of active participation as equal partners in the treatment planning process.

J. Services and Supports

The mix of services and supports provided should be dictated by family needs and strengths, serve to strengthen their family, Services and supports and the manner of service provision should be

developmentally appropriate for the individual. It is important to discuss the roles and responsibilities of the team members with the individual and family to ensure they understand the roles and responsibilities of each. This is especially important to clarify the role of the peer or mentor, as this person may promote social connectedness and assist in the development of a support network of friends outside of the program.

Network Service Providers shall offer an array of formal treatment interventions and informal supports provided in the home or other community locations convenient and beneficial to the individual and family. Network Service Providers shall assist the individual and family to develop connections to natural supports within their own network of associates, such as friends and neighbors, through connections with community, service and religious organizations, and participation in clubs and other civic activities. Natural supports ease the transition from formal services and provide ongoing support after discharge. Formal treatment services may include evidenced-based practices appropriate to the circumstances of the young person and their family. Network Service Providers shall leverage resources and opportunities to implement evidenced-based practices with fidelity, which may include partnering with other teams or organizations in the local system of care.

Chapter 394. 491, Florida Statute - Guiding principles for the child and adolescent mental health treatment and support system.

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.491.html 3

Transition Youth with Serious Mental Illness: http://www.apa.org/about/gr/issues/cyf/transition-youth.pdf

Support services and natural supports are interventions developed on an individualized basis and tailored to address the individual's and family's unique needs, strengths, and preferences. Support services may include but are not limited to: Family Support Specialists; participation in recreational activities; youth development and leadership programs; temporary assistance in meeting and problem-solving basic needs that interfere with attaining treatment goals; and independent living skills.

K. Discharge

As part of the discharge planning process, CAT Tier 3 teams assist in identification of additional resources that help individuals and families maintain progress made in treatment. Throughout treatment, the Network Service Provider should focus on successful transition from services to appropriate step-down programs. As the individual moves into the discharge phase of treatment, the team may determine the need to modify the service array or frequency of services to ease transition to less intensive services and supports.

Network Service Providers are encouraged to implement a discharge planning process that:

1. Begins at admission;
2. Includes ongoing discussion as part of the Plan of Care review;
3. Includes active involvement of the individual and family;

4. Includes a transition plan submitted to and developed in collaboration with the individual and family that leverages available community services and supports.

Within seven calendar days of an individual's discharge from services, the Provider shall complete a Discharge Summary containing the following items, at a minimum:

1. The reason for the discharge;
2. A summary of CAT Tier 3 services and supports provided to the individual; and
3. A summary of resource linkages or referrals made to other services or supports on behalf of the individual; and a summary of the individual's progress toward each treatment goal in the Master Plan of Care.

L. Incidental Expenses

Incidental expenses pursuant to chapter 65E-14.021, Florida Administrative Code, are allowable under this program. Network Service Providers shall follow state purchasing guidelines and any established process for review and approval and shall consult the Managing Entity regarding allowable purchases.

M. Third-Party Services

Services provided by the core CAT Tier 3 Team staff and funded by contract dollars cannot be billed to any thirdparty payers. Services provided outside of the core CAT Tier 3 Team staff may be billed to Medicaid or private insurance, to the extent allowable under these programs. If there is an imperative need to provide these services or supports sooner than later, the CAT Tier 3 team should use CAT funds to meet this need, while pursuing third-party billing.

If an individual requires interventions outside the scope of a team's expertise, qualifications or licensure (i.e., eating disorder treatment, behavior analysis, psychological testing, substance abuse treatment, etc.), the team may refer to a qualified service provider. The CAT team shall work in concert with any referral providers, the individual and the family to integrate referral services into overall treatment and to monitor progress toward treatment goals.

In accordance with chapter 65D-30.003, Florida Administrative Code, all substance abuse services, as defined in subsection 65D-30.002(16), Florida Administrative Code, must be provided by persons or entities that are licensed by the department pursuant to Section 397.401, Florida Statute, unless otherwise exempt from licensing under Section 397.405, Florida Statute, prior to initiating the provision of services.

N. Performance Measures

The Network Service Provider shall follow the performance measures:

1. School, preschool, and daycare attendance if appropriate

Individuals receiving services shall attend an average of 80% percent of school days, according to the following methodology:

   a. Calculate the percentage of available school days attended by all individuals served during the reporting period. Include all individuals as appropriate Do not include individuals for

whom school attendance in an alternative education setting cannot be determined. Do not include any days an individual is considered medically excused as a result which in a crisis stabilization unit.

b. The numerator is the sum of the total number of school days attended for all individuals.

c. The denominator is the sum of the total number of school days available for all individuals.

