
**UTAH DEPARTMENT OF HUMAN SERVICES
DIVISION OF SUBSTANCE ABUSE AND
MENTAL HEALTH**

**TRAINING MANUAL FOR
CHILDREN & YOUTH CASE
MANAGEMENT SERVICES**

Fourth Edition
(June 2016)

ACKNOWLEDGEMENTS

These Guidelines have been developed by: The Utah Preferred Practice Consensus Panel under the auspices of the Utah Division of Substance Abuse and Mental Health and the Utah Behavioral Healthcare Committee

Initial Adoption December 1998
Revised December 2003
Revised May 2004
Revised June 2016

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I. INTRODUCTION

Why a Case Management Field Guide?

This guidebook was written to help prepare you for one of the most important jobs in community behavioral health today. It will be a study guide as you prepare to take a formal exam required by the Division of Substance Abuse and Mental Health. It will be a resource manual for you at the beginning of your training and a reference you may use throughout your career.

This field guide is a companion in your work. Like any new textbook or course of study, this field guide should be considered just a beginning.

Case management providers should be familiar with the following manuals:

- **Utah Medicaid Provider Manual: Rehabilitative Mental Health and Substance Use Disorder Services**
- **Utah Medicaid Provider Manual: Targeted Case Management for Individuals with Serious Mental Illness**

These manuals will help you know how case management services differ from other behavioral health services such as personal services, peer support services, skills development services, and psychosocial rehabilitative services.

A Brief Historical Perspective

On average, between 14 and 20 percent of young people experience a Mental, Emotional, or Behavioral (MEB) Disorder – such as depression, a conduct disorder, and/or a substance use disorder – at any given point in time. It is estimated that over half of all lifetime cases of diagnosable mental illness begin by age 14 and three-fourths by age 24. Early onset of MEB disorders is predictive of:

- Lower school achievement
- Alcohol Use/Abuse
- Chronic Obstructive Pulmonary Disease
- Depression
- Fetal Death
- Poor Health-Related Quality of Life
- Illicit Drug Use
- Ischemic Heart Disease
- Liver Disease
- Risk for Intimate Partner Violence
- Multiple Sexual Partners
- Sexually Transmitted Diseases (STDs)
- Smoking
- Obesity
- Suicide Attempts
- Unintended Pregnancies

A Serious Emotional Disturbance (SED) touches every part of a child's life. Therefore, children with SED and their families need many kinds of services from a variety of sources such as

schools, Local Mental Health Authorities and Local Substance Abuse Authorities, and social service organizations.

A case management service provider facilitates the individualized service plan that is being used to identify and coordinate services for a child or adolescent with SED and the family, as it relates to the child or adolescent. This person identifies the role that each service provider fills and coordinates all services. The goal is to make sure the plan builds on the child's strength and meets the unique needs of both child and family as it relates to the child. As the child's needs change, his or her case management service provider notes these changes and adjusts the mix of services, if necessary.

What is Case Management?

In Utah, the Local Mental Health Authorities (LMHAs) and Local Substance Abuse Authorities (LSAAs), under contract with the State Division of Substance Abuse and Mental Health (DSAMH), are responsible for case management in their local areas as defined by Utah Code Annotated 17-43-301(4)(b) and State Rule R523-7-4. Case Manager Certification. Case management services help consumers develop goals to coordinate, advocate, link and monitor services, and facilitate the achievement of goals. When working with children and youth, consumers refers to both children and youth and their families. Providers of case management services offer the energy and organization to see that these plans result in real benefits for consumers. Case management may be provided by one person or a team of providers, and is a service that assists consumers in gaining access to needed health (including behavioral health), social, educational, and other services. The overall goal of case management is not only to help consumers to access needed services, but to ensure services are coordinated among all agencies and providers. Case management may be done in the consumer's home, place of employment, shelter, on the streets, residential, and in various other settings. The frequency of contact may be more to less intensive depending on the individual's needs.

Like other citizens, consumers of behavioral health services have the ability to live as productively as possible and to receive the treatment they need with minimum interference and maximum support. A well-conceived recovery/treatment plan and case management needs assessment and/or case management service plan will match an individual consumer's strengths and needs to specific community resources. For many Utahans who access behavioral health services, case management can make the difference between isolation and productive community connections.

Chapter I: System of Care Values and Principles

Overview of Utah’s System of Care Values and Principles for Children with Serious Emotional Disorders and Their Families

Utah System of Care Values and Principles

The Utah System of Care Values and Principles is grounded on core principles and values. The model is multi-dimensional and interdisciplinary with families as partners in a child-focused, family driven, community based, and culturally competent manner of service delivery targeted to keep children at home, in school, and in the community.

