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Purpose 850-10-05
(Revised 7/26/13 ML# 3367)

View Archives

The purpose of this manual is to establish policy, procedures, and guidelines for providing recovery focused case management services for individuals with Serious Mental Illness in the State of North Dakota.
Definitions 850-10-10

Mental Health Disorders 850-10-10-05
(Revised 7/26/13 ML# 3367)

View Archives

Click on the following link to access definitions and information on specific mental disorders:

http://behavenet.com/apa-diagnostic-classification-dsm-iv-tr
Definitions 850-10-10

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Click on the following link to access definitions and information on specific mental disorders:

http://behavenet.com/apa-diagnostic-classification-dsm-iv-tr
Psychiatric Terms 850-10-10-15
(Revised 7/26/13 ML# 3367)

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Click on the following link to access the Glossary of Psychiatric Terms:

Department of Human Services Related Definitions

850-10-10-20
(Revised 7/26/13 ML# 3367)

960 - Refers to the State Form Number 960 (SFN 960) for the reporting of suspected child abuse or neglect.


Adult Protective Services (APS) - An entity responsible for the investigation of possible abuse, neglect, or exploitation of disabled adults and elderly.

CMS – Center for Medicare and Medicaid Services – The agency within the Department of Health and Human Services that is responsible for federal administration of the Medicaid, Medicare and State Children’s Health Insurance Program (SCHIP) programs.

Continuum of Care - A functional philosophy that seeks to ensure clients receive the right service in the right place at the right time.

DMHSAS – Division of Mental Health & Substance Abuse Services is a division of the North Dakota Department of Human Services

Developmental Disability - Refers to a condition that constitutes a lifelong mental or physical impairment, which became apparent during childhood and has hampered an individual's ability to participate in mainstream society, either socially or vocationally.
Refer to the Developmental Disabilities Act (Pub.L.106-402) for the legal definition.

**DHS** – Department of Human Services

**Dual Diagnosed** - Diagnosed with two disorders such as those individuals diagnosed with mental illness and chemical dependence or individuals diagnosed with mental illness and developmental disabilities.

**Due Process** - A legal term meaning the right to an official court hearing before an individual’s freedoms is restricted in any way, such as before involuntary hospitalization or treatment of any kind.

**EAP** - Economic Assistance Policy is a division of the ND Department of Human Services that administers policy for and includes the following programs: Child Care Assistance Program, Basic Care Assistance Program, Energy Assistance (also referred to as Low Income Home Energy Assistance, or LIHEAP), Food Stamps, and Temporary Assistance for Needy Families (TANF), including Diversion Assistance and Job Opportunities and Basic Skills (JOBS). EAP is also responsible for Medicaid Estate Recovery, Quality Control, and System Support and Development.

**Guardianship** - A legal term describing the assignment of legal authority and responsibility from one person to another. This is done in a court of law and only in situations where the judge is convinced that the individual, whose guardianship is proposed, needs a guardian to protect their interest and rights.

**HIPAA** - Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 42 U.S.C. § 1301 et seq.] that among other things standardizes the format of certain health care information that is transmitted electronically and regulates the
release of health care information. HIPAA impacts entities that handle individual health care information.

**ID** - Intellectual Disability

**MA** - Medical Assistance, commonly referred to as “Medicaid,” provides medical assistance to certain specified groups of needy low-income individuals as defined by federal law.

**Medicaid** - A health insurance program for individuals with low income.

**Medicare** - Insurance program of medical services for the elderly or those who have received SSD for a period of time.

**MHA** - Mental Health America

**NAMI** - National Alliance for Mental Illness

**NDAC** – North Dakota Administrative Code

**NDCC** – North Dakota Century Code

**Olmstead Decision** - A 1999 U.S. Supreme Court decision, Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581, 119 S.Ct. 2176 (1999), in which the Court held that it is a form of discrimination under the Americans With Disabilities Act of 1990 (ADA) if a state fails to find community placements for institutionalized individuals if: 1) the state’s treatment professionals have determined that community placement is appropriate, 2) the individual does not oppose the transfer to a community setting, and 3) the placement
can be reasonably accommodated taking into account the resources available to the state and the needs of others with disabilities.

**Partnerships Program for Children’s Mental Health** – Programs located in the 8 Regional Human Service Centers offering integrated comprehensive services for children with serious emotional disorders.

**Peer Support Services** - Peer Support Services are consumer centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Support Services are provided by a person who has progressed in their own mental health or substance abuse recovery and is working to assist other people with mental health issues. Because of their life experience, peers have expertise that professional training cannot replicate.

**Peer Support Specialist** - A Peer Support Specialist is an occupational title for a person who has progressed in their own recovery from mental disorder and is working to assist other people with a mental disorder. Because of their life experience, such persons have expertise that professional training cannot replicate.

**Person-Centered Service Plan** – A document which specifies supports and services that an individual will receive based on assessed needs. This also includes informal supports provided to meet the individual’s needs to remain in the community.

**Recipient Liability** - This is the amount an individual who is eligible for Medicaid under the “Medically Needy” coverage group is expected to contribute toward his or her monthly medical expenses.

**RIS** - Regional Intervention Services provide community based intervention for individuals with serious mental health and/or
substance abuse needs to determine appropriate level of care. RIS units at the department’s human service centers conduct the admission screening for ND State Hospital admissions.

**SAMHSA** - Substance Abuse and Mental Health Services Administration is an agency of the U.S. Department of Health and Human Services (DHHS) that focuses on programs and providing funding to improve the lives of people with or at risk for mental and substance abuse disorders.

**SMI** - Seriously Mentally Ill

**SSA** - Social Security Administration

**SSDI** - Social Security Disability Insurance

**SSI** - Supplemental Security Income

**TBI** - Traumatic Brain Injury

**VR** - Vocational Rehabilitation provides training and employment services to individuals with disabilities so they can become and/or remain employed.
Administrative rules are officially promulgated agency regulations that have the force and effect of law. Generally these rules elaborate the requirements of a law or policy. Each state has its own set of administrative rules which are passed by the state legislature.

The North Dakota Administrative Code can be accessed by clicking on the following link:

http://www.legis.nd.gov/information/rules/admincode.html
Regulating Authority 850-10-15

ND Administrative Code 850-10-15-05
(Revised 7/26/13 ML# 3367)
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The North Dakota Administrative Code can be accessed by clicking on the following link:

http://www.legis.nd.gov/information/rules/admincode.html
The North Dakota Century Code is the collection of all the statutes passed by the North Dakota Legislative Assembly since the state's admission to the Union. It also includes the North Dakota Constitution.

The numbering system for the Century Code is a three-part number, with each part separated by a hyphen. The first part refers to the title, the second to the chapter, and the third to the section. For example, Section 54-35-01 refers to the first section in Chapter 35 of Title 54 (the section deals with the legislative management of the North Dakota Legislative Assembly).

The decimal point system is used to designate sections that have been inserted between two consecutively numbered sections. For example, Title 12 deals with Corrections, Parole, and Probation, while Title 13 deals with Debtor and Creditor Relationship. The state Criminal Code (which alphabetically falls between the titles) is thus numbered Title 12.1.

North Dakota Century Code can be accessed by clicking on the following link:

http://www.legis.nd.gov/information/statutes/cent-code.html
ND Century Code Chapter 50-06 relates to the Department of Human Services and can be accessed at the following:

http://www.legis.nd.gov/cencode/t50c06.pdf
The Code of Federal Regulations (CFR) is the codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register by the executive departments and agencies of the federal government of the United States.

The CFR is published by the Office of the Federal Register, an agency of the National Archives and Records Administration (NARA).

The CFR is divided into 50 titles that represent broad areas subject to Federal regulation.

The entire CFR can be accessed at the website:

http://ecfr.gpoaccess.gov
The Rehabilitation Act 850-10-15-20
(Revised 7/26/13 ML# 3367)

The Rehabilitation Act is the Federal legislation that authorizes the
formula grant programs of vocational rehabilitation, supported
employment, independent living, and client assistance. It also
authorizes a variety of training and service discretionary grants
administered by the Rehabilitation Services Administration.

To access the Rehabilitation Act of 1973 click on the following link:

DHS Policy 850-10-15-25
(Revised 7/26/13 ML# 3367)

View Archives

Other DHS Policies are located:

- Human Service Center PIs can be found at: P:\So Executive Office\HSC-PI
- ND DHS Human Resource policies are located at: p/sohr/policies
- Additional ND DHS policies are located at p/sofiscal/service chapters
DHS Service Chapters & Websites 850-10-20

DHS Service Chapters 850-10-20-05
(Revised 7/26/13 ML# 3367)
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To link to all DHS Service Chapters, click on the following link:

http://www.nd.gov/dhs/policymanuals/home/
DHS Service Chapters & Websites 850-10-20

DHS Service Chapters 850-10-20-05
(Revised 7/26/13 ML# 3367)

View Archives

To link to all DHS Service Chapters, click on the following link:

http://www.nd.gov/dhs/policymanuals/home/
Websites 850-10-20-10

ND State Government Website 850-10-20-10-05
(Revised 7/26/13 ML# 3367)
View Archives

By clicking on the following link, the viewer can access the website containing information to all aspects of North Dakota State Government:

http://www.nd.gov/
Websites 850-10-20-10

**ND State Government Website 850-10-20-10-05**
(Revised 7/26/13 ML# 3367)

[View Archives](#)

By clicking on the following link, the viewer can access the website containing information to all aspects of North Dakota State Government:

[http://www.nd.gov/](http://www.nd.gov/)
The Mission of the North Dakota Department of Human Services is to provide quality, efficient, and effective human services, which improve the lives of people. The role of the department is to provide services that help vulnerable North Dakotans of all ages to maintain or enhance their quality of life, which may be threatened by lack of financial resources, emotional crises, disabling conditions, or an inability to protect themselves. The department supports the provision of services and care as close to home as possible to maximize each person's independence while preserving the dignity of all individuals and respecting their constitutional and civil rights.

The DHS Website can be accessed by clicking on the link below. Viewer will find information about the Department’s Mission, Role, Quick Facts, Strategic Plan, Biennial Report, Executive Summary, DHS Organizational Chart, News, Public Stakeholder Meeting Comments, and other resources.

http://www.nd.gov/dhs/
Division of Mental Health and Substance Abuse Services Website 850-10-20-10-15
(Revised 7/26/13 ML# 3367)
View Archives

The Mental Health and Substance Abuse Services Division provides leadership for the planning, development, and oversight of a system of care for children, adults, and families with severe emotional disorders, mental illness, and/or substance abuse issues.

http://www.nd.gov/dhs/services/mentalhealth/
Regional Human Service Centers and ND State Hospital 850-10-20-10-20
(Revised 7/26/13 ML# 3367)

Mental health and substance abuse services are delivered through eight Regional Human Service Centers and the North Dakota State Hospital in Jamestown.
A mental health planning and advisory council exists in every State and U.S. Territory as a result of federal law enacted in 1986.

The law requires States and Territories to perform mental health planning in order to receive federal Mental Health Block Grant funds.

Stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these planning efforts through membership on the council.

In North Dakota, this group is called the Mental Health Planning Council. The Council consists of 27 members who are appointed by the Governor along with two ex officio members.

A diverse membership brings vast strengths and varying perspectives to The Council. There is a shared knowledge of individual and general consumer situations, Medicaid, service delivery systems, reimbursement issues, housing and community development, legal issues, and community resources.

Points of view are presented from consumers of mental health services, family members, advocates, referral sources, schools, institutional and community-based service providers, the general disability community, and the criminal justice system.
A majority of the membership has direct experience with issues concerning recovery, peer mentoring, service delivery, children's issues, and/or advocacy for mental health.

For further information about North Dakota’s Mental Health Planning Council click on the following link to access the website:

http://www.nd.gov/dhs/services/mentalhealth/ndmhp/c/index.html
The Mental Health Recovery Model 850-10-25
(Revised 7/26/13 ML# 3367)

North Dakota’s mental health system of care embraces the “Recovery Model”. The model is based on the concepts of strengths and empowerment - if individuals with mental illnesses have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives. This is in contrast to most traditional models of service delivery, in which consumers are instructed what to do, or simply have things done for them with minimal, if any, consultation for their opinions. Recovery from mental illness is the ultimate goal.

The concept of “recovery” originally began in the addictions field, referring to a person recovering from a substance use disorder. The term has more recently been adopted in the mental health field as people realize that, similar to recovery from an addiction, recovery from a mental illness is also possible.
Recovery Model Concepts 850-10-25-05
(Revised 7/26/13 ML# 3367)

A key point of the model is that it is not our role as providers to make decisions for consumers, but we do have a responsibility to provide education about the possible outcomes that may result from various decisions. Many staff first react with concern when they hear that mental health consumers should make decisions about their own care. “What if someone decides they don’t want to take prescribed medications?” is perhaps the most common and worrisome concern. Legally, though, no adult can be forced to take medications or undergo certain treatments unless there is a court order or legal guardian directing them to do so. The Recovery Model does not advocate anything different. The reality of practice, though, is that mental health consumers (particularly those with more chronic and debilitating disorders) are usually instructed as to what treatments and medications to take, with minimal effort to involve them in decisions. The Recovery Model states that a program’s philosophy should acknowledge and encourage consumer involvement and decision-making. Most consumers do ultimately ask for, and take, clinicians’ treatment recommendations, but consumers need to know that they have both the right and the responsibility to make those decisions.

Consumers should be included from the beginning in decisions regarding their care. When a consumer decides that he or she wants to do something, his or her decision ought to be respected, and we, as providers, should make reasonable efforts to assist. This does not mean money should be taken from group activity funds so that one consumer can take a vacation. However, if this is something the consumer has decided to do, advice and assistance ought to be provided for them to make it a reality. Maybe this means they need
to save money, get a part-time job, or learn to take medications without reminders.

The Recovery Model also does not suggest that consumer choice should be encouraged at the detriment of other consumers or program rules. A day program that requires attendance three days a week should maintain that rule, and consumers who do not follow it should have applicable consequences. Likewise, a housing program that requires consumers to have daytime activities should also enforce that rule. Or a therapist who sets rules for active participation in treatment should not take “I didn’t feel like it,” as an acceptable response for failing to do an agreed-upon task. Program rules that are set for the benefit of all should not have exceptions made in the name of the Recovery Model. However, consumers who do not like the rules of a particular program or residential facility should have the right to find a program that will better meet their needs.

What about when a consumer makes a decision that goes against clinical judgment and/or scientific evidence? The Recovery Model still suggests that wishes should be respected, and that we should assist consumers in their attainment. If their goal does not seem rational to us, then we need to help them understand the implications and realistic possibilities, but they need and have a right to make the decisions. Mental Health professionals have a responsibility to support the dignity of risk and the right to fail. Beyond clinical judgment or scientific evidence, concerns arise if a consumer’s decision is likely to cause harm. Professionals have a responsibility to intervene to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. A decision to not go to a day-program for a certain day is unlikely to cause such harm. Refusing medications, on the other hand, has a possibility of more serious harm, depending on the medication. Each case needs careful consideration and consultation with other relevant providers. When a consumer’s decision is unlikely to cause serious harm, our job is to help educate them as to possible benefits and consequences of their
decision (including if that means a possibility of involuntary hospitalization), but in the end to let them make those decisions. When a decision is likely to cause serious harm, then we should, as always, intervene so as to prevent the harm.

Another key concept of the Recovery Model is that consumers should have the right to make the same types of decisions that everyone else in society makes. Any individual who wants to live in an independent apartment in the community, for example, must make certain decisions that balance such factors as finances and behaviors. Fortunately there are laws designed to protect individuals with disabilities from housing discrimination, but each individual still has a responsibility to act in ways that are reasonably respectful of the rights of neighbors. An individual who plays excessively loud music, regardless of who they are, for example, runs the risk of receiving a warning or citation from the police. Someone who continues to be disrespectful of the rights of others would not be able to stay in the apartment. The person has the right to play music loudly, but they also must take responsibility for possible repercussions.

Consideration for the rights of others also applies to outside activities in which people participate. For many individuals this might include a gym membership or yoga class. For consumers of mental health services, this might also apply to support groups or day-treatment programs in which they participate. An individual who becomes disruptive to others in a group therapy session would be asked to leave in most cases. Individuals should have a choice about how to address their interpersonal challenges, but they also need to know of the responsibility of acting in a reasonably respectful and safe manner towards others. Again, someone who chooses to neglect their self-care, and becomes a danger to themselves or others, may need a more directive intervention such as hospitalization. This is a possibility of which each person in society needs to be aware; but each person also has the right to act in ways that will prevent or incur such an intervention.
There are many possible concerns that clinicians may express regarding allowing consumers to make decisions about their own care. Along with concerns about rejecting helpful medications, they might include not going to a program, not going to a doctor’s appointment, or not going to work. Consumers need to be as fully informed as possible about the potential benefits and consequences of each decision. They also need to know the possible results if they become a danger to themselves or others. When they break program rules, or decide that they no longer want to participate in a group, they may need to find another program that is more amenable to their interests. When such a program does not exist, then they need to be informed of what that means for their situation.

Case managers have an obligation to continue serving, supporting, and encouraging individuals to do what clinical experience has taught us to believe is best. However, we must understand and accept that helping consumers to make their own choices—good or bad—will ultimately be in the best interests of their recovery and independence, even if we believe that a particular action is a bad idea. As professionals, we need to learn to take a supportive role, rather than one as a decision maker. This may take a change in mindset for many clinicians, but it is imperative the change is made. On the other hand, there are constraints about how much we can help someone with what they want. The Recovery Model does not call for us to do things that are unrealistic, that would hinder the recovery of other consumers, or that would involve treating one consumer more favorably than another. The model calls for us to support consumers’ decisions, within reason, to the best of our abilities.