2. Children's Functional Assessment Rating Scales (CFARS) and Functional Assessment Rating Scale (FARS)

Effective once the Network Service Provider discharges a minimum of 10 individuals each fiscal year, 80% of individuals receiving services shall improve their level of functioning between admission to discharge, as determined by the Children's Functional Assessment Rating Scales (CFARS)

a. Measure improvement is based on the change between the admission and discharge assessment scores completed using the CFARS

b. The numerator is the total number of individuals whose discharge score is less than their admission assessment score. Scores are calculated by summing the score for all questions for each person discharged during the current fiscal year-to-date. A decrease in score from the admission score to the discharge score indicates that the level of functioning has improved.

c. The denominator is the total number of individuals discharged with an admission and discharge assessment during the current fiscal year-to-date.

3. Living in a Community Setting

Individuals served will spend a minimum of **90%** of days living in a community setting:

a. The numerator is the sum of all days in which all individuals receiving services qualify as living in a community setting. "Living in a community setting" excludes any days spent in jail, detention, a crisis stabilization unit, homeless, a short-term residential treatment program, a psychiatric inpatient facility or any other state mental health treatment facility. Individuals living in foster homes and group homes are considered living in a community setting. For children under 18 years of age, days spent on runaway status, in a residential level one treatment facility, or in a wilderness camp are not considered living in a community setting.

b. The denominator is the sum of all days in the reporting period during which all individuals were enrolled for services.

4. North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R)

Effective once the Provider discharges a minimum of 10 individuals each fiscal year, 65% of individuals and families receiving services shall demonstrate improved family functioning as demonstrated by an improvement in the Child Well-Being domain between admission and discharge, as determined by the

North Carolina Family Assessment Rating Scale for General Services and Reunification (NCFAS- G+R), if the individual is under eighteen (18).

a. Calculate the percentage of individuals who increased their family functioning in the Child Well-Being Domain by at least one point from admission to discharge, as measured by the NCFAS-G+R.

b. The numerator is the number of individuals whose score on the Child Well-Being domain at discharge is at least one point higher than their score on the Child Well-Being domain at admission during the current fiscal year-to-date.

c. The denominator is the total number of individuals receiving services who were discharged during the current fiscal year-to-date and for whom the NCFAS-G+R was used at admission.

Note: If an admission NCFAS assessment has been completed on a child and parent/caregiver and the child moves to a different home with a different caregiver, a NCFAS discharge assessment should be completed at that time to ensure the same parent/caregiver is assessed at admission and discharge. Additional consideration should be given to the following:

a. If services are continued in the new placement with the new parent/caregiver, an admission and discharge NCFAS assessment should be completed for the new parent/caregiver.

b. If a child changes placements multiple times, the provider and ME should discuss how to report on the NCFAS performance measure for that child, keeping in mind that the NCFAS measures family functioning in the context of services received, so we need to know who received services to determine the level of improvement in functioning.

O. Best Practice Considerations:

1. Models and Approaches for Working with Young People and Their Families

National Wraparound Initiative: Wraparound is an evidence-supported practice that is intensive, holistic, strength based, individual and family driven and individualized care planning and management process that engages and supports individuals with complex needs (most typically children, youth, and their families) to live in the community and realize their hopes and dreams. The process is typically delivered through case management activities through a team supported approach.

https://nwi.pdx.edu/wraparound-basics/

Florida Wraparound model and toolkits available for providers and Managing Entities

http://www.socflorida.com/wraparound.shtml

2. Infant mental health (IMH)

IMH refers to the social-emotional well-being of children ages 0 to 5 years. A central tenet is that infant development cannot be separated from the caregiving environment, primarily the

attachment relationships, as well as the culture in which the relationships develop. Currently there are multiple programs across the Unites States that train infant mental health practitioners. Training is generally intensive, requiring at least one year of study plus ongoing supervision, and includes the following core concepts:

Relationship-Based Assessment and Intervention: Infants and young children develop within the context of one or more dyad-specific attachment relationships. The physical, cognitive, social, and emotional capacities of the infant are mediated by the quality of the caregiver-child relationships. Similarly, the relationships between the infant mental health practitioner, the infant, and caregiver are prized. Thus, prevention and intervention occur within the context of relationships (i.e., between caregiver and provider, family and organization, etc.).