Behavioral Health Services for Children in Utah

The public behavioral health system in Utah has a primary responsibility for providing behavioral health services to children with Serious Emotional Disturbances (SED) and their families and for meeting the behavioral health needs of the children in our State.

Qualified Targeted Case Management Provider

Targeted case management for the chronically mentally ill may be provided by, or through, a behavioral health center (or other entity) under contract with or directly operated by a LMHA/LSAA.

Qualified providers are:

- A. Qualified providers of targeted case management services to recipients in this target group are employed by or under contract with one of the following:
 - 1. a local mental health and/or substance abuse authority;
 - 2. a local authority’s designated mental health and substance use disorder services provider;
 - 3. the Department of Human Services; or
 - 4. a program providing Medicaid-covered services, including targeted case management services for individuals with serious mental illness, under the authority of 1915(a) of the Social Security Act (i.e, HOME). Providers authorized under Section 1915(a) of the Social Security Act provide targeted case management services only to Medicaid recipients enrolled in the 1915(a) program.

- B. Primary providers of targeted case management services are:
 - 1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;
 - 2. licensed advanced substance use disorder counselor (ASUDC) or substance use disorder counselor (SUDC) under the general supervision of a licensed mental health therapist identified in C.1 of the Utah Medicaid Provider Manual: Targeted Case Management ;
 - 3. certified advanced substance use disorder counselor (CASUDC) or a certified advanced substance use disorder counselor intern (CASUDC-I) under direct supervision of a licensed mental health therapist identified in C.1 of the Utah Medicaid Provider Manual: Targeted Case Management, or a licensed ASUDC qualified to provide supervision;
 - 4. certified substance use disorder counselor (CSUDC) or a certified substance use disorder counselor intern (CSUDC-I) under direct supervision of a licensed mental health therapist identified in C.1 of the Utah Medicaid Provider Manual: Targeted Case Management, or a licensed ASUDC or SUDC qualified to provide supervision;
 - 5. licensed registered nurse;
 - 6. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in C. 1 of the Utah Medicaid Provider Manual: Targeted Case Management;

7. individual who is not licensed who is at least 18 years old and under the supervision of a an individual identified in C.1., C.2., or C.3.b. of the Utah Medicaid Provider Manual: Targeted Case Management, a licensed social service worker or a licensed registered nurse; or a licensed ASUDC or licensed SUDC when targeted case management services are provided to individuals with a substance use disorder who have Traditional Medicaid.
Non-licensed individuals must complete the training curriculum and certification requirements specified in Chapter 1-6 of the Utah Medicaid Provider Manual: Targeted Case Management; or
8. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or individual enrolled in a qualified substance use disorder counselor education program, exempted from licensure in accordance with Section 58-1-307 of the Utah Code and under required supervision.

C. In addition to the primary service providers specified above, individuals in C.1., C.2., and C.3., below, may also provide this service:

1. Licensed mental health therapist practicing within the scope of his or her license in accordance with Title 58 of the Utah Code:
 - a. physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;
 - b. psychologist qualified to engage in the practice of mental health therapy;
 - c. Certified psychology resident qualifying to engage in the practice of mental health therapy under the supervision of a licensed psychologist;
 - d. clinical social worker;
 - e. certified social worker; or certified social worker intern under the supervision of a licensed clinical social worker;
 - f. advanced practice registered nurse (APRN), either as a nurse specialist or a nurse practitioner, with psychiatric mental health nursing specialty certification;
 - g. marriage and family therapist;
 - h. associate marriage and family therapist under the supervision of a licensed marriage and family therapist;
 - i. clinical mental health counselor; or
 - j. associate clinical mental health counselor under supervision of a licensed mental health therapist.
2. An individual who is working within the scope of his or her certificate or license in accordance with Title 58 of the Utah Code:
 - a. Licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;
 - b. Licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty nursing certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;
 - c. licensed physician and surgeon or osteopathic physician regardless of specialty, or other medical practitioner licensed under state law (most commonly licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act); or
 - d. licensed APRN or licensed APRN intern regardless of specialty..
3. An individual exempted from licensure (as a mental health therapist), including:
 - a. In accordance with Section 58-1-307 of the Utah Code, a student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized

school approved by DOPL to the extent the activities are supervised by qualified faculty, staff, or designee and the activities are a defined part of the training program; or

- b. in accordance with Subsection 58-61-307(2)(h) of the Utah Code, an individual who was employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision.