Recovery emphasizes that, while people may not have full control over their symptoms, they can have full control over their lives. Recovery is not about ‘getting rid’ of problems. It is about seeing beyond a person’s mental health problems, recognizing and fostering their abilities, interests in dreams. Mental illness and social attitudes to mental illness often impose limits on people experiencing ill health.
Health professionals, friends and families can be overly protective or pessimistic about what someone with a mental health problem will be able to achieve. Recovery is about looking beyond those limits to help people achieve their own goals and aspirations.
Tips to Orient Your Work Towards a Recovery-Oriented Model 850-10-25-10
(Revised 7/26/13 ML# 3367)

1. Never talk about a consumer in the third person when he or she is present. In that case, they should be referred to as “you”—“What do you want to do or think?” or, “You have a follow-up appointment in two weeks,” or, “You understand that John will remind you of your appointment and take you there in two weeks?” Sometimes this may seem awkward when you are informing a family member or other caregiver of care instructions. However, you can, and should, still work the consumer into the conversation in such a way that he or she is a part of the conversation, rather than an object next to you.

2. When a consumer makes a request that you don’t agree with, as your first response does not ignore them or say “no.” Rather, ask them to explain their request. Why do they want it? What will they need to do to get it? What are the consequences and benefits? Is it a realistic request? Yes, some people become recalcitrant, and will struggle to understand explanations. Just don’t make “no” your first gut-reaction for what seems to be an irrational request. Help them to think about the request and make their own rational decision. Chances are good that you misunderstood their intent, and their request is reasonable.

3. Remember your body language and communication skills. These are frequently forgotten, especially when working with consumers who have greater disabilities. Never turn your back to a consumer when talking about their care with another person. When talking with a consumer and another provider or family member, talk to both of them, even if only one person is responding or will have direct responsibility for carrying out
instructions. Look back and forth between the consumer and other(s) to include a consumer in a conversation. Ask the consumer if he or she understands a discussion, or understands how another person will be helping them. Say things and use your body language to ensure that a consumer is a part of a conversation about his or her care.

4. Respect consumers’ cultural differences or views. A consumer who is Jewish should have the right to light Chanukah candles in December. A consumer who is Islamic should have the right to pray at sunset, even if it means he or she has to leave in the middle of a group therapy session. You and other staff need to be aware of, remember, and respect cultural differences of the consumers you serve.

5. Respect for the value and worth of each individual as an equal and important member of society.
Ten Components of Recovery 850-10-25-15
(Revised 7/26/13 ML# 3367)

Self-Direction: People lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and Person-Centered: There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment: People have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

Holistic: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social
networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

**Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the person to move on to fully engage in the work of recovery.

**Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

**Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. People in recovery encourage and engage other people in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

**Respect:** Community, systems, and societal acceptance and appreciation of people in recovery—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one’s self are particularly vital. Respect ensures the inclusion and full participation of people in recovery in all aspects of their lives.
Responsibility: People have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. People must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope: Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.
Recovery E-Courses 850-10-25-20
(Revised 7/26/13 ML# 3367)

To learn more about recovery, click on the following:

1. Recovery e-course 1: Recovery is Real
2. Recovery e-course 2: Self-determination Fuels Recovery
3. Recovery e-course 3: The Language of Recovery
4. Recovery e-course 4: Planning that Promotes Recovery
5. Recovery e-course 5: Let’s Start Living Large
6. Recovery e-course 6: The Resiliency Factor
The sentiment that “we’re not cases, and you’re not our managers” has been accepted increasingly as a fundamental challenge to the ways in which behavioral health care is conceptualized within a recovery-oriented system. Rather than replacing any of the skills or clinical and rehabilitative expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies can be framed as tools that the person can use in his or her own recovery.

Prior to attempting to embark with a client on his or her journey of recovery, however, practitioners appreciate that the first step in the process of treatment, rehabilitation, or recovery is often to engage in a relationship a reluctant, disbelieving, but nonetheless suffering, person. In this sense, practitioners accept that most people with behavioral health disorders will not know that they have an addiction or psychiatric disorder at first, and therefore will frequently not seek help on their own. The initial focus of care is thus on the person’s own understanding of his or her predicament (i.e., not necessarily the events or difficulties which brought him or her into contact with care providers), and on the ways in which the practitioner can be of assistance in addressing this predicament, regardless of how the person understands it at the time.

It also is important to note that within this model, care incorporates the fact that the lives of people in recovery did not begin with the onset of their disorders, just as their lives are not encompassed totally by substance abuse or psychiatric treatment and rehabilitation. Based on recognition of the fact that people were
already on a journey prior to the onset of their disorders, and therefore prior to coming into contact with care, the focus of care shifts to the ways in which this journey was impacted or disrupted by each person’s disorder(s). For example, practitioners strive to identify and understand how the person’s substance use or psychiatric disorder has impacted on or changed the person’s aspirations, hopes, and dreams. If the person appears to be sticking resolutely to the hopes and dreams he or she had prior to onset of the disorder, and despite of or without apparent awareness of the disorder and its disabling effects, then what steps need to be taken for him or her to get back on track or to take the next step or two along this track? Rather than the reduction of symptoms or the remediation of deficits—goals that we assume the person will share with care providers—it is the person’s own goals for his or her life beyond or despite his or her disability that drive the treatment, rehabilitation, and recovery planning and efforts.
Recovery Practice Guidelines 850-10-25-30
(Revised 7/26/13 ML# 3367)

1. The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be grounded in an appreciation of the possibility of improvement in the person’s condition, offering people hope and/or faith that recovery is “possible for me.” Practitioners convey belief in the person even when he or she cannot believe in him or herself and serve as a gentle reminder of his or her potential. In this sense, staff envisions a future for the person beyond the role of “mental patient” or “addict” based on the person’s own desires and values and share this vision with the person through the communication of positive expectations and hope.

2. Providers assess where each person is in relation to the various stages of change (e.g., pre-contemplation, preparation, etc.) with respect to the various dimensions of his or her recovery. Interventions are appropriate to the stages of change relevant to each focus of treatment and rehabilitation (e.g., a person may be in an action phase related to his or her substance use disorder but be in pre-contemplation related to his or her psychiatric disorder).

3. Care is based on the assumption that as a person recovers from his or her condition, the addiction or psychiatric disorder then becomes less of a defining characteristic of self and more simply one part of a multi-dimensional sense of identity that also contains strengths, skills, and competencies. Services elicit, flesh out, and cultivate these positive elements at least as much as, if not more than, assessing and ameliorating difficulties. This process is driven by the person in recovery through inquiries
about his or her hopes, dreams, talents, and skills, as well as perhaps the most important question of “How can I be of help?”

4. Interventions are aimed at assisting people in gaining autonomy, power, and connections with others. Practitioners regularly assess the services they are providing by asking themselves: “Does this person gain power, purpose (valued roles), competence (skills), and/or connections (to others) as a result of this interaction?” and, equally important: “Does this interaction interfere with the acquisition of power, purpose, competence, or connections to others?”

5. Opportunities and supports are provided for the person to enhance his or her own sense of personal and social agency. For example, practitioners understand that medication is only one tool in a person’s “recovery tool box” and learn about alternative methods and self-management strategies in which people use their own experiences and knowledge to apply wellness tools that work best for them. Sense of agency involves not only feeling effective and able to help oneself but also being able to positively impact the lives of others. Providers can achieve this by thoughtfully balancing when to do for someone, do with someone, or when to let someone do for him or herself. Knowing when to hold close and support and protect, when to encourage someone while offering support, when to let someone try alone and perhaps stumble, and when to encourage a person strongly to push themselves is an advanced, but essential, skill for practitioners to develop. While these are intuitive skills that all practitioners must struggle to refine over time, prior to taking action it is always beneficial for practitioners to ask the question: “Am I about to do for this person something she or he could manage to do more independently.” Strong messages of low expectations and incapability are given, and reinforced, every time unnecessary action is undertaken for a person, instead of with them.

6. Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn. People in recovery
report that they have found meaning in adverse events and failures and that these have subsequently helped them to advance in their recovery. In accordance with this, practitioners recognize that their role is not necessarily to help people avoid adversity or to protect them from failure. For example, the re-experiencing of symptoms can be viewed as a part of the recovery process and not necessarily a failure or setback. The “dignity of risk” ensues following a thoughtful and proactive planning process in which practitioners work collaboratively with individuals to develop relapse prevention plans, including advance directives which specify personal and treatment preferences in the event of future crises.

7. People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions attributed to symptoms or relapse.

8. Care is not only attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but incorporates this sensitivity at the level of the individual. Only an individual-level process can ensure that practitioners avoid stereotyping people based on broad or inaccurate generalizations (e.g., what all lesbians want or need), and enable them instead to tailor services to the specific needs, values, and preferences of each person, taking into account each individual’s ethnic, racial, and cultural affiliations.

9. Rather than dwelling on the person’s distant past or worrying about the person’s long-term future, practitioners focus on preparing people for the next one or two steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person avoid or move around potential obstacles in the road ahead. Although the practitioner deemphasizes the person’s early personal history (because it may not be relevant) and long-term outcome (because it cannot be predicted), either of these perspectives may be invoked should they prove useful in the current situation. Especially as
these issues pose barriers to recovery, practitioners utilize appropriate clinical skills within the context of a trusting relationship in order to enhance the person’s capacity to overcome, compensate for, or bypass these barriers (see section #H below).

10. Interventions are oriented toward increasing the person’s recovery capital as well as decreasing his or her distress and dysfunction. Grounded in a person’s “life-context,” interventions take into account each person’s unique history, experiences, situations, developmental trajectory, and aspirations. In addition to culture, race, and ethnicity, this includes less visible but equally important influences on each person’s development, including both the traditional concerns of behavioral health practitioners (e.g., family composition and background, history of substance use and relapse triggers) as well as less common factors such as personal interests, hobbies, and role models that help to define who each person is as an individual and as a member of his or her network.

11. Practitioners are willing to offer practical assistance in the community contexts in which their clients live, work, and play. In order to effectively address “individuals’ basic human needs for decent housing, food, work, and ‘connection’ with the community,” practitioners are willing to go where the action is, i.e., they get out of their offices and out into the community. They are prepared to go out to meet people on their own turf and on their own terms, and to “offer assistance which they might consider immediately relevant to their lives”.

12. Care is not only provided in the community but is also oriented toward increasing the quality of a person’s involvement in community life. Thus, the focus of care is considered more important than locus of where it is provided. The focus of care includes the process of overcoming the social and personal consequences of living with psychiatric and/or substance use disorders. These include gaining an enhanced sense of identity and meaning and purpose in life and developing valued social
roles and community connections despite a person’s continued symptoms or disability. Supporting these goals requires that practitioners have an intimate knowledge of the communities in which their clients live, the community’s available resources, and the people who are important to them, whether it is a friend, parent, employer, landlord, or grocer. Practitioners also are knowledgeable about informal support systems that are in communities such as support groups, singles clubs, and other special interest groups, and actively pursue learning more about other possibilities that exist to help people connect.

13. Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit. This is done both by helping the person assimilate into his or her environment (through symptom management, skill acquisition, etc.) and by helping the community to better accommodate people with disabilities (through education, stigma reduction, the creation of niches, etc.), with the common goal being to develop “multiple pathways” into and between members of communities.

14. In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals (e.g., being a parent, a worker, a friend, etc.), continuing to view people in recovery squarely within the context of their daily lives (i.e., as opposed to within institutional settings).

15. Community-focused care supplements the practitioner’s existing expertise and services. Rather than devaluing professional knowledge and experience, the “recovery guide” approach moves psychiatry much closer to other medical specialties in which it is the health care specialist’s role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions. There is an expectation that practitioners engage
in on-going professional education so that they are aware of, and can deliver, a wide range of evidence-based and emerging practices. But no matter how expert or experienced the practitioner, it is then ideally left up to the person and his or her loved ones to make decisions about his or her own care.

16. Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners. Interventions serve to minimize the role that professionals play in people’s lives over time and maximize the role of natural supports. While the provider-person relationship can be a powerful component of the healing and recovery process, individuals must also develop and mobilize their own natural support networks to promote sustained recovery and independent community life.
Supervision is imperative for all case managers regardless of their level of expertise or length of employment. There are two distinct forms of supervision – Clinical Supervision and Administrative Supervision. The Extended Care Coordinator is the supervisor for SMI Case Managers and will arrange supervision time for each employee.
Clinical Supervision is an intervention by a more senior member of a profession to a more junior member of members of that same profession. This relationship is evaluative, extends over time, and enhances the professional functioning, monitors service quality, and acts as a gate-keeping process for those who are entering the profession. Clinical supervision means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. All case managers must have ongoing clinical supervision. Clinical supervision ensures the appropriateness of assessment and of services planned and provided, and provides case managers with direction and guidance on provision of services to individual clients.
Administrative Supervision for SMI Case Managers
850-10-30-10
(Revised 7/26/13 ML# 3367)

Administrative Supervision, on the other hand, is concerned with the correct, effective, and appropriate implementation of agency policies and procedures. The supervisor has been given authority by the agency to oversee the work of the supervisee. The primary goal is to ensure adherence to policy and procedure.
At one time, people with serious and persistent mental illness received all of their treatment and the basic requirements of living within hospitals. Between 1965 and 1980, 358,000 residents of public mental health hospitals in the United States were discharged to live in the community. In addition, many younger people with mental illness were not admitted for long-term hospitalization. The focus of care and treatment shifted from the institution to the community; this was known as the “deinstitutionalization” movement of the 1960’s. Many individuals with mental illness had neither the skills nor the resources to live independently in the community. Thus, a need for case management services emerged.

SMI Case Management is a core service delivered through the eight Regional Human Service Centers. In general, case management services help clients reach their recovery goals. Case management consists of, but is not limited to the following components in the provision of direct services to clients and their families: (1) outreach, referral, client identification, and engagement; (2) initial and ongoing assessment of the client; (3) the development of a service plan; (4) implementation of the service plan; (5) coordination and monitoring of service delivery; (6) advocacy on behalf of the client including creating, obtaining, or brokering needed client resources; and (7) monitoring outcomes.

Case management services can be provided by one person, or a team of providers. Case management is usually done in the community as opposed to an office setting and may be done in the client’s home, place of employment, shelter, on the streets, and in residential and other settings. The frequency of contact may be more intensive or less intensive based on the client’s needs.
The role of a case manager can be compared to that of a “Recovery Guide” as they assist individuals in their recovery journey.
Partnerships for Children’s Mental Health and Transition to Independence Program (TIP)  
850-10-35-05  
(Revised 7/26/13 ML# 3367)  
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Other types of case management services provided at the human service centers are Partnerships for Children’s Mental Health and the Transition to Independence Program (TIP). See the respective service chapters for additional information regarding these programs. It is important to note that young people between the ages of 18-21 participating in Partnerships can choose to remain in the program until they are 21 or they can choose to participate in SMI Case Management. In addition, there are times that Partnership and SMI Case Management will work together to improve the life of younger individuals who are at risk. The Transition to Independence Program provides case management services for young people who do not otherwise qualify for any case management services. The goal of the program is to help the youth successfully transition to independence. An individual who is 14 to 24 years of age and requires assistance to achieve independence will work one-on-one with a Transition Facilitator to identify strengths, future planning, and work towards independence. Individuals must meet at least one of the following criteria: at risk of entering into or already involved in foster care; at risk of entering into or already involved in the juvenile justice system; at risk of deprivation; at risk due to a serious mental illness or developmental disability and does not qualify for case management or at risk due to suicidal tendencies yet not at immediate risk of out of home placement.
SMI Case Management Eligibility 850-10-35-10
(Revised 7/26/13 ML# 3367)

An individual is generally interested in, or referred to, case management services because they need help in coping with their mental illness. Typically, the illness has caused significant disruptive episodes in their lives and they would benefit from case management services to assist them with obtaining services and resources such as daily living skills; finding and maintaining housing, jobs and friends to help them accomplish goals and live independently.

An individual must meet the definition of seriously mentally ill, as well as meet eligibility requirements to receive case management services. North Dakota’s Medicaid State Plan, as well as North Dakota Century Code (NDCC) 57-38-01 provides the following definition of Chronically Mentally Ill: “Chronically mentally ill” means a person who, as a result of a mental disorder, exhibits emotional or behavioral functioning which is so impaired as to interfere substantially with the person’s capacity to remain in the community without verified supportive treatment or services of a long-term or indefinite duration. This mental disability must be severe and persistent, resulting in a long-term limitation of the person’s functional capacities for primary activities of daily living such as interpersonal relationships, homemaking self-care, employment and recreation.