Cultural Competence: Just as infants cannot be understood outside of the context of their primary relationships, relationships cannot be understood outside of the culture in which they grow. The impact of socioeconomic or minority status, race, ethnicity, sexuality, and culture on the caregiver, child, and relationship must be acknowledged and explored. Infant mental health is an ecologically valid discipline, accounting for all factors impacting the infant and the caregiving dyad. Therefore, not only do IMH providers offer preventive support and evidence-based intervention to the child, dyad, and family, but they also advocate for services and/or social change, as necessary, for infants/families to thrive.

Reflective Practice: A large core knowledge base that includes child development, adult development, ability to observe behavior, ability to translate between caregiver and child, ability to work across service systems, etc. is required of an IMH specialist. This knowledge base is necessary but not sufficient; an IMH specialist must also have the ability to engage with a caregiver-child dyad while holding each in mind and being aware of what each member, including the specialist, brings to the relationships. Reflection is a necessary skill and responsibility involving the specialist's acknowledging and examining his/her own responses to the dyad and regularly accessing appropriate supervisory or consultative relationships.

Collaborative Systems: The practice of IMH rarely occurs solely within a therapist's office; rather it is community based. Infants and young children are uniquely dependent upon their caregivers at all times. It is crucial that an IMH specialist be able to assess and coordinate intervention as part of a team of significant figures who interact with a child. This may include health and allied health professionals, educators, extended family members, etc. and is especially important where there are developmental concerns. Some of the most successful prevention and intervention programs have been developed in collaboration with child welfare/courts, education, and primary care practices (e.g., Zero to Three Safe Babies Court Teams, mental health consultation in Early Head Start, embedded mental health professionals in pediatric settings).

Trauma-Informed/Empirically Based Assessment and Intervention: Understanding trauma from a developmental perspective is a core competency of infant mental health. While young children do not have the words to describe traumatic events, they are impacted by

trauma at a preverbal level (biological, cognitive, social, and emotional). Young children are especially impacted by interpersonal trauma because they experience the world through the lens of their primary caregivers. Early trauma may include exposure to domestic violence, community violence, parental addiction, or chronic maltreatment. Traumatized infants and dyads have a special need for trained providers who are sensitive to relational and developmental stages. An IMH specialist whose practice implements all of the core concepts previously stated will need additional training and supervision in working with trauma exposed infants and their caregivers. For infants and young children, it is particularly important that evidence-based interventions be implemented in the context of relationship based practice. Additionally, it is key to identify those providers who offer Infant Mental Health Services, and to disseminate a list with provider contact information to community partners.

3. Screening and Assessment Resources

The California Evidenced-based Clearinghouse for Child Welfare: Assessment ratings and how to determine if an assessment is reliable and valid.

http://www.cebc4cw.org/assessment-tools/assessment-ratings/

US Department of Education "Watch Me Thrive": *Birth to 5: Watch Me Thrive!* encourages healthy child development, universal developmental and behavioral screening for young children, and support for the families and providers who care for them.

Birth to 5: Watch Me Thrive! (ed.gov)

CDC Fetal Alcohol Spectrum Disorders: Fetal alcohol spectrum disorders (FASDs) are a group of conditions that can occur in a person who was exposed to alcohol before birth. FASDs have lifelong effects, including problems with behavior and learning as well as physical problems. FASDs are preventable if a developing baby is not exposed to alcohol.

Developmental Screening And Referral Early Head Start and the Program for Infants and Toddlers with Disabilities

DEVELOPMENTAL SCREENING AND REFERRAL: Early Head Start and the Program for Infants and Toddlers with Disabilities (Part C of IDEA) (ectacenter.org)

Infant and Early Childhood Mental Health Consultation and Your Program | ECLKC (hhs.gov)

Strengths, Needs and Culture Discovery Assessment:

To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.

https://nwi.pdx.edu/

Florida Association for Infant Mental Health: Supporting and strengthening an infant mental health workforce to better serve the young children and families of Florida. The association also provides certified training for clinical staff.

https://www.faimh.org/home

US Department of Health And Human Services: Screening, Assessing, Monitoring Outcomes and Using Evidence-Based Interventions to Improve the Well-Being of Children in Child Welfare. Provides in depth education and resources.

Screening, Assessing, Monitoring Outcomes and Using Evidence-Based Interventions to Improve the Well-Being of Children in Child Welfare (hhs.gov)

Early Learning Coalition: While DEL governs day-to-day operations of statewide early learning programs and administers federal and state child care funds, across the state 30 regional early learning coalitions and the Redlands Christian Migrant Association are responsible for delivering local services.

Coalitions | DEL (floridaearlylearning.com)

CDC Children's Mental Health: Mental health of children and parents; a strong connection. Provides education and resources for parents of children experiencing mental and behavioral health.