Supervision (when applicable) of individuals above must be provided in accordance with requirements set forth in Title 58 of the Utah Code, and the applicable profession's practice act rule as set forth by the Utah Department of Commerce and found at the Department of Administrative Services, Division of Administrative Rules, www.rules.utah.gov/publicat/code.htm. In addition, all individuals providing targeted case management services must know Medicaid regulations pertaining to targeted case management as described in this provider manual.

Targeted Case Management Training Curriculum

To meet the State DSAMH's training standards, all non-licensed individuals will be required to:

- A. successfully pass a written examination which tests basic knowledge, attitudes, ethics, and case management skills;
- B. successfully complete a DSAMH case management practicum; and
- C. successfully complete recertification requirements.

In addition, all providers of case management services must know Medicaid regulations pertaining to targeted case management as described in Targeted Case Management for Individuals with Serious Mental Illness, *Utah Medicaid Provider Manual*. Division of Medicaid and Health Financing, July 2015.

Chapter II: Delivery of Services

Ethical Guidelines

It is important that limits and boundaries be known and clear to the consumer and the case management provider. Some limits originate with the LMHA/LSAA policy or the Code of Conduct (see Preferred Practice Guidelines, Provider Code of Conduct, and the National Association of Case Management Ethical Guidelines). These should be studied and understood by each case management provider. Most limits and boundaries are maintained by sound judgment of the case management provider. *Case management providers must never, under any circumstances, date or in any way encourage intimacy with consumers.* They should not routinely receive phone calls at their homes or otherwise indirectly suggest that the professional relationship may become a personal one. Supervisors and other staff members should be used to help the case management providers answer specific questions about this.

Case management providers who were previously or may still be consumers, may have special problems in clarifying which role is appropriate. The consumer/case management provider can have special understanding and sympathy for the problems of consumers, but that very strength may at times result in conflicting loyalties and misunderstandings. The consumer/case management providers need to discuss these problems with his/her supervisor and know the specific expectations of the agency.

Case management providers need to be conscientious about providing services within local, state, and federal laws, as well as general ethical practices. Issues of concern may include substance abuse, confidentiality, dual relationships, setting and maintaining appropriate boundaries, imposing one's own values, etc. Case management service providers need to refer to the LMHA/LSAA policy and procedures, the provider code of conduct, the National Association of Case Management (NACM) ethical guidelines, and use supervision appropriately.

NACM Ethical Guidelines:

As a Case Management Service Provider, I:

- Am committed to respect the dignity and autonomy of all persons and to behave in a manner that communicates this respect.
- Am committed to each individual's right to self-determination, and the rights of people to make their own life choices, and I am committed to embarking hopefully on a recovery journey with every person I serve, letting them direct their own healing process.
- Am committed to fight stigma wherever I find it, to educate the community, and to promote community integration for the people I serve.
- Do not allow my words or actions to reflect prejudice or discrimination regarding a person's race, culture, creed, gender or sexual orientation.
- Strive to both seek and provide culturally sensitive services for each person and to continually increase my cultural competence.
- Am committed to helping persons find or acknowledge their strengths and to use these strengths in their journey of recovery.
- Am committed to helping persons achieve maximum self-responsibility and to find and use services that promote increased knowledge, skills and competencies.

- Acknowledge the power of self-help and peer support and encourage participation in these activities with those I serve.
- Am honest with myself, my colleagues, the people I serve, and others involved in their care.
- Keep confidential all information entrusted to me by those I serve, except when to do so puts the person or others at grave risk. I am obligated to explain the limits of confidentiality to the persons I serve at the beginning of our working together (including consumer information, dates of services, diagnostic information, etc.).
- Am committed to a holistic perspective, seeing each person I serve in the context of their family, friends, other significant people in their lives, their community, and their culture, and working within the context of this natural support system.
- Must strive to maintain healthy relationships with the people I serve, avoiding confusing or multiple relationships and keeping the relationship focused on the individual's needs, not my own.
- Maintain a commitment to prevent crisis situations with the people I serve, to present and support crisis alternatives, to develop an advanced instruction crisis plan with the individual whenever possible, and to avoid forced treatment unless there is a clear and present danger to the person served or another.
- Have an obligation to consult with my supervisor, obtain training, or refer to a more qualified case management providers any individual with a need I do not feel capable of addressing.
- Have an obligation to remain curious; learning, growing, developing, and using opportunities for continuing education in my field or profession.
- Am committed to a regular assessment of my service recipients' expectations of me and to consistently improving my practice to meet their expectations.
- Have an obligation to advocate for the people I serve, for their rights, for equal treatment and for resources to meet their needs.
- Am obligated to learn the laws and regulations governing my practice and to abide by them, including the duty to warn anyone in danger of physical harm, and the duty to report physical, sexual, emotional and/or verbal abuse to the proper person or agency.
- Am obligated to work supportively with my colleagues and to keep their confidences.
- Am obligated to urge any colleague who appears impaired to seek help and, failing this, to discuss my concerns with the appropriate agency authority.