Based on this definition, the Department of Human Services developed and utilizes the SMI Determination and Case Management Eligibility Checklist as a means to identify which clients meet the definition of Serious Mental Illness and qualify for SMI Case Management Services. Eligibility is based on the individual’s age, diagnoses, functional impairment, functional domain, and duration of...
the mental illness. The same eligibility requirements apply regardless of an Individual’s Medicaid status and payment source.
DSM (Diagnostic and Statistical Manual)
850-10-35-15
(Revised 7/26/13 ML# 3367)
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To access the current version of the DSM click on the following link:

http://behavenet.com/apa-diagnostic-classification-dsm-iv-tr
SMI RECOVERY

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Specific Mental Disorders 850-10-35-15-05
(Revised 7/26/13 ML# 3367)

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Click on the following link to access information on specific mental disorders.

http://behavenet.com/apa-diagnostic-classification-dsm-iv-tr
SMI Determination and Case Management Eligibility Checklist 850-10-35-20
(Revised 7/26/13 ML# 3367)

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The SMI Determination and Case Management Eligibility Checklist Training Document is located at:

SMI Determination and Case Management Eligibility Checklist Training Doc

You can also click on the following link to access the training document to learn everything you need to know about the checklist:

SMI Determination and Case Management Eligibility Checklist Training Document

As stated in the training document, you will complete the SMI Determination and Case Management Eligibility Checklist in ROAP.
Recovery in the sense we are using it in this manual, refers to a prolonged or long-term process. It does not refer to an acute phenomenon such as recovery from the flu or from a broken bone. This is not to say that substance use or mental illness cannot also be acute in nature. Many people do, in fact, experience one episode of mental illness or a short-lived period of substance use and do not develop prolonged conditions to begin with.

For those individuals for whom being in recovery is a meaningful goal, the nature of their struggle with mental illness and/or addiction is likely to be sustained and an acute model of care is not the most useful or appropriate. Particularly in terms of system design, prolonged conditions call for longitudinal models that emphasize continuity of care over time and across programs. These models are based on the belief that full recovery is seldom achieved from a single episode of treatment, and that providers, as well as clients, families, and policy makers, should not be disappointed or discouraged by the fact that there are no quick fixes. Similar to (other) chronic medical illnesses, previous treatment of a person’s condition also should not be taken to be indicative of a poor prognosis, of non-compliance, or of the person’s not trying hard enough to recover. Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as further evidence of the severity of the person’s condition rather than as causes for discharge (e.g., we do not discharge a person from the care of a cardiologist for having a second or third heart attack). All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care offered by different providers, but through a carefully crafted system of care that ensures continuity of the person’s most significant healing
relationships and supports over time and across episodes, programs, and agencies.

You will know that the MH System is ensuring continuity of care when:

1. The central concern of engagement shifts from: “How do we get the client into treatment?” to: “How do we nest the process of recovery within the person’s natural environment?” For example, people have often asked for meeting places and activities to be available on weekends, especially for those individuals who are in the early stages.

2. Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care. There also is an emphasis on outreach and pre-treatment recovery support services that can ensure that individuals are not unnecessarily excluded from care. If a person is denied care, they receive written explanations as to why and are connected to appropriate alternatives including appointment and transportation.

3. Eligibility and reimbursement strategies for this group of individuals (i.e., outreach and pre-engagement) are established and refined as necessary over time by administrative leadership.

4. People have a flexible array of options from which to choose, and options are not limited to what “programs” are available. These options allow for a high degree of individualization and a greater emphasis on the physical/social ecology (i.e., context) of recovery.

5. Individuals are not expected or required to progress through a continuum of care in a linear or sequential manner. For example, individuals are not required to enroll in a group home as a condition of hospital discharge when this is determined.
solely by professionals to be the most appropriate level of care. Rather, within the context of a responsive continuum of care, individuals work in collaboration with their recovery team to select those services from within the array that meet their particular needs and preferences at a given point in time.
SMI RECOVERY

Division 20  Service 850
Program 850  Chapter 10

Medical Necessity 850-10-40-05
(Revised 7/26/13 ML# 3367)
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Note: Case managers are required to complete the ND Department of Human Service’s ELM Learning Module on Medical Necessity located on People Soft. Visit with your supervisor for assistance with locating the module.

There is no one agreed upon definition of “medical necessity”, but generally, Medically Appropriate and Necessary is a term used to describe those services, supplies or treatments provided by a health care provider to treat an illness or injury that satisfy the following criteria:

A. The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of an individual’s illness or injury.

B. The services, supplies or treatment are consistent with professionally recognized standards of health care.

C. The services, supplies or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the individual’s illness or injury.

In behavioral health, there are three essential components to establish medical necessity:

1. Diagnosis of a mental, behavioral, or emotional disorder.

2. The diagnosis must have been diagnosed in the past year.
3. The disorder results in functional impairment which substantially interferes with or limits one or more daily life activities.

This means that functional impairment in the individual’s daily living activities must be present in clinical documentation in order to establish medical necessity.

Medical Necessity implies focus on functioning in three key documents: Diagnostic Assessment, Person Centered Treatment Plan, and the Progress Note. This is referred to as pulling the “Golden Thread” from the diagnostic assessment through to the individualized treatment plan and finally to the progress note.

1. **Diagnostic Assessment:**

   What does proving Medical Necessity look like in a Diagnostic Assessment? Describing signs and symptoms associated with diagnosis is not sufficient; you must describe specific functional impairments. The Department of Human Services requires the DLA-20 to be completed at a minimum of every 90 days so the specific functional impairments are identified.

2. **Treatment Plan:**

   What does proving Medical Necessity look like in a Treatment Plan? Symptom-based plans are not enough. We must include functionality-based treatment goals.

3. **Progress Note:**

   What does medical necessity look like in a progress note? Progress reviews cannot be purely subjective. They must
document specific and measurable improvements in functioning. Every progress note is a bill for services. Would you pay for what you read in a progress note? We don’t get paid to “see clients” or for “conversations that meander with the client”.

Case management services must be medically necessary and the goal of case management is rehabilitation. Medicaid defines rehabilitation as: “any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level”. Source: Federal Register, Section 1905(a)(13) of the Act and 42 VFR 440-130(d). Rehabilitation is the treatment goal. As with medical necessity, note the focus on functioning.

The DLA-20 functional assessment defines the functional impairments that are present due to the mental illness. The DLA-20 objectively assesses client’s current functioning which can define specific functionality-based treatment goals, which can lead to documented functional improvements over time. In doing so, you will meet the requirements for establishing medical necessity and focusing on client rehabilitation.
Levels of Recovery 850-10-40-10
(Revised 7/26/13 ML# 3367)
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Click here to view the Levels of Recovery Document utilized by the Department of Human Services.

The goal of case management is recovery for the individual. This includes increasing the ability of the individual to cope and function independently, managing his/her own symptoms, and finding and maintaining services and community living requirements.

Individuals will present with varying degrees and intensities of symptoms at different times. Consequently the intensity and frequency of their need for case management and other services will vary. It is imperative the tiered system approach allows for these variances and accommodates potential relapses. An effective tiered system approach provides the appropriate type, level, and length of services to meets the unique needs of each individual. Services are planned, efficient, and coordinated resulting in safe, adequate and appropriate care which is likely to improve the recipient's condition and produce positive outcomes.

Expected outcomes or results are important in a tiered system. No one should continue to receive the same service over and over again with no clear results. No results (after a reasonable period of time) suggest a need to consider other approaches. However, keep in mind that stability of condition can be a positive result for some clients. If it can be shown that the stability is the result of the service provided (e.g., medication, or a job) and that withdrawal of that service will result in destabilization or worsening of the client's symptoms, functioning or behavior, then upon review, that level of care may legitimately be continued. Care must be taken not to mistake
stability with the best a client can expect or achieve. While a few clients may need to rely on a particular level of service for life, the Recovery Model does not assume that will occur. Treatment geared toward simply maintaining the recipient's current level of functioning is only acceptable when, without such treatment, the individual would be likely to suffer a relapse which is serious enough to require the provision of services which are more intensive than those currently being received. The community and the payer have an interest in assuring that public dollars are stretched as far as possible and used well, and that the community as a whole benefits from the expenditure of those funds by increasing the productivity, safety and well-being of service recipients.

The DLA-20 is completed to determine the Recovery Level. See 850-10-45-12 for further information on the DLA-20.

While functional assessment findings are key indicators for level assignment, there are additional factors to be considered for each individual. Among these considerations are:

- Client choice must be a primary factor in the assignment decision.
- Willingness is closely associated with client choice. Client may be temporarily satisfied with their lives and circumstances, not desiring to begin work on more progressive goals. Willingness must be cautiously evaluated by providers of case management and must not be used as an “excuse” for undeserving. It is important to note that case managers can positively influence willingness through demonstration of hope and belief in the client while working to enable the client to have the ability to manage themselves and live successfully in the community.
- Social resources and natural supports available to clients are also a very important factor in decision about the intensity of case management. Clients who are living in supervised housing/group homes or residences associated with psychosocial rehabilitation and/or clubhouses may well require a less intensive case
management service. Clients who live with family or significant others may not need or choose an intensive case management service. However, care must always be taken not to make the family or significant others the “de facto” case manager. The availability of client’s self-help opportunities and other natural support and social services will also affect the level of case management required.

- Safety may play a role in the case management assignment decision. People who are vulnerable to violence or abuse, or who are themselves prone to abusive behavior, may require a more intensive level of case management.

- Culture is also a critical determinate for case management. While all providers of case management services must be aware of the ethnicity and heritage of the clients they serve, providers must also employ case managers who are representative of the various culture so the service area to assure cultural sensitivity in the level of case management services. Specific training in cultural competence should be required from all providers.

- Co-occurring conditions or situation will also affect assignment. Clients with a mental illness and a co-occurring substance abuse problem should work with providers who are trained in the provision of substance abuse services. Serving clients who live with mental illness who are elderly, physically or development disabled or involved with the criminal justice system requires specialized skills.

- Legal issues are a factor in the selection of case management intensity. Clients with guardians or who are involuntarily committed may be assigned a particular level of case management intensity. Clients with involvement in the criminal justice system require coordination with those systems.
Termination of Case Management Services
850-10-40-15
(Revised 7/26/13 ML# 3367)
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Termination occurs for a number of reasons, including the client’s attainment of stated goals, rehabilitation, noncompliance, the client or the case manager’s withdrawal, or the client’s death. Although an agency will set certain criteria for terminating a case, it is the responsibility of the case manager, the client, and significant others to prepare for the effects of termination. The case manager should make appropriate arrangements with the service providers and conclude the financial aspects of the case.

After termination, it may be necessary to follow up on the client and the client’s family to ensure that the current situation is adequate and appropriate. Follow-up also may be performed to collect program evaluation measures pertaining to client outcomes. Follow-up may include assessing the adequacy of the client’s current living arrangements and the stability of the client’s functioning.
A case manager shall carry a reasonable caseload that allows the case manager to effectively plan, provide, and evaluate case management tasks related to client and system interventions.

The size of the case management staff shall be related to the scope and complexity of the case management system and to the nature of the populations to be served. Staffing shall be sufficient to enable the provision of timely quality services by the case manager. The composition of the staff also shall be related to the ethnic and cultural composition of the client populations to provide for culturally sensitive case management practice and to allow staff to effectively respond to the unique needs of particular client groups. Appropriate and adequate supervision and multidisciplinary consultation services should be available to and used by case management supervisors and staff.

A number of variables affect caseload size. Caseload standards should be based on the scope of professional responsibilities, the volume of clients to be served, the amount of time the case manager needs to spend with clients, the breadth and complexity of client problems or services, and the length and duration of case mix in determining case manager-client involvement. The number of cases a case manager can realistically handle is limited to the degree to which caseloads consist of acute, high-risk, multi-need clients. Caseload size must realistically allow for meaningful opportunities for face-to-face client contact. As caseload size increases, the case manager has a decreasing capacity to perform ongoing case management activities such as follow-up, monitoring, and reassessment. It is the joint responsibility of the agency and the case manager to address and remedy caseload issues and concerns.
The Recovery Levels chart identifies the recommended number of clients per case manager per level.
Critical Functions of Case Management 850-10-45
(Revised 7/26/13 ML# 3367)
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For the purposes of this manual, the functions or tasks of case managers are grouped into the following 4 areas:

1. Engagement/Connecting with the Client
2. Intake (Including DLA 20 Assessment)
3. Person Centered Plan
4. Coordination
Engagement/Connecting with the Client
850-10-45-05
(Revised 7/26/13 ML# 3367)
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A primary factor in providing case management services is the working relationship. A good case management relationship is based upon trust, mutual respect and a willingness to work together to attain agreed-upon objectives. The case manager does not attempt to change or judge the client’s beliefs, values or emotions. A strong partnership, when it is conscientiously pursued, can assist clients to succeed in their recovery. The case management relationship, like any other, thrives on consistency, openness, honesty and the careful building of trust.

Engagement involves making contact with the person rather than with the diagnosis or disability, building trust over time, attending to the person’s stated needs and, directly or indirectly, providing a range of services in addition to clinical care. The process of engagement benefits from new understandings of motivational enhancement, which sees people standing at various points on a continuum from pre-readiness for treatment to being in recovery, rather than being either motivated or unmotivated.

Engagement involves sensitivity to the thin line between persuasion and coercion and attention to the power differential between the service provider and the client or potential client, and the ways in which these factors can undermine personal choice. Finally, methods of ensuring access and engagement are integrated within and are part of providing good clinical and rehabilitative care, not adjuncts or qualifications to them.
A Mental Health Service System promotes access and engagement when:

1. The service system has the capacity to go where the potential client is, rather than always insisting that the client come to the service. Services and structures (e.g., hours of operation and locations of services) are designed around client needs, characteristics, and preferences.

2. The team provides, or can help the person gain access to, a wide range of services.

3. There is not a strict separation between clinical and case management functions, though there may be differences in expertise and training of the people providing these services. Services and supports address presenting clinical issues, but are also responsive to pressing social, housing, employment, and spiritual needs. For example, employment is valued as an important element of recovery. Skill building and finding employment are competencies included in all staff job descriptions, including clinical providers, with only the most difficult-to-place clients being referred to specialized programs.

4. The assessment of motivation is based on a stages of change model, and services and supports incorporate motivational enhancement strategies which assist providers in meeting each person at his or her own level. Training in these strategies is required for all staff who work with people in order to help move people toward recovery.

5. Staff and agencies look for signs of organizational barriers or other obstacles to care before concluding that a client is non-compliant with treatment or unmotivated for care, e.g., meeting the needs of women with children for daycare.

6. Agencies have “zero reject” policies that do not exclude people from care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program
activities. For example, vocational rehabilitation agencies do not employ screening procedures based on arbitrary “work readiness” criteria, as such criteria have limited predictive validity regarding employment outcomes. In addition, such procedures suggest that individuals must attain, and maintain, clinical stability or abstinence before they can pursue a life in the community, when, in fact, employment and other meaningful activities are often a path through which people become stable in the first place. Staffs have an “open case” policy which dictates that a person’s refusal of services, even despite intensive and long-term outreach and engagement, does not require that he or she be dropped from the “outreach” list. This person may still accept services at another time. Committee structures and supervision are in place to evaluate the fine line between assertive outreach versus potential harassment or coercion. In addition, the agency establishes guidelines regarding what defines an “active” versus an “outreach” client, and considers how such definitions impact program enrollment, documentation standards, 30 day drop out lists, case load definitions, and reimbursement strategies.

7. From an administrative perspective, the system builds on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports. This includes flexibility in outpatient care, including low-intensity care for those who do not presently benefit from high-intensity treatment.

8. Professionals capitalize on the moment of crisis that can lead people to accept treatment, and to gain access to their appropriate level of care.

9. Mental health professionals, addictions specialists, and people in recovery are placed in critical locales to assist in the early stages of engagement, e.g., in shelters, in courts, in hospital emergency rooms, and in community health centers. The agency develops and establishes the necessary memoranda of agreement and protocols to facilitate this co-location of services.
10. The team or agency employs staff with first person experience of recovery who have a special ability to make contact with and engage people into services and treatment.

11. Housing and support options are available for those who are not interested in, or ready for, detoxification, but who may begin to engage in their own recovery if housing and support are available to them. Provider ambivalence regarding harm reduction approaches and the issue of public support for persons who are actively using must be addressed in regard to this point.

**Connecting with the Client – The Process**

**Introduction, Exploration and Engagement:** In this initial phase, the case manager will introduce himself/herself to the client. They will explain the case management process and the goals of this service. The case manager will begin to assess the client’s current ability to independently access needed services and whether they want case management services. It should be kept in mind that willingness to participate in case management services is closely associated with client choice. Clients may be temporarily satisfied with their lives and circumstances, not desiring to begin work on more progressive goals and objectives. Engagement must be cautiously evaluated by the case manager and must not be used as an "excuse" for under-serving.

The client is the "expert" about their own unique strengths, interests, aspirations and natural supports. Case managers can positively influence engagement by fostering hope and belief in the client receiving services. This principle allows the client to share in the recovery process to the greatest extent possible.
Active listening, reflection and verbal support are critical to the acceptance and empowerment of the client. In this process the case manager may respond to the information presented by the client by restating what they have heard the client say. The case manager should encourage the client to explore their situation to identify their own personal strengths. For example, "You said you'd like to live in an apartment; tell me what kinds of things you can do to live on your own."

Through the engagement/connecting phase, regular contact is maintained, depending upon needs and wherever they reside, i.e., hospital, jail, group home, independent apartment, etc.

Motivational Interviewing is the key to connecting with clients. See below for details on MI and Stages of Change:

Missing information here!!!!
Motivational Interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change. It is an empathic, supportive counseling style that supports the conditions for change. Practitioners are careful to avoid arguments and confrontation, which tend to increase a person's defensiveness and resistance.