Mental health of children and parents —a strong connection (cdc.gov)

4. Treatment Planning Resources

CDC Children's Mental Health: The Centers for Disease Control and Prevention (CDC) joins the Substance Abuse and Mental Health Services Administration (SAMHSA), along with other agencies, in learning more about strategies for integrating behavioral health with primary health care, child welfare, and education.

Child Mental Health | CDC

The Fundamentals of Infant-Early Childhood Mental Health: articles provide infant-early childhood mental health professionals with an understanding of effective promotion, prevention, and treatment strategies.

The Fundamentals of Infant-Early Childhood Mental Health - ZERO TO THREE

Individual and Family Team meetings: The Wraparound process promotes Individual and Family team meetings that includes the individual, their family, professionals working with the family and their natural support systems. The initial Wraparound plan is developed during the initial Child and Family Team meetings. Individual and Family team meetings are held every 30 days to monitor the Wraparound plan to ensure effectiveness and to revise as needed to ensure the plan best matches the individual's and family's self-identified needs.

https://nwi.pdx.edu/NWI-book/Chapters/SECTION-4.pdf

Infant and Early Childhood Mental Health Resources and Services: A Guide for Early Education and Care Professionals.

early-childhood-mental-health-resources-and-services.pdf (mass.gov)

5. Developing a Plan of Care

   The Wraparound Approach in Systems of Care

   http://www.oregon.gov/oha/amh/wraparound/docs/wraparound-approach-soc.pdf

   Florida Wraparound model and toolkits available for providers and Managing Entities

   http://www.socflorida.com/wraparound.shtml

   Journal of Child and Family Studies (May 2017): Increasing Youth Participation in Team-Based Treatment Planning: The Achieve My Plan Enhancement for Wraparound:

   https://www.pathwaysrtc.pdx.edu/pdf/pbJCFS-Walker-AMP-Enhancement-for-Wraparound-05-2017.pdf

6. Services and Supports Resource

   Pathways Transition Training Collaborative (PTTC): Community of Practice Training: Provides training and TA materials for serving youth and young adults – Set of competencies; Transition Service Provider Competency Scale; On-line training modules focused on promoting positive pathways to adulthood.

   https://www.pathwaysrtc.pdx.edu/pathways-transition-training-collaborative

   RTC Pathways -Youth Peer Support

   https://www.pathwaysrtc.pdx.edu/pdf/proj-5-AMP-what-is-peer-support.pdf

Community Action Treatment (CAT) Team for Ages 0-10, (CAT Tier 3 Variation) will be administered according to DCF Guidance 38, which can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities/.

Appendix 2 Guidance

The following guidelines shall be used by CAT Network Service Providers and Managing Entities when reporting the required quarterly data using **Appendix 2**.

1. **Discharge placements for individuals identified at admission as at risk of out of home placement**

A primary CAT program goal is diverting these individuals from placement within the juvenile justice, corrections, residential mental health treatment or child welfare systems, and enabling them to live effectively in the community. The considerations below are non-exhaustive guidelines by which CAT Network Service Providers can determine if an individual is at high risk of out of home placement at the time of admission.

a. Residential Mental Health Treatment, including therapeutic group homes
- Has a recommendation from a psychologist/psychiatrist for placement in residential mental health treatment center?
- Has a recommendation from a Qualified Evaluator for placement in residential treatment (child welfare)?
- Has previously been placed in residential treatment?
- Is the parent/legal guardian is requesting placement in a residential mental health treatment center?

b. Department of Juvenile Justice (DJJ) Placement
- Are there current DJJ charges or is there a long history of charges?
- Was there previous DJJ commitment placement?
- Does a child aged 12 and under have current or previous DJJ charges?

c. Child Welfare Out of Home Placement
- Is there an open Child Welfare case or investigation?
- Were there previous child welfare cases, investigations or services?
- Were there any previous out-of-home Child Welfare placements?

2. Gainful Activity for Individuals Not Enrolled in School or Vocational Program

Participation in gainful activities by individuals aged sixteen and older who are not enrolled in school or vocational programs is an indicators of program success in fostering self-sufficiency. These activities should focus on employment, continued education, vocation training and certification, work readiness, career planning, and skill development related to obtaining and keeping a job. These activities are opportunities for a therapeutic mentor to assist individuals in identifying personal goals and developing plans.

Examples of enrichment activities include, but are not limited to, employment and supported employment; internships and apprenticeships; linkage to and services from entities such as Vocational Rehabilitation; and activities that support career planning, occupational research and assessment.