Chapter III: The Care Coordination Tool Box

Overview

Case management is a service that assists children and families in gaining access to needed health (including behavioral health), social, educational, and other services. The overall goal of the services is not only to help Medicaid recipients to access needed services, but to ensure that services are coordinated among all agencies and providers involved.

Case management service providers actively coordinate with the family, service providers, and allied agencies to ensure that required services are effectively and efficiently provided. Consistent monitoring and ongoing contact with the child and family members are essential to ensure that services are being provided appropriately. Case management service providers advocate for the child and family, assess needs and problems identified by the child and family members, plan specific service goals to achieve desired outcomes, and link children and family members to appropriate services. Varying levels of case management are offered and tailored to the unique needs of the child and family.

Case management assumes the care coordination of a child with SED in collaboration with the child's parents or guardians. Case management is a community-based service. Community settings include the child's home, school, neighborhood, and other natural sites. The frequency of contact between the case management service provider and the child and family is to be consistent enough to assess and monitor to make sure the goals and service plan are meeting the needs of the child. The case management service provider coordinates care for the child across all systems in which they are involved.

A child's system includes their parents/guardians, siblings, and extended family and may include neighbors, child welfare, hospitals, physical health care, behavioral health, school, juvenile court, church, etc. Case management begins with a thorough needs assessment across all life domains: residence, family, education, health and substance abuse, legal, safety, cultural/social and emotional/behavioral.

Case management services begin with an Individualized Service Plan (ISP) that includes addressing the manifesting symptoms of the serious emotional disorder and the psychosocial problems the child and family are experiencing. The problems include, but are not limited to, transportation; application and attainment of entitlements; acquiring food; clothing; housing; health and behavioral health care, as well as medications; education; and linking with community resources and supports.

Individualized Service Planning

Individualized service planning is the cornerstone for children with SED and multiple needs and their families. An ISP will be developed and followed by the core team (also referred to as the family team). Core teams include parents and, unless clinically inappropriate, the child, the clinician and case management provider, educators, and partner agency staff appropriate to the

child's and family's needs. Service planning will be ineffective unless the family is involved at every level.

The ISP is based upon a comprehensive needs assessment, using an ecological perspective, which considers the child and family strengths. These strengths should be used throughout service and the goal planning process. The ISP will consider eight dimensions: mental health, substance abuse, social, educational, physical health, vocational, recreational, and operational. In addition, the core team will assess eligibility for financial assistance and services under Federal, State, and local programs.

Cultural competency is an underlying value of individualized service. Children, within the context of the family, deserve services that are respectful and accommodating to their culture. The needs assessment should reveal the unique needs, values, norms, and strengths of the child or children in the context of their family, culture, and community.

With this information, the core team will consider the least restrictive services and activities, traditional and non-traditional, needed for the child to remain with or return to his family and community. It is recommended the ISP coordinate with any existing plans, such as an IEP, a 504-accommodation plan, probation contract, or a DCFS service plan.

- Description of the need for services;
- Recognition of existing family strengths;
- Objectives that meet the needs of child and family and which build on existing family's strengths;
- The methodology for meeting these objectives;
- A record of the provision of the services as appropriate, including, for those children 14 years or older who require them, vocational counseling and rehabilitation services, and transition services offered under Individuals with Disabilities Education Act (IDEA)¹; and
- Designation of responsibility for case management services to be provided under the plan.
- Review and revision of the appropriateness of services in the ISP when necessary.

Needs Assessment

A needs assessment is an evaluative, strength based, and solution focused service. It is a collaborative determination of the child and/or family needs, taking into consideration factors contributing to the problems, as well as, the strengths and resources available to the child or family. It is the basis from which recommendations for services and goals are determined. Once this assessment is made, a service plan is developed which outlines long-term goals and the smaller steps which must be taken to achieve those goals.

Rationale for a Family Strengths Conversation²

The strengths approach to assessment is as much an attitude as it is a skill. The essence of the

¹ Individuals with Disabilities Education Act aims to strengthen academic expectations and accountability for children with disabilities, and to bridge the gap that has too often existed between what those children learn and the regular curriculum.

² Donner, R. Ph.D. *Developing a Comprehensive Strengths Assessment*.

approach is this – getting to know someone. That may sound too simple; however, it is amazing how difficult it is for one to actually adopt that approach in working with families. Much of the reason for this has to do with the nature of work with families. We are present to assist them in working out whatever problems they have experienced; hence, our focus becomes just that, their problems. Assessments typically involve gathering all the information we need about the problems in order to begin developing a service plan. Then we are off and running – many times without truly “knowing” the family with whom we are working.