Motivational interviewing is a proven and effective way to:

- Engage individuals with co-occurring disorders
- Develop therapeutic relationships
- Determine individualized goals

Motivational interviewing is used for the treatment of many conditions. Specific strategies have been successfully applied to working with individuals with co-occurring disorders include:

- Assessing the person's perception of the problem
- Exploring the person's understanding of his or her condition
- Examining the person's desire for continued treatment
- Ensuring a person's attendance at initial sessions
- Expanding the person's perceptions for the possibilities of successful change

Research shows that motivational interviewing techniques, including counseling, assessment, multiple sessions, and brief interventions, are associated with greater participation in treatment and positive treatment outcomes.
To access additional information on MI, click on the following links:

http://www.samhsa.gov/co-occurring/topics/training/motivational.aspx

http://www.motivationalinterview.org/quick_links/manuals.html
People go through a series of stages when they change behavior. The Stages of Change Model describes five stages of readiness and provides a framework for understanding the change process. By identifying where a person is in the change cycle, interventions can be tailored to the individual's "readiness" to progress in the recovery process. Interventions that do not match the person's readiness are less likely to succeed and more likely to damage rapport, create resistance, and impede change. Anything that moves a person through the stages toward a positive outcome should be regarded as a success.

The Stages of Change Model has five phases:

**Pre-Contemplation Stage**
People are not thinking about making a change. This may be because they have never thought much about their situation or they have already thought things through and decided not to change their behavior. Sometimes people may want to change, but not feel as if they could successfully make the change they desire. People in this stage might find it useful to get more information about their situation.

**Contemplation Stage**
In this stage, people start thinking about their situation. They are unsure about what to do. There are both good and not-so-good things about their present situation. People in this stage also struggle with the good and not-so-good things that might come with change. During this stage they often both want change and yet want to stay the same at the same time. This
can be a bit confusing for them as they feel torn between these options.

**Preparation Stage**
When people have been thinking through whether or not to change, they may come to feel that the reasons for change outweigh the reasons not to change. As this weight increases on the side of change, the person becomes more determined to do something. During this stage, they begin thinking about how they can go about making the change they desire, making plans and then taking some action toward stopping old behaviors and/or starting new, more productive behaviors. They often become more and more “ready” and committed to making changes.

**Action Stage**
During this stage people begin to implement their “change plans” and trying out new ways of being. Often they let others know what’s happening and look for support from them in making these changes. They experience success in making and keeping some changes over a period of time.

**Maintenance/Relapse Prevention Stage**
During this stage, people try to sustain the changes that have been made and to prevent returning to their old ways. Many times the person is able to keep up the changes made and then make a permanent exit from the wheel (or spiral) of change. During this stage it is also common for people to have some “slips” or “lapses” where old habits return for a short time.

Sometimes people also have “relapses” which may last a longer period of time. When they have a relapse, he or she typically returns to the pre-contemplation or contemplation stages. The person’s task is to start around the wheel of change again rather
than getting stuck. Relapses, slips, and lapses are normal as a person tries to change any long-standing habit. Often they will go around the wheel of change 3 or 4 times before permanent change takes hold.

There is good evidence that people should not skip stages. Someone that jumps right into the action stage may not spend enough time preparing for change. The result is they have trouble in keeping the changes they have made. For this reason, it is important for the person to know which stage they are in and what things they need to do to move to the next stage.

Adapted from:
Motivational Interviewing: MI Counseling Strategies.

The table below shows characteristic, communication styles, and areas to avoid when working with an individual on change and through the stage of change.
### Stages of Change Table 1 (Ferns, 2002, Fuller & Taylor, 2009).

<table>
<thead>
<tr>
<th>Stage of change</th>
<th>Pre-contemplation</th>
<th>Contemplation</th>
<th>Preparation</th>
<th>Action</th>
<th>Maintenance</th>
<th>Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics</td>
<td>Arguing, Challenging, Denying</td>
<td>Blaming, Justifying, Minimizing, Redefining</td>
<td>Realization that something must change, May have started some behavior change, May have an interest in developing a plan</td>
<td>Actual behavior change, Trying out new behaviors, Focused and purposeful, and Fearful of failure</td>
<td>Has changed overt behavior for more than 6 months, Old behavior is not a constant temptation, Confidence can slip into complacency</td>
<td>Avoiding community supports, Boredom, Missed appointments, Excessive excuses</td>
</tr>
<tr>
<td>Communication tactics</td>
<td>Listen and reflect more then you talk, Express accurate empathy, Reflect and build on any statements of self-doubt of the problem, Inquire about risks and problems with current behavior</td>
<td>Create or amplify discrepancies between their current behavior and what they say is important to them, Look for and leverage ambivalence, Use cognitive dissonance, Support pro-social thinking and get the individual to reflect on risk thoughts</td>
<td>Reflect and support skills, knowledge and past experiences supportive or change, Make referrals, Support self-efficacy, Ask questions that get to specifics of the plan</td>
<td>Developing on-going support, Focus on successful activities, Offer information about other successful models, Reaffirm decisions for change</td>
<td>Focus on relapse prevention strategies (do role play), Reflect complacency, Focus on strengthening community support</td>
<td>Make the invitation to renew the process, Support the acknowledgement of relapse, Show appropriate disapproval of relapse behavior, Show appropriate approval of the individual’s accountability</td>
</tr>
<tr>
<td>Avoid</td>
<td>Demanding, Confronting, Labeling, Blaming</td>
<td>Proposing a plan, Fixing it, Debating or arguing the individual into a new behavior</td>
<td>Fixing-making it your plan, Doing the individual work, Taking credit, Supporting unrealistic goals</td>
<td>Assuming the work is over, Taking ownership for the individual success,</td>
<td>Supporting over confidence, Assuming the work is done</td>
<td>Giving up, Showing disgust, Making Judgments</td>
</tr>
</tbody>
</table>
To access additional information on the Stages of Change Model, visit the following website:

http://www.samhsa.gov/co-occurring/topics/training/change.aspx
The case manager shall conduct a face-to-face assessment of the client to identify strengths as well as weaknesses through a systematic evaluation of the client’s current level of functioning. To understand the client as a whole person, the case manager must assess the interplay among physical, environmental, behavioral, psychological, economic, and social factors. Areas commonly evaluated by the case manager include mental health status; preexisting health or mental health problems; an appraisal of the client’s needs and the resources of the client’s informal support system, including family members, friends, and organizational memberships; social role functioning; environmental issues, including economic situation, employment status, educational, and other basic needs; and relevant cultural and religious factors. The case manager formulates an intervention plan based on the findings of this assessment.

The assessment includes the input of relevant professionals, family members, and the client. Where such joint action is impossible, the case manager should gather necessary information and initiate, coordinate, conduct, and document the assessment.

**Utilizing a Strengths-Based Assessment Process**

Focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her recovery. Strengths-based approaches allow providers to balance critical needs that must be met with the
resources and strengths that people possess to assist them in this process.

**You will know that you are providing strengths-based assessment when:**

1. A discussion of strengths is a central focus of every assessment, care plan, and case summary. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles. This strengths-based assessment is conducted as a collaborative process and all assessments in written form are shared with the individual.

2. Initial assessments recognize the power of simple, yet powerful, questions such as “What happened? And what do you think would be helpful? And what are your goals in life?” Self-assessment tools rating level of satisfaction in various life areas can be useful ways to identify diverse goal areas around which supports can then be designed.

3. Practitioners attempt to interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder. For example, an individual who takes their medication irregularly may automatically be perceived as “non-compliant,” “lacking insight,” or “requiring monitoring to take meds as prescribed.” This same individual, however, could also be seen as “making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medications” or could be praised for “working collaboratively to develop a contingency plan for when medications are to be used on an ‘as-needed’ basis.”

4. While strengths of the individual are a focus of the assessment procedure, thoughtful consideration also is given to potential
strengths and resources within the individual’s family, natural support network, service system, and community at large. This is consistent with the view that recovery is not a solitary process but rather a journey toward interdependence within one’s community of choice.

5. The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected.

6. In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered “strengths,” e.g., the individual’s most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, educational achievements, personal heroes, most meaningful compliment ever received, etc.

7. Assessment explores the whole of people’s lives while ensuring emphasis is given to the individual’s expressed and pressing priorities. For example, people experiencing problems with mental illness or addiction often place less emphasis on symptom reduction and abstinence than on desired improvements in other areas of life such as work, financial security, safe housing, or relationships. For this reason, it is beneficial to explore in detail each individuals’ needs and resources in these areas.

8. Strengths-based assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan. People are more likely to use strategies that they have personally identified or developed rather than those that have been prescribed for them by others.

9. Illness self-management strategies and daily wellness approaches such as WRAP are respected as highly effective, person-directed, recovery tools, and are fully explored in the strengths-based assessment process.
10. Cause-and-effect explanations are offered with caution in strengths-based assessment as such thinking can lead to simplistic resolutions that fail to address the person’s situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as “the first cousin” of deficit-based models of practice. For example, to conclude that an individual did not pay his or her rent as a direct consequence of his or her “non-compliance” with medications could lead to an intrusive intervention to exert control over the individual’s finances or medication. Strengths-based assessments respect that problem situations are usually the result of complex, multi-dimensional influences, and explore with the person in more detail the various factors that led to his or her decisions and behavior (e.g., expressing displeasure with a negligent landlord).

11. Strengths-based assessments are developed through in-depth discussion with the individual as well as attempts to solicit collateral information regarding strengths from the individual’s family and natural supports. Since obtaining all of the necessary information requires time and a trusting relationship with the person, a strengths-based assessment may need to be completed (or expanded upon) after the initial contact as treatment and rehabilitation unfold. While each situation may vary, the assessment is written up as soon as possible in order to help guide the work and interventions of the Recovery Planning Team.

12. Efforts are made to record the individual’s responses verbatim rather than translating the information into professional language. This helps to ensure that the assessment remains narrative-based and person-centered. If technical language must be used, it is translated appropriately and presented in a person-first, non-offensive manner, e.g., avoiding the language of “dysfunction, disorder.” Practitioners are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric diagnoses, addictions, and their loved ones.
Language is used that is empowering, avoiding the eliciting of pity or sympathy, as this can cast people with disabilities in a passive, “victim” role and reinforce negative stereotypes. For example, just as we have learned to refer to “people who use wheelchairs” as opposed to “the wheelchair bound” we should refer to “individuals who use medication as a recovery tool” as opposed to people who are “dependent on medication for clinical stability.” In particular, words such as “hope” and “recovery” are used frequently in documentation and delivery of services.

13. Practitioners avoid using diagnostic labels as “catch-all” means of describing an individual (e.g., “she’s a borderline”), as such labels yield minimal information regarding the person’s actual experience or manifestation of their illness or addiction. Alternatively, a person’s needs are not well captured by a label, but by an accurate description of his or her functional strengths and limitations. While diagnostic profiles may be required for other purposes (e.g., decisions regarding medication, justification of level of care), asset-based assessment places limited value on diagnosis per se. In addition, acknowledging limitations and areas of need are not viewed as accepting one’s fate as a mentally ill person or an addict. Rather, identifying and accepting one’s current limitations is seen as a constructive step in the process of recovery. Gaining a sense of perspective on both strengths and weaknesses is critical in this process as it allows the person to identify, pursue, and achieve life goals despite the lingering presence of disability.

14. Language used is neither stigmatizing nor objectifying. At all times “person first” language is used to acknowledge that the disability is not as important as the person’s individuality and humanity, e.g., “a person with schizophrenia” versus “a schizophrenic” or a “person with an addiction” versus “an addict.” Employing person-first language does not mean that a person’s disability is hidden or seen as irrelevant; however, it also is not to be the sole focus of any description about that person. To make it the sole focus is depersonalizing, and is no longer considered an acceptable practice.
15. Exceptions to person-first and empowering language preferred by some persons in recovery are respected. For instance, the personal preferences of some individuals with substance use disorders, particularly those who work the 12-Steps as a primary tool of their recovery, may at times be inconsistent with person-first language. Within the 12-Step Fellowship, early steps in the recovery process involve admitting one’s powerlessness over a substance and acknowledging how one’s life has become unmanageable. It is also common for such individuals to introduce themselves as: “My name is X and I am an alcoholic.” This preference is respected as a part of the person’s unique recovery process, and it is understood that it would be contrary to recovery principles to pressure the person to identify as “a person with alcoholism” in the name of person-first language or principles. Use of person-first language is in the service of the person’s recovery; it is not a super-ordinate principle to which the person must conform. While the majority of people with disabilities prefer to be referred to in first-person language, when in doubt ask the person what he or she prefers.
SMI RECOVERY

Division 20    Service 850
Program 850   Chapter 10

**Narrative Summary 850-10-45-10-05**
(Revised 7/26/13 ML# 3367)

[View Archives](#)

In the following links you will find additional information to help you complete a good NS and PCTP:

- The Ten P’s for the Narrative summary P:\So Mental Health-substance Abuse\Person Center Workgroup\Training Documents\The Ten P’s.docx

- Integration of the Narrative summary P:\So Mental Health-substance Abuse\Person Center Workgroup\Training Documents\NARRATIVE SUMMARY.docx
The Department of Human Services utilizes the Daily Living Activities (DLA) Functional Assessment (DLA-20) as a tool to assess what daily living areas are impacted by the mental illness. The symptoms, behavior/or functioning an individual exhibits helps determine the appropriate level of care for the individual. In addition, the DLA assessment tool is used in the Person Centered Treatment Planning process as it quickly identifies where outcomes are needed. This is discussed in more detail in the Person Centered Treatment Plan section of the manual. The use of this tool provides opportunities and methods to review service approaches and benefits received at regular intervals.

SMI Case Managers initially complete the DLA-20 with the new client when a new client is assigned to them and not less than every 180 days thereafter or as often as the case manager and client determine is necessary based on the needs of the client.

Every 180 days, at a minimum, the case manager will complete the DLA-20 to reassess the client’s needs and progress in meeting the objectives in accordance with established benchmarks to ensure the effective and timely provision of services. Re-assessments provide the case manager with new information he or she will use to re-assign the client’s Recovery Level, reformulate the person centered treatment plan and alter the client’s services to meet their needs.

Click the links below to access the DLA -20, accompanying documents, and training documents located on the DMHSAS P:Drive:

DLA-20
SMI RECOVERY

Division 20 Service 850
Program 850 Chapter 10

DLA Anchors

DLA MGAF

DLA and Symptoms Training Document

DLA Power Point

DLA Pre-Post Test DOT 2012

DLA Pre-Post Test Scores DOT 2012

DLA Homework Tracy

DLA FAQ Wilma’s
Person Centered Treatment Plans 850-10-45-15
(Revised 7/26/13 ML# 3367)

View Archives

Person Centered Treatment Plans (PCTP) are the chosen platform by which the Department of Human Services has endorsed for the provision of the clinical services to clients in the state of North Dakota.
A treatment plan must be completed and staffed within 20 days of the intake. The treatment plan is developed by the client and the provider together, to determine what goals and objectives the client is willing and able to work on at this time. It is a set of objectives with interventions to help the client achieve the goals/objectives they have set. The role of the case manager is to assist the client to prioritize their needs, establish a main goal or two if necessary, identify the necessary action steps (with the client) to accomplish their goal(s) and to assist the client in designing a plan that will support the client’s progress. The plan is primarily developed by the client with the assistance of the provider. The goal of Person-Centered Treatment planning is to allow the client to identify their goals and the action steps required to achieve those goals.

A way to strengthen the medical necessity link is to have a quality functional assessment and treatment plan in the file. In the treatment plan a clinician is able to clearly document the strengths and goals of a client, barriers to achievement of those goals, the nature and extent of the mental illness and clearly delineate how that mental illness interferes with the client’s goals in the various domains. The DLA-20 will help to define the functional impairments that are present due to the mental illness and reference to the areas of concern in the DLA-20 is perfectly appropriate for the treatment plan. Finally, the treatment plan outlines a scope of services that will be provided to a client in an effort to overcome the barriers the mental illness has created in their life.

The case manager, in collaboration with the client and his or her family selects and outlines an array of services and interventions in the treatment plan. The case manager is responsible for coordinating
and documenting the development of the treatment plan with the client’s participation. Ideally, the case manager will have involved professionals from relevant disciplines in the assessment and the development of the treatment plan; ideally, these professionals will have agreed to assume specific functions and responsibilities.

Two important aspects of the plan are the client’s personal goals. Other important factors are the case manager’s knowledge of the following: resources, informal and formal linkages with agencies that provide services, the client’s use of services, and applicable costs of use, as well as the case manager’s selection of alternate resources. The case manager should recognize that care planning is an important resource allocation function and be cognizant of the costs and financing of the particular service plan.

This service plan incorporates the client’s expectations and choices and the short- and long-term goals to which the client clearly has agreed. Outcome criteria should be selected that will be used to evaluate whether objectives have been accomplished and goals have been attained. A schedule for reassessing and modifying the initial goals and plans should be part of the initial plan. Whenever possible, the client and/or the family should sign the service plan to indicate agreement with and participation in the development of the plan as well as the expected concomitant behaviors.

The treatment and rehabilitative services and supports provided need to be based on an individualized, multidisciplinary recovery plan developed in collaboration with the person receiving these services and any others that he or she identifies as supportive of this process. While based on a model of collaboration and partnership, significant effort will be taken to ensure that individuals’ rights to self-determination are respected and that all individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions. The individualized recovery plan will satisfy the criteria of treatment, service, or care plans required by other bodies (e.g., Center for Medicaid Services) and will include a
comprehensive and culturally sensitive assessment of the person’s hopes, assets, strengths, interests, and goals in addition to a holistic understanding of his or her behavioral health conditions and other medical concerns within the context of his or her ongoing life. Typical examples of such life context issues include employment, education, housing, spirituality, social and sexual relationships, and involvement in meaningful and pleasurable activities. In order to ensure competence in these respective areas, including competence in addressing the person’s cultural background and affiliations, the multi-disciplinary team will not be limited to physician/psychiatrists, nurses, psychologists, and social workers, but may also include rehabilitative and peer staff, and wherever possible, relevant community representatives and/or others identified by the person.