The strengths approach challenges the typical way of operating by broadening the scope of the assessment. The focus of the assessment is no longer simply on the problems that the family has encountered, but on their successes as well. The strengths approach serves to remind us, and the family, that they have not always had problems. The shift is away from “deficits” and toward knowing the family in a more holistic way.

The strengths approach to assessment requires that one comes to know families more completely. It is a more affirmative way of interacting with families as compared to the traditional diagnostic interview. It establishes an interaction between the worker and the family which is intended to systematically gain information about their perspectives, desires, and goals so that the worker can help pull together all available resources, including systems and natural supports of the family’s behalf.

What is a Strengths Assessment?

- A tool to obtain and assess the ongoing growth and changing interests of the child;
- An assessment of the child’s situation and circumstances across **Seven Life Domains**:
 - Living Arrangements
 - Financial Resources
 - Vocational/Educational Involvement
 - Social Supports
 - Physical Health
 - Behavioral Health Services
 - Leisure/Recreational Activities
- Assessment of each life domain based upon:
 - A history of where the child has been
 - The child’s current status
 - Stated personal goals
 - Internal and external resources
 - Priority of needs
- A working document that has a beginning, but not end; the assessment is ongoing and is to be updated when the child’s status is altered, the goals are changed, or new resources are acquired. This will occur at least every 90 days.

The Use of Life Domains

Life domains are the areas of the assessment devoted to gathering information about the child’s entire life situation. Information gathered from the seven life domains serves as the basis for setting goals and developing a service plan. Each life domain is explored with five dimensions, or questions. These dimensions flow from one to another and help maintain the direction of the

assessment.

The five questions include:

- **Past history:** What kind of experiences has the child had up to this time?
- **Current status:** What is going on now for the child?
- **Personal goals:** Where would the child like to be?
- **Resources:** What resources can he/she use to make the desired changes? What talents or experiences can the child use to meet the desired goals?
- **Prioritized needs:** What steps does he/she need to take to make the changes? What is the most important goal/need at this time?

Conducting a Strengths Conversation

The procedure should be flexible and natural. Some important principles that apply:

- Focus on strengths not problems. This is not the time to be problem solving.
- Select a comfortable environment to conduct the strengths assessment.
- All of the life domains do not need to be addressed at one time.
- Avoid “why” questions; instead direct questions to what the child would like.
- Follow the child’s natural pace - don’t hurry the process.
- Involve family members when appropriate in the process.
- Stay with the present and go forward.
- Don’t use the assessment process and time to oppose the child’s information.
- Be creative in the process. Relax and enjoy the discussion.

At a minimum the strengths “conversation” outcomes should include:

- Understanding the capacities, capabilities, desires, attributes, hobbies, personality, etc. of the family.
- The family’s culture – being able to identify the values and preferences of the family.
- Identification of the patterns that have worked for the family.
- Identification of who the family is involved with – where and how they get support – including their spirituality.
- Reframing the positive within the problem behaviors identified.

The process should include listening to the family’s story and identifying the following areas:

- What do you like or have in common with the family: shared interests, experiences, values?
- What has allowed the family to keep it together up until now? Listen for behaviors, attitudes, perceptions of the problem, values, desires, capacities, perseverance, and use of social supports. Things haven’t always been so bad; what was it like when things were going well?
- How have they handled difficult situations? Find out what worked, what didn’t work. Are they aware of the trigger events?
- What has it been like for them to live in their family? What are some of positives/negatives?
- What kind of supports do they have? How do they cope? What are their strategies? Who can they depend on to help them?
- Do they utilize spirituality? If so, how?
- What are their values and cultural preferences?
- What do they think it would take to keep everyone together or return a child who has been

removed?

- What do they need to keep the child at home? What formal/informal services? What kind of support? What kind of information?
- When they have trouble with a child or situation, what sort of backup plan have they used?

If families cannot think of strengths, one suggestion might be to ask to see family pictures as a way to get the process started. This is particularly good when a parent may be having trouble thinking of strengths of their teenager.

Prioritizing Needs

After completing the strengths assessment, the case management provider and child must identify which areas should be selected as priorities for goal setting. These are first based on critical survival needs (e.g., food, shelter, clothing, and health care) and then on less fundamental requirements. Once the needs have been prioritized, the case management provider and child are ready to develop a service plan to accomplish one or more of the goals.