Building on the strengths-based assessment process, individualized recovery planning both encourages and expects the person to draw upon his or her strengths to participate actively in the recovery process. It is imperative throughout this process that providers maintain a belief in the individual’s potential for growth and development, up to, and including, the ability to exit successfully from services. Providers also solicit the person’s own hopes, dreams, and aspirations, encouraging individuals to pursue their preferred goals even if doing so presents potential risks or challenges. For example, many people identify returning to work as a primary recovery goal. It is not uncommon for practitioners to advise against this step based on an assumption that an individual either is not “work ready” or that employment will be detrimental to his or her recovery (e.g., by endangering his or her disability benefits). While such advice is based on good intentions, it sends a powerful message to the individual and can reinforce self-doubts and feelings of inadequacy. Rather than discouraging the person from pursuing this goal, the practitioner can have a frank discussion with the person about his or her concerns while simultaneously highlighting the strengths that the individual can draw upon to take the first step toward achieving this goal.
In this vein, individualized recovery planning explicitly acknowledges that recovery entails the person’s taking risks to try new things, and is enhanced by the person having opportunities to learn from his or her own mistakes and their natural consequences. This represents an important source of progress in the person’s efforts to rebuild his or her life in the community that—similar to exercising one’s muscles—cannot proceed without an exertion of the person’s own faculties.

You will know that you are offering Individualized Recovery Planning when core principles of “person-centered” planning are followed in the process of building individualized recovery plans. For example:

1. Consistent with the “nothing about us, without us” dictum, providers actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery services and supports.

2. The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved, including conserved persons who wish to have an advocate or peer support worker present. Planning meetings are conducted and services are delivered at a time that does not conflict with other activities that support recovery such as employment. The individual can extend invitations to any person she or he believes will be supportive of his or her efforts toward recovery. Invitations extended are documented in the recovery plan. If necessary, the person (and family as relevant) are provided with support before the meeting so that they can be prepared and participate as equals.

3. The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supports. Where technical or professional terminology is necessary, this is explained to all participants in the planning process.
4. When individuals are engaged in rehabilitation services, the rehab practitioners are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.

5. Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery. These choices and service options are clearly explained to the individual, and documentation reflects the options considered.

6. Goals are based on the individual’s unique interests, preferences, and strengths, and objectives, and interventions are clearly related to the attainment of these stated goals. In cases in which preferred supports do not exist, the recovery team works collaboratively with the individual to develop the support or to secure an acceptable alternative.

7. Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing areas of strength to move toward recovery and his or her vision for the future. Individuals, including non-paid, natural supports who are part of the planning process, commit to assist the individual in taking those next steps. The person takes responsibility for his or her part in making the plan work. Effective recovery plans help people rise to this challenge regardless of their disability status.

8. A discussion of strengths is a central focus of all recovery plans. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.

9. Information on rights and responsibilities of receiving services is provided at all recovery planning meetings. This information should include a copy of the mechanisms through which the individual can provide feedback to the practitioner and/or
agency, e.g., protocol for filing a complaint or compliments regarding the provision of services.

10. The individual has the ability to select or change his or her service providers within eligible guidelines and is made aware of the procedures for doing so.

11. In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan. Clients are automatically offered a copy of their written plans, assessments, and progress notes. Knowing ahead of time that a copy will be shared is a simple but powerful strategy that can dramatically impact both the language of the plan and the content of its goals and objectives.

12. The team reconvenes as necessary to address life goals, accomplishments, and barriers. Planning is characterized by celebrations of successes, and meetings can occur beyond regular, established parameters.

Core principles of “person-centered” planning are followed in the process of building individualized recovery plans. For example:

A wide range of interventions and contributors to the planning and care process are recognized and respected. For example:

1. Practitioners acknowledge the value of the person’s existing relationships and connections. If it is the person’s preference, significant effort is made to include these “natural supports” and unpaid participants as they often have critical input and support to offer to the team. Interventions should complement, not interfere with, what
people are already doing to keep themselves well, e.g.,
 drawing support from friends and loved ones.

2. The plan identifies a wide range of both professional
 supports and alternative strategies to support the person’s
 recovery, particularly those which have been helpful to
 others with similar struggles. Information about
 medications and other treatments are combined with
 information about self-help, peer support, exercise,
 nutrition, daily maintenance activities, spiritual practices
 and affiliations, homeopathic and naturopathic remedies,
 etc.

3. Individuals are not required to attain, or maintain, clinical
 stability or abstinence before they are supported by the
 planning team in pursuing such goals as employment. For
 example, in some systems access and referral to
 vocational rehabilitation programs may be controlled by a
 clinical practitioner, and people are often required to
 demonstrate “work readiness” or “symptomatic stability”
 as a prerequisite to entry. In addition to an abundant
 literature which has shown that screening procedures and
 criteria have limited predictive validity, this structure also
 neglects that fact that activities such as working are often
 the path through which people become clinically stable in
 the first place.

4. Goals and objectives are driven by the person’s current
 values and needs and not solely by commonly desired
 clinical/professional outcomes, e.g., recovery is a process
 that may or may not begin with the individual
 understanding or appreciating the value of abstinence or
 of taking medications.
Community inclusion is valued as a commonly identified and desired outcome. For example:

1. The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability or abstinence. Person-centered plans document areas as physical health, family and social relationships, employment/education, spirituality, housing, social relations, recreation, community service and civic participation, etc., unless such areas are designated by the person as not-of-interest. For example, traditional planning has often neglected the spiritual and sexual aspects of peoples’ lives. Achieving interdependence with natural community supports is a valued goal for many people in recovery who express a strong preference to live in typical housing, to have friendships and intimate relationships with a wide range of people, to work in regular employment settings, and to participate in school, worship, recreation, and other pursuits alongside other community members. Such preferences often speak to the need to reduce time spent in segregated settings designed solely to support people labeled with a behavioral health disorder.

2. Recovery plans respect the fact that services and practitioners should not remain central to a person’s life over time, and exit criteria from formal services are clearly defined. Given the unpredictability of illness, and life more generally, however, readmission also remains uncomplicated, with avenues clearly defined for people on discharge.

3. Recovery plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can, in turn, give back to others. People have identified this type of reciprocity in relationships as being critical to building recovery capital and to the recovery process as a whole. Therefore, individuals should be encouraged to explore how they can make meaningful
contributions in the system or in the community, e.g., through advocacy, employment, or volunteering.

4. A focus on community is consistent not only with person-centered care principles but with the need for fiscal efficiency. Practitioners and people in recovery should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking “Am I about to recommend or replicate a service or support that is already available in the broader community?” At times this has direct implications for the development of service interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as exercise classes without first exploring to what extent that same opportunity might be available in the broader community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, individuals should be informed of these opportunities and to the extent to which what is offered is culturally responsive and accessible, they should be supported in pursuing activities of choice in integrated settings.

The planning process honors the “dignity of risk” and “right to fail” as evidenced by the following:

1. Prior to appealing to coercive measures, practitioners relentlessly try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.

2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions.

3. Practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, outlining for the person the range of options and their possible consequences.
4. In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans.

**Key Components of Person Centered Treatment Planning**

**STRENGTHS:**

- Identify the individual’s past accomplishments, current aspirations, etc... These can be used to **help accomplish the objective or remove the barrier**.

- What are your supports, what do people say you do well?

- This is also where you, as a clinician, will note any strength you see with clients. What has brought them this far?

**GOALS**

- Need to be expressed in person’s own words- use quotes if you can

- May not necessarily be attainable in the classic sense, but it is their goal so allow it to happen

- Broad, global, and long-term

- Focus is on the alliance and collaboration between provider and clients

- Goals are not symptom or diagnosis related

- Goals are not necessarily measurable, although the achievement of the goal is something that can be realized or apparent to others
• Goals are not always time framed

• We are talking one goal at a time in most instances, although this may vary

TRANSITION/DISCHARGE CRITERIA:

How will you/we know when you are done with services or can move on to another service (i.e. med only)?

BARRIERS:

• This is key in specifying the objectives as well the interventions.

• What is keeping the clients from their goal(s)?

• What is keeping you from moving forward?

• Clinicians can also include what they see as a barrier to the movement forward.

OBJECTIVES:

• Focus on the removal of barriers

• Should capture the positive behavior change instead of a reduction of symptoms

• Start with” Sally will... John will demonstrate....“ –Keep it action orientated

• Specific time frame- 90days max time frame is recommended

• Measurable
• Achievable

• Straight forward

• Is it understandable to the client

• Should not be a description of what the provider will do or should not be confused with services (soon to be interventions).

• Objective should only address one change at a time.

• No more than two objectives should be listed

• Shouldn’t merely really include the attendance or participation as an objective.

**INTERVENTIONS**

• Who is responsible

• （What)--Type of service

• When and how often

• （Why)--Purpose of service-- **THIS IS THE MOST CRITICAL ELEMENT**

• Steps taken by staff, clients, family and others to help achieve the objective
Implementation of the Person-Centered Treatment Plan 850-10-45-15-10
(Revised 7/26/13 ML# 3367)

Implementation of the service plan involves arranging for a continuum of services to be provided to the client through formal and informal systems and ensuring that these services both meet the client’s needs and are cost effective. The case manager selects agencies that clearly meet established standards and expectations for the services they are to provide. The case manager explains his or her role in arranging for the services, describes to the client the services to be provided, informs the client when services are to begin, and promotes those activities that foster client self-sufficiency.

The case manager will offer both practical support and encouragement throughout this process. The ultimate attainment of client-based goals rests with the client, but the case manager is critical in helping to overcome barriers to the client’s progress.

Growth and movement are supported by helping a client attain goals by reviewing goals and being sensitive in offering assistance. The case manager’s job is to help in a way that strengthens the client and helps him/her to become independent. Active outreach to the client is a cornerstone of case management. The case manager should maintain contact with the client whether the client is in crisis, acute care or hospitalization.

Practices Which Support Recovery
After each interaction with someone, reflect on whether or not you were supporting their recovery and ask yourself:
Did I...

- Actively listen to help the person to make sense of their mental health problems?

- Help the person identify and prioritize their personal goals for recovery (not professional goals)?

- Demonstrate a belief in the person’s existing strengths and resources in relation to the pursuit of these goals?

- Identify examples from my own “lived experience” or that of other service users, which inspires and validates their hope?

- Pay particular attention to the importance of goals which take the person out of the “sick role” and enable them actively to contribute to the lives of others?

- Identify non mental health resources – friends, contacts, organizations – relevant to the achievement of their goals?

- Encourage the person’s self-management of their mental health problems?

- Discuss what the person wants in terms of therapeutic interventions, for example psychological treatments, alternative therapies, joint crisis planning, respecting their wishes wherever possible?

- Behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together, indicating a willingness to “go the extra mile”?

- While accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of
achieving these self-defined goals – maintaining hope and positive expectations?

Click here to view:
“Putting recovery at the heart of all we do – What does this mean in practice?”

http://www.devonpartnership.nhs.uk/fileadmin/user_upload/publications/info/Putting_Recovery_at_the_heart_of_all_we_do.pdf
Monitoring the Treatment Plan 850-10-45-15-15
(Revised 7/26/13 ML# 3367)

Monitoring involves active observation of the service plan to make sure it is being properly implemented and continues to fit the needs of the client. Monitoring also involves consistent help to the client in identifying problems, modifying plans with the client as the needs arise, and helping the client identify and utilize resources to complete goals. For example, in monitoring, the case manager may identify/observe the need for medication management services, housing issues, or a change in service needs. It is important to remember the treatment plan is person-centered and the provider of case-management assists the client in reaching the goals the client had set for themselves. The plan helps clients evaluate their recovery progress.

When the case manager is monitoring a client’s progress towards meeting the treatment plan goals, he or she will be attempting to answer these questions:

- Is the client working toward meeting their goal(s) established in the treatment plan?
- Are the interventions appropriate to helping the clients achieve their objectives?
- Are the plan’s objectives appropriate to the client’s current needs, skills and abilities?
- Does the client need additional services or interventions to be able to continue making progress?
If the current treatment plan is not meeting the needs of the client, a revised plan may be in order. Case management is a fluid activity; providers of case management services are community based- not office based. To monitor service delivery, the case manager must actively watch, listen and interact with both the client and all the treatment/service providers.

When the case manager is monitoring a client’s progress towards meeting the service plan goals, he or she will be attempting to answer these questions:

1. Is the client getting the services established by the service plan?
2. Are the services provided in such a way that the client can benefit from them?
3. Are the services provided to the client meeting the objectives of the service plan?
4. Are the services provided in a manner that is beneficial or usable to the client?
5. Are the plans objectives appropriate to the client’s current needs, skills, and abilities?
6. Will meeting the plan’s interventions give the client the ability to live in the community?
7. Does the client need additional services or intervention to be able to continue making progress?

The questions point to the effectiveness of the service delivery, the appropriateness of the service and the appropriateness of the service plan. The answer to the questions will lead to the next action. And if the current service plan is not helping the client, a revised assessment and service plan may be in order.
To monitor service delivery, the case manager must actively watch, listen and interact with both the client and all the treatment/service providers.
Coordination includes referring clients to services and supports and is essential to positive outcomes. Case managers are responsible to coordinate multiple services and help streamline access to services. The case manager should be knowledgeable about the client’s medical providers and medical needs, and other community supports and resources available to clients such as public and private treatment providers, advocacy and self-help groups, low-income housing, employment and training programs, financial benefits, social and natural supports in the community and other services. The case manager should be knowledgeable of and work on building relationships with the various service groups to aid client access.

The case manager must maintain the client focus and simultaneously allocate service resources and provide critical feedback regarding program, agency, and delivery system performance. Thus, the case manager is responsible both for delivering appropriate services to the client and for carefully allocating and managing agency services and financial resources.

Case managers must fully disclose the following to clients: the resources that are available and that are unavailable, required copayments and cost sharing, time limits on service provision, timing and frequency of required reassessments, and appropriateness and fiscal effects of treatment choices.

As a resource allocator, the case manager collects information and provides feedback on the fiscal effects on the agency, necessary program modifications, required delivery system changes, quality of
provider performance, and effectiveness of the agency’s contracting system.
It is difficult to anticipate all the service needs that might be encountered in the case management work but certain issues seem to arise frequently. These include monitoring medications, mental health, transportation, money management, hygiene, wellness, medical and dental care, housing and home management, education, employment, life skills, crisis interventions and legal situations.

Advocacy is often required to ensure that the agency meets its commitment to provide access to and adequacy of services, the services are actually delivered, the needs of the client are recognized, and the client is not prematurely discharged by the service providers. It also is the case manager’s responsibility to present agency leaders with documented information about resource limitations and other major case management problems, and recommend solutions. The case manager has a responsibility to participate in resource development to see that the needs of clients are identified and understood and that community action—public, private, or voluntary—is initiated to meet particular needs.

The case manager may need to advocate for individual clients and their families for them to receive entitlements or obtain needed services, including those provided by the case manager’s own agency. The case manager also serves as an advocate to ensure that services actually are delivered, gaps in service are identified and filled, the individual’s needs are recognized, client services are not prematurely terminated, and client services are terminated when appropriate. Data collected during the implementation and monitoring phases of the plan should be used in advocacy on behalf of the client.
Medication Management: For many clients, medication management may be essential to help alleviate and/or prevent the recurrence of symptoms of mental illness. These medications work to stabilize brain functioning. These medicines do not cure mental illness, but they can help control symptoms.

Many clients view medications as a benefit and as a necessary part of treatment and actively engaged with their prescriber. Other clients may not see the benefits of medication. Medications used to treat mental illness may help clients in their recovery by stabilizing symptoms which empowers them to live independently in the community and attain their goals. The role of the case manager may include monitoring and supporting a client in their medication treatment. The case manager may collaborate with the client and the prescriber to communicate any client concerns and/or observations with medications. This responsibility may include requesting a routine appointment or an urgent appointment with the prescriber and helping the client to get prescriptions filled.

The decision to use medications is carefully considered by the client. The case manager can be supportive in that decision. The prescriber is responsible for the assessment, prescription and monitoring of psychiatric medicine when prescribed for clients. Part of that responsibility involves discussing the need for medication, (informed consent), its effects and possible side effects with each client.

A basic knowledge of psychiatric medicines and their proposed benefits and possible side effects will help the case manager monitor the client’s mental health. Case managers have a responsibility to have a basic understanding of medication issues and should consult with the prescriber and other treatment team members in these matters.
To learn more about Medications commonly used in the treatment of mental illness, as well as side effects, click on the following link from the National Institute of Mental Health:


Providers of case management should always consult with a physician or nurse regarding any medication issues or problems encountered with clients.

**Transportation:** As a case manager, one of your duties may be to transport clients. Some points to keep in mind are:

- Know and follow your agency policies about transporting clients. Discuss these policies with your supervisor.
- DO NOT transport clients alone when their behaviors appear unstable or unpredictable.

**Hygiene and Grooming:** Adequate hygiene and grooming may be problems for clients. Case managers must carefully assess hygiene needs being careful to not push their own values on clients. Case managers should make a nonjudgmental and thoughtful assessment of the possible reason for poor hygiene and grooming. Hygiene and grooming issues may be the result of financial barriers, medical or mental health symptoms.

**Medical and Dental Care:** Adequate, timely medical and dental care may be a problem for clients. Providers of case management services need to stay educated on public entitlements, community resources and to know or find out what medical and dental care can be obtained for the client. The client needs to actively take part in
this process, although the provider may offer resources to the client for their medical and dental care.

**Natural Supports:** Incorporate families and friends as invaluable resources with the clients’ release of information. They may know the client’s history of mental and physical health problems, the treatments and responses and may be able to propose approaches that have worked in the past. They can be a resource in managing these needs and are encouraged to work with them to support the client’s needs. The case manager must ensure that an authorization to release information is signed by the client before including family members or other natural supports to the client.

**Education/Training/Employment:** Education may be suitable for clients. Providers of case management should assess clients’ desire to reach education goals and if so, link clients to services and resources to pursue educational opportunities. Case management services may assist and empower the clients to achieve educational goals but must remember it is the client’s choice to receive an education and ultimately to pursue it. Training and Employment may be suitable for clients. Some key questions for the clients and the case manager are:

- Does the client have the skills and abilities to work successfully?
- How can they acquire skills, abilities, and learn to apply them?
- How can the client minimize barriers?
- Where can the client get a job in a sheltered or regular work environment?

Each of these major questions deserves attention. Like other inseparable aspects of effective case management, the answers to these questions depend on many things including the client’s skills and readiness for employment and the availability of work. Clients
who desire to be employed may benefit from transitional employment and supported employment. These models offer social, educational, pre-vocational, and vocational opportunities to clients. Full-time, part-time and volunteer work may also provide significant benefits to clients. The case manager can help the client by linking them to employment agencies including State of North Dakota’s Vocational Rehabilitation to develop necessary work skills in order to return to productive employment in the community.

**Housing and Home Management:** Case managers can help the client by linking them to available housing and help them apply for the Housing Authority or Housing vouchers in their community if they do not already have them. Clients may struggle to manage their homes and apartments and case managers assist clients to maintain goals for home management (i.e. helping with chore charts, getting an independent living counselor, linking clients to cleaning services if they cannot perform the tasks on their own, etc.).

**Life Skills to include Social Skills and Coping Skills:** Clients may need assistance in obtaining skills that will help them to live independently in the community. Case managers may help client develop social skills and coping skills as part of the client’s goals in the person-centered treatment plan. Clients may be linked with skills groups to assist them to further establish strong life skills and may require the assistance of the case manager to help manage day to day living.

**Crisis Interventions and Legal Situations:** Case managers may encounter situations with clients in crisis and in legal situations. Clients in crisis may need support, a safety plan, to see a counselor, detox, shelter placement or may need hospitalization. It is the responsibility of the case manager to help link the client to the correct resources when the client is in crisis. The provider may have to attend to legal matters with clients and must advocate for the client when necessary. When a legal matter requires the case manager to provide testimony, documentation or any client
SMI RECOVERY

Division 20  
Service 850
Program 850  
Chapter 10

information, contact North Dakota’s Department of Human Services legal department for verification on the correct protocol for the specific matter. Case manager is not to go directly to the State’s Attorney’s office; rather they need to contact the NDDHS legal department.

Public Entitlement Programs: Clients may need case management to obtain entitlements. The most important kinds of assistance required are income support (SSI, SSA- GA or TANF) and special services for people without money, such as donated medical or legal assistance. In most communities, the public and private social welfare system is fragmented, restrictive and characterized by complex intake and reporting procedures. A case manager can assist the client to gain access to public entitlements. It is also the case manager’s responsibility to develop the expertise and understand the eligibility process.

Often, applicants for social security benefits are turned down the first time they apply but are eligible to appeal. It is the case manager’s responsibility to inform the client of the appeal process in the event of unfavorable decisions. To obtain state entitlements such as General Assistance (GA) or Temporary Aid to Needy Families (TANF), applicants will need to provide the following:

- Birth certificate or a church or tribal record of birth
- Picture identification (Driver's License or Utah State ID Card)
- Social Security Card

Additional information may be required including rent payments, bank balances, or insurance policies depending upon the situation. Clients must have the above documents to successfully complete an application for state assistance.
Federally Administered Entitlement Programs:

Medicare - Medicare is a federal health insurance program.

Social Security Disability Insurance (SSDI) - This is a federally funded insurance program for the blind and disabled, funded by deductions from the applicant's payroll wages. Eligibility is based upon medical documentation of a disabling physical or mental illness. As with other insurance programs, a person must have contributed to it to receive payments later.

Supplementary Security Income (SSI) - This is a federal benefits program for the needy, aged, blind, and disabled. Eligibility is based upon medical documentation of a disabling physical or mental illness together with financial need. A thorough medical assessment and diagnosis with laboratory findings and other supporting evidence is required to support a successful application. It is the responsibility of the case manager to inform the client of the appeal process with any findings of ineligibility, particularly at the first step. Entitlements are retroactive to the original date of application.

State Administered Entitlement Programs:

Medicaid - This is a federal program administered by the state to help low-income citizens with disabilities obtain medical care. Clients who qualify for SSI also qualify for Medicaid, but they must apply for each program separately. Not all providers of medical service accept Medicaid, so you will need to become familiar with the providers in your area who accept this insurance. If a client earns money or receives SS-DI, they may qualify for Medicaid however, they may have to pay for this benefit depending on their income which is called a spend-down. Case managers must become familiar with the regulations regarding spend-down as the amount of the spend-down varies depending on the client’s income.
Temporary Assistance to Needy Families (TANF) - This program is designed to meet the subsistence needs of children through payments to parents. Application for this program is by completing the same state application form used for all state programs listed above including the food stamp program. Clients have the right to special assistance, foreign language translators, and sign language assistance to complete the application process.

Food Stamps - Food stamps are used to supplement income to help purchase food. Most households must spend some of their own cash along with their food stamp benefits to buy the food they need.

Day Care: The State of North Dakota licenses day care providers to provide childcare to eligible parents. Clients may be eligible to use these services while they receive treatment, participate in vocational training, and/or participating in other services.
Mental Health Technicians 850-10-50
(Revised 7/26/13 ML# 3367)

View Archives

Note: Mental Health Technicians are also referred to as Case Aides. For the purpose of this manual the two terms will be used interchangeably.

Case Aide services are provided by Mental Health Technicians who have completed the Department of Human Service’s Mental Health Technician certification program.

Mental Health Technicians (MHTs) are an integral part of the service delivery system for clients in Extended Care. MHTs are the often the “eyes and ears” for the case managers, nurses, and psychiatrists. The role of MHTs is to provide the hands on assistance for clients as they strive for living as independently as possible in the community of their choice.

Some Mental Health Technicians are employed by a private provider and a contract is in place between the HSC and the private provider while some Mental Health Technicians are employees of the HSC. Although there are some similarities between case management and MHTs duties, there are distinct roles for each.

MH Technicians assist clients with serious mental illness SMI maintain independence in the community. The MHTs teach, demonstrate, assist, and guide clients in various tasks such as Activities of Daily Living (ADLs), household tasks, social skills, grocery shopping, maintaining appointments, and other tasks identified in the individual service plan (ISP).
Refer to your Regional Human Service Center’s case aide protocol for specific details and documentation requirements regarding case aide services.

MHTs are used across the continuum of services with individuals; the frequency will vary depending on the treatment plan, symptom presentation, and level of functional impairment present. For example, a treatment plan may call for MHT services up to three times a week at the early engagement stage of services with a client or when the symptoms are extremely problematic. Similarly, if a client is working to learn a new skill set such as how to take public transportation, how to buy groceries which are healthier given a new diagnosis such as diabetes, or how to purchase a week’s worth of groceries on a budget; all of these would be examples of when MHT services may be used.

Along the other end of the continuum, MHTs may be used for more sporadic intervention with clients, or with clients who have met many of their treatment goals and they are in need of less intervention services from their case manager and MHT services. Hereto, clients who are in this level of care may have an increased connection with Peer Support. It can even be an intervention to have the MHT work with a client to bridge a relationship with a Peer Support Specialist, given this is an objective on the PCTP and it is medically necessary for the client to proceed down this path. An example of MHT services at this level could be; a client meets with a MHT every other week for the purpose of coaching a client on a new skill they have been learning via the Peer Support Program meetings or a skill they agreed to work on with their therapist. Or, perhaps housekeeping issues have historically been an issue where when it was out of hand the client risked eviction. If a MHT is going in the home to role model or prompt to keep up with certain tasks around the home, this would be acceptable as long as it again is clearly a medically necessary task.
Again, keep in mind the function of the MHT services are to assist clients in acquisition, retention, or improvement in skills. Another way to view this is if you are teaching, role modeling, or prompting/coaching a client in a new endeavor and they require this level of intervention as indicated in the PCTP, then you are providing MHT services.

There are a few examples of what may be seen as a case manager duty that in effect could be a MHT function, but it depends on the purpose of the intervention. For example, completing paperwork, assisting with paperwork and attending appointments is not a MHT function. However, if on a PCTP (and it needs to be there) a MHT is attending an appointment to teach and model appropriate behavior then the time spent at the appointment is a code able/billable activity. Although make sure the documentation in the note is clear as to what you were teaching, role modeling or prompting. Now on the other hand, if the purpose of the intervention was to coordinate services or monitor the outcome of services that would clearly be a case manager function.

Case managers can do the activities of MHTs, but consider the following first.

1. Can a MHT do this? Is it role modeling, prompting, and teaching? If “yes”, build the PCTP to include them as a service as to free up case manager resources for other clients to be accepted for case management service.

2. Is there a role that a Peer Support Specialist can play in this work? How can we connect the clients to other natural supports? Could a MHT work with the client to reconnect with a family member or neighbor to meet a need (transportation to services on Sunday or the grocery story on Saturday)?

3. How are Recovery and increased independence being addressed in your intervention/service? Historically, case managers have been mistaken as the “caretakers” for individuals in extended
care services or that “once in extended care client, always an extended care client”. Now we know differently and know that recovery is possible and that with supports and coaching every person as an ability to find their own purpose and meaning in life. Therefore, have a specialist such as a MHT teach, model and prompt with a client a certain skill set we are helping the client achieve a level of independence they may not have experienced before or help they regain what the mental illness symptoms took from them temporarily.
Peer Support Services in North Dakota are provided by individuals who have progressed in their own mental health recovery and are assisting peers with their own personal journey towards recovery. Because of their life experience, peers have expertise that professional training cannot replicate. Peer Specialists foster their peer’s ability to make informed, independent choices; help their peers recognize, and build on their strengths; and help their peers get the information and support they need from the community to make their goals a reality.

Peer Support Services are client centered with rehabilitation and recovery focus designed to promote skills for coping with and managing symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Specialists perform a wide range of tasks to assist peers in attaining their recovery goals.

There are contracts with the Recovery Center in their region to provide Peer Support Services. The Peers Specialists employed by the Recovery Centers, as well as those employed at the ND State Hospital must undergo training and complete the certification process developed and recognized by the North Dakota Department of Human Services. A copy of the certification process can be obtained from the Division of Mental Health and Substance Abuse Services at the following:

P:\So Mental Health-substance Abuse\Peer Support\Peer Specialist Certification.docx
For further information on Peer Support Services within your region, or to refer an individual for Peer Support contact your HSC liaison or local Recovery Center.

From Consumer to Provider – Peer Specialists in the Workforce

Mental health professionals have worked for years to improve opportunities for individuals with mental illnesses, including opportunities to obtain jobs in fields of their choice. Not surprisingly, as advances in mental health treatments and knowledge evolve, former and current consumers of social work services are increasingly pursuing careers in the field that has done so much to serve them, and in which they have personal experience to guide their work. There are no simple answers to questions that arise as consumers begin working in the mental health system. Some individuals will obtain degrees, and we will never know they were once consumers, and others will be Peer Support Specialists, and we may know of their past experience as consumers before they start work. Remember though, that certain rules of professional practice and development apply to any employee, regardless of their background.

Peer Specialists and Access to Confidential Information

As former and current consumers seek jobs where they would have access to personal information about individuals who were previously their peers, legitimate questions and concerns arise for providers who now find these former consumers to be their peers. Maintaining the confidentiality of information is always important, and sharing an individual's confidential information with someone who used to be their peer may feel disconcerting. Every hiring agency, however, has a responsibility to screen all applicants, and to determine their capability of maintaining the confidentiality of information before hiring them or providing such information to them. Likewise, if you
are in a position to share or grant access to private information, it is your responsibility to assess the person's likelihood to use it appropriately. If you suspect they may not, it is your obligation to reserve access and to raise the issue with your supervisor and colleagues. If an individual has been assigned to your organization, office, or team, you still have a responsibility to appraise their ability to use confidential information appropriately, and to raise concerns with your supervisor and colleagues.

Personal experience can help an individual work with people who undergo problems similar to their own. Many would even argue that no amount of “book learning” or experience in the field can provide the same knowledge that can be learned as a consumer. Experience as a consumer, however, also cannot replace information learned by studying the trials, successes, and failures of others, and the clinical experience from working in the field as a service provider. Each consumer and situation is unique, and a provider who has only learned from personal experience may be ill-prepared to work with a client who does not present a similar history and problems. Learning to cope with a wide array of problems and professional responsibilities in implementing the most appropriate approaches can only be properly learned through a combination of education and professional experience.

This issue emphasizes the value of having clearly defined qualifications for each position in an agency. To ensure the highest quality services to consumers, guidelines can direct what tasks each individual is qualified to perform. The important points to consider when giving responsibilities to a consumer-provider are the same as with any other provider: what combination of experience and education does a person have; what references do they provide that indicate how they have handled situations in the past; and what have they demonstrated to be their abilities when handling new and stressful situations? Any job applicant or individual seeking a promotion would be judged on the same factors. Consumers need to have opportunities to work in provider roles, and their personal
experience will be invaluable when assessing them for a position. But if evidence suggests that any applicant might not be a good candidate for a position working with certain consumers, then one must carefully consider hiring them for the position.
Evidence Based Practices 850-10-60
(Revised 7/26/13 ML# 3367)

SAMHSA’s mission is to improve services, accountability, capacity, and effectiveness through the widespread adoption of Evidence-Based Practices. SAMHSA developed the following toolkits “EBP Knowledge Informing Transformation” to assist mental health agencies with implementation of evidence based practices found to consistently produce specific, intended outcomes.

- Illness Management and Recovery;
- Supported Employment;
- Family Psychoeducation;
- Assertive Community Treatment;
- Integrated Treatment for Co-Occurring Disorders
- Medication Treatment, Evaluation and Management.

The Division of Mental Health and Substance Abuse Services, in collaboration with the Regional Human Service Centers, are in various stages of implementation of the following evidence-based practices: Illness Management and Recovery, Integrated Dual Disorder Treatment, and Supported Employment.
Illness Management and Recovery 850-10-60-05
(Revised 7/26/13 ML# 3367)

Illness Management and Recovery (IMR) is an evidence-based aimed to empower clients to:

- Manage their illness;
- Find their own goals for recovery; and
- Make informed decisions about their treatment by acquiring necessary knowledge and skills.

Practitioners meet weekly with clients—either individually or as a group—for 3 to 10 months. The information covered in IMR sessions includes the following:

- Recovery strategies;
- Practical facts about mental illnesses;
- Stress-Vulnerability Model and treatment strategies;
- Building social support;
- Using medication effectively;
- Drug and alcohol use;
- Reducing relapses;
- Coping with stress;
- Coping with problems and persistent symptoms; and
• Getting your needs met by the mental health system.

For detailed information on IMR sessions, click on the following link to access the “Illness Management Recovery Group Teaching Manual”:


Core Components of Illness Management and Recovery

IMR includes a variety of interventions, including motivational, educational, and cognitive-behavioral strategies designed to help clients improve their ability to overcome the debilitating effects of their illness. The core components of IMR are:

• **Psychoeducation** provides the basic information about mental illnesses and treatment options.

• **Behavior tailoring** helps clients manage daily medication regimes by providing strategies for remembering to take medications.

• **Relapse prevention** teaches clients to identify triggers of past relapses and early warning signs of an impending relapse and develop relapse prevention plans.

• **Coping skills training** involves identifying client’s current coping strategies for dealing with psychiatric symptoms and either increasing their use of these strategies or teaching new strategies.
Basic Characteristics of Illness Management and Recovery

- Small number of people in session or group
- At least 3 months of weekly sessions or the equivalent
- Comprehensive curriculum
- Provision of educational handouts
- Involvement of significant others
- IMR goal setting
- MR goal follow-up
- Motivation-based strategies
- Educational techniques
- Cognitive-behavioral techniques
- Coping skills training
- Relapse prevention training
- Behavioral tailoring for medication

For detailed information on IMR, the SAMHSA Illness Management Recovery Tool Kit can be viewed at:

Integrated Dual Disorder Treatment (IDDT)  
850-10-60-10  
(Revised 7/26/13 ML# 3367)  
[View Archives]

Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime. Yet most consumers with co-occurring disorders receive treatment from different agencies or for their mental illness or substance use disorder only—if they receive treatment of any kind. This kind of fragmented treatment often leads to poor outcomes. Consumers with co-occurring disorders have a better chance of recovering from both disorders when they receive mental health and substance abuse treatment in an integrated fashion from the same practitioner (an integrated treatment specialist).