The Service Plan: Development and Implementation

Once a strengths assessment is complete, the identified goals of the child are recorded in a service plan. A service plan is a set of action steps designed to achieve one or more of the child's goals as stated during the strengths assessment.

The plan contains:

- Long term goals;
- Short term goals or action steps;
- The names of person(s) responsible for helping the child complete the steps;
- Dates for the steps to be accomplished; and
- Signatures of the child, case management provider, the supervisor, and others on the family team.

Just as the strengths assessment is completed based upon the individual child, so is the service plan. Consequently, there are given guidelines for completing the plan, but the design and emphasis of the plan are based upon the individual child.

Service planning for children's case management is a collaborative process between family and service providers that is based on an ongoing needs and strengths assessment of the child and family across each life domain.

Throughout this process the case management provider educates and reinforces the child's right and responsibility to identify and make choices. Many children have such low self-esteem that they feel unable to make important choices for themselves. The case management process should help them reclaim some confidence in their ability to choose.

A service plan is a descriptive term for an individualized and comprehensive case management service plan. An individualized plan is one that is developmentally appropriate and seeks to meet the needs of the child across each life domain. A case management provider designing a service plan asks families what they need and 'wraps' services around them to meet these needs. This is in contrast to telling families what 'the program' has to offer and requiring that the family fit

only into traditional services. Case management services strive for being ‘family focused’ rather than ‘program focused.’

The service plan is designed to help the child meet his/her goals, which may include accessing needed physical health, behavioral health, social, educational, and other services. The overall goal of the service plan is not only to help the child access needed services, but to ensure that services are coordinated among all agencies and providers involved.

Goal Setting

“If you can’t measure it, you can’t manage it.”-George Odiorne³

Each goal must be broken down into a set of action steps. These steps are listed and include who, how, and when the step will be accomplished. The art of designing a personal plan is to develop action steps that are small enough and a plan of support large enough so that disappointments and, if any, failures are not overwhelming.

The following is a checklist of writing quality action steps:

- Are the action steps stated in positive terms?
- Are the action steps realistic and achievable?
- Are the action steps observable and behavioral?
- Are the action steps stated in specific terms, not global terms?
- Are the action steps child-oriented, not clinically oriented?
- Is the initial action step immediate with a high probability of success?
- Are the action steps in sequential order and serve to accomplish a short-term goal?
- Is the number of action steps small enough not to overwhelm the child, but large enough to set a direction and a challenge?

Monitoring the Service Plan

Once the strengths assessment has resulted in a specific, time-limited, individualized service plan, the case management provider, the child, and their family begin the exciting process of implementing the plan. Expect that the plan will need to be changed and revised from time to time.

Monitoring involves active observation of the service plan to make sure it is being properly implemented. Monitoring also involves consistent help to the child in identifying problems and modifying plans. For example, there may be a need for a special medication check or a revised apartment rental agreement. Occasionally monitoring may indicate that a child needs more intensive service, such as a hospitalization.

Case management providers are community based, not office bound. To monitor service delivery, the case management provider must actively watch, listen, and interact with the child, family, various agencies, and the treatment providers. Monitoring involves being with the child in his/her natural surroundings. Therefore, the case management provider might be at one of many locations. These might include the child’s home, school, any office of a treatment provider,

³ Harris, Blaine & Charles Coonrad (2001). *The Four Laws of Debt Free Prosperity*, Chequemate International, page 17.

or in a community setting.

When the case management provider is monitoring a child's progress towards meeting the service plan goals, they will be attempting to answer these questions:

- Is the child getting the services established by the service plan?
- Are the services provided in such a way that the child can benefit from them?
- Are the services provided to the child meeting the objectives of the service plan?
- Are the services provided in manner that is beneficial or usable to the child?
- Are the plan's objectives appropriate to the child's current needs?
- Will meeting the plan's objectives give the child the ability to continue living in the community?
- Does the child need additional interventions to continue making progress?

These questions point to the effectiveness of the service delivery and the appropriateness of both the services and the service plan. The answers to these questions will lead to the next action. If the current service plan is not helping the child, a revised assessment and service plan may be in order. The core team remains intact to implement, monitor, and refine the service plan as needed. At a minimum, the service plan of the child will be reassessed every 180 days and will be modified accordingly. The needs of the child and family will be reassessed every 90 days and the ISP will be modified accordingly.

Indicators of Effective Case Management Service Planning and Implementation

- The service plan is based on an ongoing assessment that considers the child and family needs across all life domains.
- The case management provider has linked the family to all necessary services.
- The case management provider has organized all services for the child and family in a coordinated manner.
- The case management provider is overseeing all relevant services to assure they are meeting the stated needs.
- The case management provider has invited the family to participate in the service planning and design and has given them a copy.
- The case management service plan is specific as to what activities need to be done by whom and when they need to be done to accomplish stated goals and objectives.
- The case management provider has consistently documented progress towards goals.