Integrated Dual Disorder Treatment (IDDT) model is an evidence based practice proven to be effective in improving outcomes for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. IDDT helps people address both disorders at the same time – in the same service organization - by the same team of treatment providers.

Integrated Treatment programs are based on a core set of practice principles that form the foundation of the program (see below). A mid-level manager (called a program leader) with both administrative and clinical skills and authority oversees the Integrated Treatment program. The program leader supervises integrated treatment specialists and develops policies and procedures to ensure that these practice principles and other core components of the evidence-based model guide the way treatment and services are provided.
The IDDT Practice Principles

- Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.

- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.

- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.

- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.

- Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.

- Multiple formats for services are available, including individual, group, self-help, and family.

- Medication services are integrated and coordinated with psychosocial services.

Basic Characteristics of IDDT:

- Multidisciplinary teams

- Integrated treatment specialists

- Stage-wise interventions

- Access to comprehensive services

- Time-unlimited services
• Outreach
• Motivational interventions
• Substance abuse counseling
• Group treatment for co-occurring disorders
• Family interventions for co-occurring disorders
• Alcohol and drug self-help groups
• Pharmacological treatment
• Interventions to promote health
• Secondary interventions for non-responders

For detailed information on IDDT, see the toolkit available on the SAMHSA website:

http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367
Evidence-based Supported Employment (SE) is an approach to vocational rehabilitation for people with serious mental illnesses. The majority of individuals with mental illness want to work and SE facilitates the recovery process by supporting consumers in their efforts to get on with life beyond illness. SE emphasizes helping people obtain competitive work in the community and providing the supports necessary to ensure success in the workplace. SE programs help consumers find jobs that pay competitive wages in integrated settings (i.e., with others who don’t necessarily have a disability) in the community. Competitive employment means work in the community that anyone can apply for that pays at least minimum wage. The wage should not be less than the wage (and level of benefits) paid for the same work performed by people who do not have a mental illness.

In contrast to other approaches to vocational rehabilitation, SE de-emphasizes prevocational assessment and training and puts a premium on rapid job search and attainment. The job search is conducted at a pace that is comfortable for consumers and is not slowed down by any programming prerequisites.

People with serious mental illnesses differ from one another in terms of the types of work they prefer, the nature of the support they want, and the decision about whether to disclose their disability to the employer or coworkers. SE programs respect these individual preferences and tailor their vocational services accordingly.

In addition to appreciating the importance of consumer preferences, SE programs recognize that most consumers benefit from long-term
support after successfully attaining a job. Therefore, SE programs avoid prescribing time limitations on services. Instead employment specialists help consumers become as independent and self-reliant as possible.

The overriding philosophy of SE is the belief that every person with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found. Rather than trying to sculpt consumers into becoming “perfect workers,” through extensive prevocational assessment and training, consumers are offered help finding and keeping jobs that capitalize on their personal strengths and motivation. Thus, the primary goal of SE is not to change consumers but to find a natural “fit” between consumers’ strengths and experiences and jobs in the community.

As consumers succeed in working in the community, their self-perceptions often change, and they view themselves as workers and contributors to society. Furthermore, as people in the community see consumers working, consumers are less stigmatized for their mental illness and become more socially accepted.

Core components of Supported Employment

- SE programs help anyone who expresses the desire to work. Consumers are not excluded because they are not “ready” or because of prior work history, substance use, or symptoms.

- Employment specialists help consumers look for jobs soon after they enter the program. Instead of requiring extensive pre-employment assessment, training or intermediate work experiences (like prevocational work units, Transitional Employment Positions, or sheltered workshops), employment specialists and consumers begin the job search rapidly.
• Support from employment specialists continues as long as consumers want it. Participation in SE is not terminated unless requested by the consumer.

• Jobs are seen as transitions. Employment specialists help consumers find new jobs as needed.

• SE programs are staffed by employment specialists who are a part of a clinical treatment team. Employment specialists meet weekly and communicate frequently with team members.

• SE is individualized. All choices and decisions about work are based on consumers’ preferences, strengths, and experiences.

**Basic characteristics of Supported Employment**

• Employment specialists manage caseloads of up to 25 consumers.

• Employment specialists provide only vocational services.

• Each employment specialist carries out all phases of vocational service.

• Employment specialists are part of the mental health treatment teams with shared decision making.

• Employment specialists function as a unit.

• There are no eligibility requirements to enter the SE program.

• Vocational assessment is an ongoing process.

• The search for competitive jobs occurs rapidly after program entry.

• Employer contacts are based on consumers’ job preferences.
• Employment specialists provide job options that are in a variety of settings.

• Employment specialists provide competitive job options that have permanent status.

• Employment specialists help consumers end jobs when appropriate and then find new jobs.

• Individualized follow-along supports are provided to employers and consumers with no time limitations.

• Vocational services are provided in community settings.

• Assertive engagement and outreach are conducted as needed.

**Practice principles of Supported Employment**

SE programs are based on a core set of practice principles. These principles form the foundation of the program.

**Principle 1: Eligibility is based on consumer choice**

All consumers who want to participate in SE are eligible—no one is excluded. Consumers who are interested in work are not prevented from participating in SE regardless of their psychiatric diagnosis, symptoms, work history, or other problems, including substance abuse and cognitive impairment.

The core philosophy of SE is that all consumers can work at competitive jobs in the community without prior training, and no one should be excluded from this opportunity.
SE does not try to bring consumers to some preconceived standard of "work readiness" before they seek employment. Consumers are "work ready" when they say they want to work. Research shows that symptoms, substance abuse, and other consumer factors are not strong and consistent barriers to work when consumers receive assistance from an SE program. Therefore, no justification exists for excluding consumers who are interested in work from SE programs.

**Principle 2: SE services are integrated with comprehensive mental health treatment**

Closely coordinating SE services with other mental health rehabilitation and clinical treatment ensures that all mental health practitioners (not just the employment specialist) support consumers’ vocational goals.

The employment specialist participating in team meetings provides a vehicle to discuss clinical and rehabilitation issues relevant to work, such as the following:

- Medication side effects;
- Persistent symptoms (e.g., hallucinations);
- Cognitive difficulties; or
- Other rehabilitation needs (e.g., skills training to improve ability to socialize with co-workers or self-assertion skills).

Moreover, regular contact amongst team members enhances the likelihood of the consumer achieving vocational goals.

**Principle 3: Competitive employment is the goal**
SMI RECOVERY

Division 20 Service 850
Program 850 Chapter 10

SE helps consumers obtain competitive jobs. Competitive jobs have these characteristics:

- They are part-time or full-time jobs that exist in the open labor market;
- They pay at least a minimum wage; and
- They are jobs that anyone could have regardless of disability status.

Competitive jobs are not jobs that are set aside for people with disabilities. The wage should not be less than the wage (and level of benefits) paid for the same work performed by people who do not have a mental illness.

Competitive work is valued for several reasons:

- Consumers express a strong preference for competitive work over sheltered work. Consumers want to work in community settings.
- Competitive work promotes integrating consumers into the community and reduces the stigma of mental illness.
- Consumers’ self-esteem often improves. As consumers see that they are able to work competitively, that their work is valued, and that they can contribute to society, some experience improvements in symptoms and self-esteem.

Historically, many vocational programs have placed consumers into noncompetitive jobs, often paying subminimum wages, with only rare progression into competitive employment. Experience shows that consumers can successfully work at competitive jobs without previously participating in training programs or sheltered jobs.
**Principle 4: Personalized benefits counseling is important**

Fear of losing benefits (e.g., Social Security and health insurance) is a major reason that consumers may not seek employment. For this reason, it is vital that consumers who are interested in working obtain accurate information to guide decisions about work.

**Principle 5: Job searches start soon after consumers express interest in working**

Rapid job search is crucial for several reasons:

- Beginning the search early demonstrates to consumers that you take their desire to work seriously and conveys optimism that multiple opportunities are available in the community to help them achieve their vocational goals.

- Looking for jobs soon after consumers have been referred to an SE program may also be important for consumers who want to work but who question their own ability. Fears and misconceptions about work can often be best confronted by helping consumers actually explore possible jobs.

- Seeking work immediately takes advantage of consumers’ current motivation. Studies show that fewer consumers get jobs when the job search is delayed by prevocational preparations and requirements.

- As consumers begin identifying and exploring specific job possibilities, they (and their employment specialists) learn more about the type of work and work setting they desire. Similar to most people who become steady workers, consumers commonly try several jobs before finding one that they keep. Since many jobs may need to be explored before the right one is selected,
beginning this process early increases the chances of eventual success.

**Principle 6: Follow-along supports are continuous**

Some consumers struggle with symptoms that persist or change over time. For this reason, despite their vocational success, consumers receiving SE services are never terminated unless they directly request it. Follow-along supports are time-unlimited.

While follow-along supports are continuous, for many consumers, the extent of support gradually decreases over time. Consumers are assisted with becoming independent as possible by teaching them to meet their own needs at work. For example, consumers learn to arrange for their own transportation to work, perform their own job tasks without coaching, build socialization skills, and develop skills for responding to supervisor feedback. Thus, the goal of employment specialists is to remain available to provide support and assistance while helping consumers become independent.

**Principle 7: Consumer preferences are important**

Consumers who obtain work that they find interesting tend to have higher levels of satisfaction with their jobs and longer job tenures. Thus, attending to consumer job preferences will make your work easier because consumers are more likely to remain on the job. Allow consumer preferences to guide the type of job that is sought, the nature of support you provide, and whether to disclose their mental illness to the employer.

Some consumers are willing to disclose their mental illness to prospective employers and may ask for assistance in all aspects of work, including the following:
- Identifying jobs;
- Interviewing;
- Maintaining ongoing contact with the employer; and
- Offering onsite and offsite job support.

Other consumers prefer to keep their mental illness confidential and will look to you to provide “behind the scenes” support without direct contact with employers. Honor these preferences because it is crucial to listen to how consumers want to be supported in their pursuit of vocational goals. In addition, under HIPPA and other confidentiality laws providers are required to obtain a consumer’s consent to disclose.

For detailed information, see the Supported Employment Toolkit available on the SAMHSA website:

http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365
Employment Programs 850-10-65
(Revised 7/26/13 ML# 3367)

View Archives

EBP Supported Employment Programs

EBP Supported Employment is included in the Evidence Base Practice Section of this manual. Refer to Section 850-10-60-15 for information on EBP Supported Employment.
Division of Vocational Rehabilitation Services
850-10-65-05
(Revised 7/26/13 ML# 3367)
View Archives

The Division of Vocational Rehabilitation Service’s website can be accessed by clicking on the following link:

http://www.nd.gov/dhs/dvr/index.html

DVR assists individuals with disabilities to achieve competitive employment and increased independence through rehabilitation services. The division provides training and employment services to eligible individuals with physical or mental impairments so they can become and remain employed. Services that result in competitive employment are either provided or purchased.

Services include (but are NOT limited to)

- Diagnosis and evaluation
- Vocational counseling and planning
- Information and referral
- Adaptive equipment
- Physical and mental restoration services
- Employment maintenance
- Transportation
- Vocational training including supported employment
• Job placement and follow-up

Eligibility

DVR has a responsibility to serve anyone who is eligible and living in the state.

Eligibility for individuals who want to obtain or maintain employment is based on the following:

• The individual must have a physical or mental impairment

• The physical or mental impairment must affect the individual's ability to obtain or maintain employment

• The individual must require Vocational Rehabilitation services

Division of Vocational Rehabilitation’s Supported Employment Services

DVR’s Supported Employment is intended to provide services that lead to employment for people with the most significant disabilities who have traditionally been excluded from consideration for community employment. Supported employment services are authorized through the federal Rehabilitation Act, as amended. Official North Dakota Vocational Rehabilitation policy regarding supported employment is located in Administrative Code 75-08-01. The ultimate goal of the Supported Employment Program is for the individual with a most significant disability to be working in an integrated setting where, with wages and benefits, they reduce or eliminate their need for public financial support.
DVR Supported Employment emphasizes the following beliefs and values:

- People with disabilities are capable of being employed.
- People with disabilities who want to work have the same right to work and earn a living wage as people who do not have a disability.
- Facilitating community employment allows people (who have traditionally been excluded from community life) the fullest community participation.
- People learn a job best on the job, not in simulated segregated environments.
- Employment options are based upon preferences, skills and needs of the applicant.
- Jobs may be carved or created to fulfill the specific needs of an employer and the specific skills of the employee.
- Employer/employee consultation and support is provided after a job has been found for as long as the employer and employee feel it is necessary.

Click on the following link to obtain detailed information on VR’s Supported Employment Program:

Some individuals with disabilities need ongoing support services in order to remain employed. The Extended Services (ES) Program assists these clients to maintain the integrated, competitive, community-based employment achieved during their time spent under the Division of Vocational Rehabilitation’s Supported Employment Program. The ES program makes long-term support services available to persons with disabilities who work in community-based employment settings. The goal of the ES Program is either regular or customized employment at minimum or prevailing wages with ordinary benefits or else self-employment. Integration and interaction with individuals without disabilities is assured under the ES program.

The ES Program is administered and managed by Rocky Mountain Rehab, P.C. (RMR) of Billings, Montana under a contract with the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services. Extended Services are currently provided by twelve independent community rehabilitation providers across the state. You may contact them for more information about the services they provide.

Anytime an individual with a disabling condition seeks Vocational Rehabilitation (VR) services from the State of North Dakota's Vocational Rehabilitation office, a VR counselor must assess the condition's effect on the person's ability to work. The knowledge gained through the evaluation helps the counselor and the consumer determine a suitable vocational goal and ascertain any need for Supported Employment services.
If Extended Services (ES) are deemed necessary to help the consumer remain employed, the VR counselor will complete the application for services on the following website in the consumer's name. The Extended Services Coordinator will determine eligibility and forward his or her decision to Rocky Mountain Rehab (RMR). If the ES coordinator deems the applicant eligible, RMR will then place the consumer's name on the waiting list for Extended Services.

For detailed information on the ES Program, as well as links to numerous resources, visit the following website:

https://ndextendedservices.org/
Here is the link to the ROAP Service Code Manual:

P:\So Doit\ROAP Reference\CODING\Service Activity Coding Manual.docx

Service Code questions/concerns/inquiries should be emailed to Info-DHS ROAP Help.

The Field Services Training Coordinator provides ROAP training to new staff.
The case manager participates in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates as well as the case manager’s own case management services, and to otherwise ensure full professional accountability.

The accountability of the staff and the agency should be ensured through ongoing quality assurance efforts and periodic evaluation of the appropriateness, adequacy, and effectiveness of both the case management system and of the services provided through this system.

The case manager is involved in evaluating the quality, appropriateness, and effectiveness of the case management services on two levels. At the level of the individual client, the case manager, through completion of data collection forms, record keeping, and participation in peer review, obtains accurate and timely information about each case and the case manager’s activities that provide a basis for monitoring, evaluation, and cost-accounting systems. At the delivery system level, achieving program improvements and ensuring the equitable allocation of resources depends on reliable aggregate case data to demonstrate needs and service gaps and to document both the absence and presence of problems. Evaluation and quality assurance ensure that intended outcomes of services are attained and that the services are implemented in a consistent manner according to standards.

The quality, effectiveness, and appropriateness of case management services shall be regularly reviewed, evaluated, and ensured using
established criteria and standards. Such criteria and standards shall relate to the indicators of need for services and to the effectiveness of required interventions. Contracted providers shall be reviewed and evaluated in the same manner. Appropriate client feedback should be sought on the services they have received and that feedback should be incorporated in this process. The review and evaluation of case management services shall be documented and shall include feedback and implementation of corrective measures, when necessary.
Confidentiality

It is the policy of the Department to protect the privacy of individuals to the fullest extent possible while nonetheless permitting the use and disclosure of information required to fulfill: 1) client treatment; 2) payment for client services; 3) the administrative and the program responsibilities of the Department; and 4) responsibilities of the Department to disclose records to which the general public is entitled to have under the Constitution and laws of the State of North Dakota. Confidentiality restrictions preserve the dignity and self-respect of clients and assure the integrity and efficiency of departmental programs.

An ever-present trust and condition of employment within the Department is the safeguarding of client-related information. All employees are expected to be extremely circumspect in their daily handling of client information so that unwarranted and potentially illegal disclosures are scrupulously avoided. It is improper to unnecessarily divulge client information to co-workers or to discuss any such information unless in the context of fulfilling one's responsibilities.

The advent and use of automated systems within the Department has added another dimension in the safeguarding of confidential material. Information generated by the computer should receive no less consideration than traditionally stored information.

Case managers shall ensure the client’s right to privacy and ensure appropriate confidentiality when information about the client is
released to others. Case Managers must familiarize themselves with Service Chapter 110, which is the Confidentiality Manual used by the entire Department of Human Services. In addition, there are online EML Modules your supervisor will have you complete. Further questions should be directed to your supervisor.

Non-Discrimination

Programs and services administered and supervised by the Department, directly or through contractual agreements, must be made available without regard to race, color, religion, national origin, age, sex, political beliefs, disability, or status with respect to marriage. There is a DHS Discrimination online EML module that all DHS employees are required to complete.