Criteria for Case Management Discharge

Discharge from case management is preferred when the child and family have had a period of stability that has allowed them to achieve and maintain individual and family improvement at home, in school, and in the community.

Indicators of successful child and family discharge from case management services:

- Services have been accessed, utilized, were effective, and no longer need significant coordination;
- The child and family have gained new coping skills and are staying linked with other

appropriate services;

- Manifestations of the SED are managed and minimized;
- The child and family have developed and maintained some natural supports;
- The family and the child are understanding of the risks for relapse and have a plan to engage in when symptoms resurface before significant regression occurs;
- When it is determined that case management services are no longer needed and the family or team has agreed upon it.

Chapter IV: Family & Professional Partnership

Family participation in an integrated service delivery system for children is increasingly the norm around the nation.

Behavioral health of children depends on family involvement. A broad definition of family should be considered in who may be a resource to a child with SED:

A primary caregiver or adult with substantial and ongoing involvement in the life of a child who has (or lives of children who have) emotional, behavioral, or mental disorders. This could include anyone who functions in the role of a family member, including parents, aunts, uncles, grandparents, siblings, foster parents, guardians . . . (System of Care Principles and Values, Promising Practices for Children)

Families as Effective Participants in System Development

For family members to participate actively as partners, they must be informed, educated, and persistent. Participation is a right of all parents, not only those who have these qualities.

Providers may support families' participation by:

- Developing and maintaining a climate that is respectful of parents and supportive of participation;
- Giving information in a timely, straightforward, and accessible fashion, free of jargon and acronyms;
- Opportunities to exercise their management skills;
- Safety, closeness, and appreciation;
- Expressions of opinions and emotion;
- Acceptance of their differences;
- Access to appropriate services;
- Voice in and ownership of service plan development;
- Freedom from labels such as 'dysfunctional', etc.;
- Give families meaningful roles; from the outset they should actively work on the planning, design, implementation, and evaluation of programs, supports, policies, and services;
- Respect families' choices, ideas, and opinions;
- Make sure that families have access to all information given to other board or committee members;
- Make sure that the invited family members truly represent the needs of the working group;
- Conduct meetings at mutually convenient times; ask families for "best" and "worst" times before scheduling during the workday; and
- Provide families opportunities to assume leadership roles within the group; have the chairperson rotate or have co-chairpersons.

What Families Bring to the Case Management Relationship

When families are engaged with case management providers and other treatment professionals, what emerges is a positive picture of team decision making which family members play an important role in shaping. Family members contribute many important functions in making a core service team and case management work for children. Some of these include:

- A perspective, along with important information, which is unique in its comprehensive and holistic approach. Family members assimilate multiple assessments, monitor multiple interventions, oversee daily living, implement 24-hour crisis intervention, and advocate for their child's needs. They usually know best what works with their child.
- Communications that are free of jargon and may help professionals from different disciplines talk to each other.
- Knowledge and understanding of the strengths and needs of family members, which may be vital to the success of a service plan.
- An emotional investment that rarely quits at the end of the workday or workweek. Any service provider is ultimately transient in the life of the family, in a given day, week, month, or year. Family caregivers rarely are.
- Ability to monitor progress or relapses. Family members are on the front line when the child begins to relapse; they are the first to notice when the child improves. Family members are in an ideal position to help monitor the child's response to medication and other interventions.
- If they are satisfied, families are the best advocates a public behavioral health agency can have. Family members do not operate under the same legal and institutional constraints as professionals. With support and encouragement, they can become powerful voices in helping to support system developers and community projects.
- Families can generate funds and public commitment by articulating the value of services and encouraging long-term community commitment to realistic initiatives.

Strategies for Involving Families

- Involve multiple family members.
- Make sure that the group is diverse; be sensitive to ethnic, gender, geographic and disability factors.
- Make sure that the invited family members truly represent the needs of the working group.
- Conduct meetings at mutually convenient times; ask families for "best" and "worst" times before scheduling during the workday.
- Provide families for opportunities to assume leadership roles within the group; have the chairperson rotate or have co-chairpersons.
- Give families meaningful roles; from the outset they should actively work on the planning, design, implementation, and evaluation of programs, supports, policies, and services.
- Respect families' choices, ideas, and opinions.

Chapter V: Education and Case Management

Schools and education are critical in the life of children. Education is their “work” as well as a major part of their social life. Next to families, school personnel constitute a major source of knowledge and information about children. Unlike parents, school personnel observe children not only as individuals but also in relationship to one another across a number of environments: academic, social, and recreational, in both structured and unstructured settings. School staff can be a primary source of information, input, and feedback on an ongoing basis.