These programs and services must also be accessible to persons with disabilities and comply with:

- Title I and Title II of the Americans with Disabilities Act of 1990 as amended
- Section 504 of the Rehabilitation Act of 1973 as amended
- Title VI of the Civil Rights Act of 1964 as amended
- Age Discrimination Act of 1975 as amended
- North Dakota Human Rights Act of 1983

Persons needing accommodation or who have questions or complaints regarding the provision of services according to these Acts may contact the following Civil Rights Officers:
A valid civil rights complaint must be in writing and include the name of the individual or organization against whom the complaint is made; the basis of the discrimination, e.g. race, age, religion, national origin, color, gender, disability or status with respect to marriage or public assistance; and the reason for the complaint (details of when, where, and how the alleged discrimination occurred).

**Abuse, Neglect, Exploitation**

If providers of case management have any reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify the nearest peace officer, law
enforcement agency, or Adult Protective Services intake within the Department of Human Services, Division of Aging and Adult Services Protection and Advocacy Project at 1-800-472-2670 should be contacted as they focus on the protection and advocacy for the rights of people with disabilities. See section on Protection and Advocacy Project for more information.
A crisis intervention is a planned response to a crisis situation, which can range from a suicide threat to non-lethal problems such as eviction, divorce, or death of a loved one. A crisis is not necessarily always negative and the case manager can help the client understand and even benefit from many apparent crises of daily living. An individual crisis, such as the loss of entitlements or the loss of a job, may ultimately have a positive outcome in that it helps the client to learn and grow. Good crisis planning is essential.

In a recovery oriented system of care, the planning process honors the “dignity of risk” and “right to fail” as evidenced by the following:

1. Prior to appealing to coercive measures, practitioners try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.

2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions. As part of their recovery, they are encouraged and supported by practitioners to take risks and try new things. Only in cases involving imminent risk of harm to self or others is a practitioner authorized to override the decisions of the individual. Person-centered care does not take away a practitioner’s obligation to take action to protect the person or the public in the event of emergent or crisis situations, but limits the authority of practitioners to specifically delimited circumstances involving imminent risk as defined by relevant statutes.

3. In all other cases, practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a
collaborative relationship, clearly outlining for the person his or her range of options and possible consequences. Practitioners support the dignity of risk and sit with their own discomfort as the person tries out new choices and experiences that are necessary for recovery.

4. In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans such as a Mental Health Advanced Directives or the crisis plan as part of the WRAP model. Ideally, such plans are directed by the individual but developed in collaboration with the entire team so as to share responsibility and resources in preventing or addressing crises. Such plans provide detailed instructions regarding preferred interventions and responses in the event of crisis, and maximize an individual’s ability to retain some degree of autonomy and self-determination at a time when he or she is most likely to have these rights taken away. This plan is kept in an accessible location and can be made available for staff providing emergency care.
Mental Health Advanced Directives 850-10-90
(Revised 7/26/13 ML# 3367)
View Archives

Mental Health Advance Directives are similar to general Advance Directives in that they assist clients in defining what they would like to have happen in the event they become incapacitated due to their mental illness or are involuntarily committed.

“The Protection & Advocacy Project (P&A) and its Advisory Council for the Protection & Advocacy of Individuals with Mental Illness (PAIMI) have researched ways to more actively involve individuals with mental illness in their treatment planning. Mental Health Advance Directives (also known as Psychiatric Advance Directives) have been one of the more promising innovations in recent years to give individuals with a severe mental illness a greater voice in their treatment. Mental Health Advance Directives are now widely recognized across the country.

A Mental Health Advance Directive is a legal and medical document. Individuals are encouraged to use this tool as a way to inform and collaborate with their treatment providers. The goal is for the individual to receive the treatment most conducive to his or her mental health needs.” (NDPA, 2008).

For the full document on Mental Health Advance Directives click on:

http://www.ndpanda.org/news/docs/booklet.mh.5.08.pdf
For the actual form to complete click on:

http://www.ndpanda.org/news/docs/form.mh.5.08.pdf
Mental Health Commitments 850-10-95  
(Revised 7/26/13 ML# 3367)  
View Archives

MENTAL HEALTH COMMITMENTS

Individuals suffering from mental disorders are sometimes unable to understand the severity of their illness, may refuse to take their prescribed medications, or are unable to recognize their need for medical assistance.

Even the love and support from family members may not be adequate to keep a person with severe mental illness safe and functioning. Sometimes, the most caring option is to seek an involuntary commitment for someone in order to stabilize their mental health and get their psychological functioning to a place where they can manage their illness.

Involuntary commitment is a process in which a judge decides whether a person who is not managing his/her mental illness should be required to go to a psychiatric hospital or accept other mental health treatment. This choice to follow through with this civil procedure is certainly a difficult one, but it may also be the ultimate life-saving choice. A civil commitment is not a criminal conviction and will not go on a criminal record. In the mental health community, involuntary commitment is considered a “last resort” option. When a civil commitment petition has been filed, an investigator will investigate the need for the commitment. Depending on the investigator’s decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a lawyer and witnesses testify. The judge then makes a decision whether the person should be committed. A person can be committed if after hearing from
witnesses a judge finds by clear and convincing evidence that the person has a mental disorder and, because of that mental disorder, is:

• Dangerous to self or others

• Unable to provide for basic personal needs such as health and safety

If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting.

The Regional Extended Care Coordinator requested the following forms be included in this manual:

**PETITION FOR INVOLUNTARY COMMITMENT**
NORTH DAKOTA SUPREME COURT
SFN 17260 (GN-1) (Rev. 03-2006)

http://www.ndcourts.gov/mhforms/adobe_mhforms/sfn%2017260%20(gn-1)%20petition%20for%20involuntary%20commitment.pdf

**APPLICATION FOR EMERGENCY ADMISSION**
NORTH DAKOTA SUPREME COURT
SFN 17264 (GN-5) (Rev. 03-2006)

REQUEST FOR TRANSPORTATION FOR EMERGENCY DETENTION
NORTH DAKOTA SUPREME COURT
SFN 17265 (GN-6) (Rev. 03-2006)

http://www.ndcourts.gov/mhforms/adobe_mhforms/SFN%2017
265%20(GN-6)%20-%20Request%20for%20Transportation%20for%20Emergency%20Detention.pdf

NOTICE OF EMERGENCY DETENTION
NORTH DAKOTA SUPREME COURT
SFN 17266 (GN-7) (Rev.03-2006)

http://www.ndcourts.gov/mhforms/adobe_mhforms/SFN%2017
266%20(GN-7)%20-%20Notice%20of%20Emergency%20Detention.pdf

REPORT ASSESSING AVAILABILITY AND APPROPRIATENESS OF ALTERNATIVE TREATMENT
NORTH DAKOTA SUPREME COURT
SFN 17245 (F-1) (Rev. 3-2006)

http://www.ndcourts.gov/mhforms/adobe_mhforms/SFN%2017
245%20(F-2A)%20-%20Report%20Assesing%20Avail%20of%20Approp%20of%20Alternative%20Treatment.pdf
PETITION FOR CONTINUING TREATMENT
NORTH DAKOTA SUPREME COURT
SFN 17248 (F-5) (Rev. 03-2006)

http://www.ndcourts.gov/mhforms/Adobe_MHForms/SFN%2017248%20(F-5)%20-%20Petition%20for%20Continuing%20Treatment.pdf

CERTIFICATE OF CONTINUING TREATMENT
NORTH DAKOTA SUPREME COURT
SFN 17249 (F-6) (Rev. 03-2006)

http://www.ndcourts.gov/mhforms/Adobe_MHForms/SFN%2017249%20(F-6)%20-%20Certificate%20of%20Continuing%20Treatment.pdf

PETITION FOR ORDER FOR LESS
RESTRICTIVE TREATMENT
NORTH DAKOTA SUPREME COURT
SFN 17250 (F-7) (Rev. 03-2006)

http://www.ndcourts.gov/mhforms/Adobe_MHForms/SFN%2017250%20(F-7)%20-%20Petition%20for%20Order%20for%20Less%20Restrictive%20Treatment.pdf
Application for Modification of Alternative Treatment Order and Order for Notice of Hearing
NORTH DAKOTA SUPREME COURT
SFN 17270 (GN-11) (Rev. 3-2006)

http://www.ndcourts.gov/mhforms/Adobe_MHForms/SFN%2017270%20(GN-11)%20Applic%20for%20Modif%20of%20Alt%20Treatment%20Order%20and%20Order%20of%20Notice%20of%20Hearing.pdf

ND STATE COURT WEBSITE

http://www.ndcourts.gov/mhforms/Adobe_MHForms/default.asp

The following link is to the MH Commitment Manual developed by Region VII and the information contained in the manual applies to Region VII:

Region VII MH Commitment Manual
The following information was developed by Region IV and the information applies to Region IV:

Regional IV MH Mental Health Commitment Guide

Mental Health Transportation and Possible Restraint Cover Sheet
What is an Individual Justice Plan (IJP)?

Individuals with disabilities have special needs, and when encountering the Criminal Justice System (CJS) may require assistance beyond what is already available. For this reason the Individual Justice Plan is a potential source of assistance.

A person’s disability may or may not impair that person’s ability to interact with the Criminal Justice System. The IJP manual is designed to assist the people for whom the disability limits their ability to adequately interact with the CJS and to help people whose disability interferes with the full expression of their rights by the consideration of alternatives not explicitly offered through routine legal processes.

An IJP is not appropriate for all individuals or situations and may not be agreed upon by all parties in the CJS process.

The IJP manual is an attempt to integrate issues from the area of human services and the CJS and is designed to be a tool that can be used by people involved in these systems. This process is not intended as a safe-harbor from all consequences or as a shortcut to negate civil rights – both of which can occur. Not everyone with a disability who encounters the CJS needs support beyond that of their attorney and other natural networks (family, friends, etc.). Therefore, an Individualized Justice Plan (IJP) is only effective when a concerned, caring, and respectful exchange of information results in the mutual advantage of both the society and the individual. The safety of the public is a priority in development of IJP services.
In order for this process to be effective, all people involved must share a common understanding and philosophy of how the process can be used and what can be accomplished with the use of an IJP. The IJP process is voluntary, provides a framework for services, and does not carry any legal authority to mandate or require services.

The purpose of Individual Justice Planning manual is two-fold:

1. First, it presents alternatives for the CJS to consider, as well as the resources, contacts, and tools needed to follow through with the process.

2. Second, it provides a framework for education of and cooperation between private/public human service agencies and the various facets of the CJS. It is through this framework the two systems can provide the most appropriate services for people with disabilities with the best outcomes for everyone.

Click on the following link to access the IJP Manual:

There is a protection and advocacy system for people with disabilities in each state and territory. Legislation establishing this system was passed by Congress in 1975.

In North Dakota, the organization designated by the Governor to serve as the protection and advocacy system is the Protection & Advocacy Project (P&A). P&A is an independent state agency established in 1977 to advance the human and legal rights of people with disabilities. P&A strives to create an inclusive society that values each individual.

People served include infants, children and adults of all ages. The majority of funds for program operations are from federal grants. Additional support is provided by the State of North Dakota. There is no cost for services, however, P&A does implement general eligibility requirements, including that the individual must reside within the State of North Dakota. P&A has eight different advocacy programs that serve individuals with disabilities:

- Developmental Disabilities Advocacy Program
- Mental Health Advocacy Program
- Protection & Advocacy Project for Individual Rights
- Protection & Advocacy for Beneficiaries of Social Security
- Assistive Technology Advocacy Program
P&A has a governing board called the Committee on Protection & Advocacy. It consists of seven members whose terms are specified in State statute. Appointments are made by the Governor (2 members), Legislative Council (2 members), The Arc of North Dakota, Mental Health America of North Dakota, and a non-profit advocacy group for people with disabilities selected by the Committee. Currently this seat is filled by an appointee of Family Voices of ND.

P&A's staff comes from a wide variety of backgrounds. They are all trained to be knowledgeable about service delivery systems and the legal rights of people with disabilities.

The North Dakota Protection and Advocacy website can be accessed at:

http://www.ndpanda.org/
Guardianship 850-10-110
(Revised 7/26/13 ML# 3367)

The Guardianship Handbook, developed by the ND Department of Human Services can be accessed at the following website:


The North Dakota Guardianship – Standards of Practice for Adults, developed by the ND Department of Human Services can be accessed at the following website:


GUARDIANSHIP ESTABLISHMENT FUNDS PROTOCOL

1. The proposed Ward must be ineligible for case management services through the Developmental Disabilities program.

2. The proposed Ward must have a current diagnosis of a serious mental illness, or a documented traumatic brain injury or age 60 or over. Proposed Wards living independently in community settings will have preference in this program.

3. If the proposed Ward has been diagnosed with a serious mental illness, the proposed Ward must be receiving case management services at the regional human service center. The proposed
Ward’s case manager is responsible for making referral to the Guardianship Establishment Fund program.

4. For proposed Wards diagnosed with a traumatic brain injury or are over the age of 60, the individual making referral may be from County Social Services, independent provider, medical facility, Human Services Center or similar agency.

5. The referral source will complete SFN 1177 Request For Guardianship Establishment Funds and forward it to the Aging Services Division. Incomplete or indecipherable forms will be returned without review.

6. Within three (3) working days of receiving the completed SFN 1177, staff members from the Aging Services Division and the Division of Mental Health and Substance Abuse Services will review SFN 1177 and make recommendations on the case. Recommendations will be for Approval, Denial, or Request Additional Information.

7. If the request is approved, the referral source will initiate action to complete the guardianship process. The proposed guardian will be responsible for securing an attorney. The Court will appoint a Guardian Ad Litem, and Court Visitor, if necessary. However, the referral source may provide suggestions, guidance, and assistance. The case manager will sign the petition, if appropriate, and the attorney will handle the legal work. Case managers will be informed in writing of the amount of funds available to secure the guardianship. Bills are to be submitted to the Aging Services Division for payment.

8. Emergency requests will be accepted. The primary criteria necessary for an emergency request would be for the safety of the client who is in eminent danger. Upon approval, the proposed guardian will secure the services of an attorney etc. to accomplish the request, as outlined above.
9. Full guardians may receive a one-time payment of $500 per Ward where a guardianship was established with this program. This funding is through a pilot program that will end on June 30, 2013.

10. Concerning confidentiality:

   a. If the North Dakota Department of Human Services believes that a client needs a guardian and the lack of guardian is affecting the North Dakota Department of Human Services’ ability to treat the individual or affects reimbursement (payment), the North Dakota Department of Human Services can disclose PHI to an attorney for the attorney to draft a petition. A business associate agreement is not required as HIPAA allows the North Dakota Department of Human Services to disclose PHI for treatment and payment purposes. In addition, the attorney is not providing a service to the North Dakota Department of Human Services as the attorney is representing the proposed Guardian.

   b. If the North Dakota Department of Human Services acts in good faith and believes that the use or disclosure of PHI is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, the North Dakota Department of Human Services can disclose PHI.

   c. The North Dakota Department of Human Services can also disclose the information based on a valid authorization that allows the North Dakota Department of Human Services to disclose the information.

   d. The North Dakota Department of Human Services cannot disclose any 42 CFR Part 2 information, without an authorization or a 42 CFR Part 2 petition, notice, and court
order. The regional human service centers can disclose non-42 CFR Part 2 information as set forth above.

e. Entities outside of the North Dakota Department of Human Services are to secure the proper authorizations and follow confidentiality guidelines when accessing this program.

Click on the following link to access the SFN 1177 - Request For Guardianship Establishment Funds form:

Taking Care of Yourself 850-10-115
(Revised 7/26/13 ML# 3367)
View Archives

Visit the following resources for information on taking care of your physical and mental health:

**NDPERS Wellness Programs**

The NDPERS Wellness Center can be accessed by clicking on the following link:

http://www.ndwellnesscenter.com/

**Time Management**

Effective time management is a primary means to reduce stress. The following website provides time management tips:

http://www.mayoclinic.com/health/time-management/WL00048

**Stress Management**

Job stress is something faced by all workers. There is no getting around it. But, not all stress is bad, and learning how to deal with and manage stress is critical to maximizing job performance, staying safe on the job, and maintaining our physical and mental health. Infrequent doses of job stress pose little threat and may be effective in increasing motivation and productivity, but too much -- and too
prolonged -- can lead to a downward spiral -- both professionally and personally. It is important to take care of yourself.

Further information on stress can be accessed at the following website:

Forms 850-10-120
(Revised 7/26/13 ML# 3367)
View Archives

North Dakota State Government Internal and Public Forms can be accessed at the following website:

http://www.nd.gov/eforms

- Internal - Forms used by customers internal to North Dakota State Government.
- Public - Forms used by the general public or entities external to North Dakota State Government

The Extended Care Coordinators requested links to the following forms be included in the manual:

ND DEPARTMENT OF HUMAN SERVICES
LEGAL SERVICES

SFN 1059 (Rev. 05-2003) AUTHORIZATION TO DISCLOSE INFORMATION
MULTI-AGENCY AUTHORIZATION TO DISCLOSE INFORMATION
ND DEPARTMENT OF HUMAN SERVICES
SFN 970 (Rev. 05-2003)


REVOCATION OF AUTHORIZATION TO DISCLOSE INFORMATION
ND DEPARTMENT OF HUMAN SERVICES
SFN 91 (Rev. 4/2005)


APPLICATION FOR COMMUNITY RESIDENTIAL SERVICES
ND DEPARTMENT OF HUMAN SERVICES
SFN 1005 (Rev. 01-2002)

The form was emailed to all of the Regional Extended Care Coordinators. The form is also stored under “State Forms” on the P: Drive in the SO Mental Health and Substance Abuse folder.