Case Management Providers, Students, and Schools

It is essential that case management providers have knowledge of the local educational resources and develop working relationships with school personnel who are involved with the children to whom they are assigned. In addition, case management providers must become acquainted with school rules, procedures, and day-to-day processes in order to provide an effective integration of services for children. Children with behavioral health diagnoses may be eligible for services through Section 504 of the Rehabilitation Act and/or Individuals with Disabilities Education Act (IDEA): Special Education. A working knowledge of the rights of children under these Federal Laws will be essential for case management providers.

Both laws require not only eligibility determination, but also individualized plans to meet children’s needs across education settings. IDEA requires an Individualize Education Plan (IEP) while Section 504 requires an Accommodation Plan. If parents/guardians agree, case management providers should participate in these planning and subsequent review meetings. In addition, schools may also be providing other special assistance programs such as Title I, bilingual classes, tutoring, and counseling. Case management providers need to become acquainted with the range of special services each school has, including the purpose and target population for each. This knowledge will be critical in meeting individual needs of children.

Special Education: IDEA, Section 504 of the Rehabilitation Act of 1973, & Americans with Disabilities Act (ADA)

The Individuals with Disabilities Education Act Amendments (IDEA) of 1997 has guaranteed that eligible children with disabilities have free appropriate public education in the least restrictive environment, based on an IEP (which may address behavioral issues and strategies) designed to meet their unique educational needs.

Section 504 of the Rehabilitation Act of 1973 provides that “No otherwise qualified individual with a disability...shall solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”⁴

The ADA expands anti-discrimination protections for persons with disabilities and provides equal opportunity for these individuals. The 5 major components of ADA are: I. Employment, II. Public Services, III. Public Accommodations, IV. Telecommunications, and V. Miscellaneous Provisions. Each of these components has implications for case management providers working across school and community settings.

⁴ 29 U.S.C. 794(a).

For more information on these <http://idea.ed.gov/> ;
<http://www2.ed.gov/about/offices/list/ocr/504faq.html> ;
<http://www.hhs.gov/ocr/civilrights/resources/factsheets/504.pdf> ;

Case Management Providers Can Help Families through the Educational Process

- Secure signed authorizations from the parents in order to obtain testing and school performance information about the child.
- Determine what services the child is currently receiving in his/her school. Determine if the child is being served in special education, or under Section 504, or in other special services at the school such as Title I, tutoring, counseling, group counseling, mentoring programs, after school program, etc.
- Review information from school (both from school records and from information secured about services in the school) and identify missing information or possible services from which the child may benefit.
- If the child is not being served in special education, Section 504, or other services, the parent may make a formal referral for services.
- Support the parents through the process of planning a child's education program through the Special Education IEP process, the Section 504 Plan development, or other special services programs available at his/her school, or refer the parent to a Family Facilitator.
- If the child is not being served, or doesn't qualify for services, in special education, help the parents to determine what accommodations she/he may need in the regular classroom to be successful.
- Help the parents be prepared with information they need to present to the school and the information they need to receive from the school. It may be necessary to go with the parent to the meeting and support the process of identifying needs and coordinating services.
- Everything the school and parents discuss needs to be in written format. If the school or teacher agrees to accommodations, they need to be in writing and then placed in the child's school records. "If it is not in writing, it didn't happen."
- Contact your local support centers such as, the Utah Parent Center, New Frontiers for Families, Allies with Families, NAMI, to get questions answered about the special education and/or the accommodation process. For a more comprehensive list please refer to www.dsamh.gov.

Chapter VII: Crisis and Safety Planning

Crisis Happens. Knowledge of crisis intervention is important for case management providers in the event of a suicide threat or even non-lethal problems such as eviction, divorce, or death of a loved one. A crisis is not necessarily a bad or destructive thing, and the case management provider can help the child and family understand and even benefit from many apparent crises of daily living. A child and family crisis, such as the loss of a job, may ultimately have a positive outcome in that it helps the child and family to learn and grow. The case management provider should consult with his/her supervisor and other team members to help identify what is happening in a given situation and to plan appropriate interventions when encountering a crisis situation.

THE BEST PREDICTOR OF FUTURE BEHAVIOR IS PAST BEHAVIOR

Predict, Prevent, and Plan

Most of the time, one can predict and prevent crisis; however, crises will still happen. The best service plan still cannot prevent some crises from happening. Begin crisis management by predicting the worst-case scenario. One does this with the child and family present.

Effective Crisis Planning

- **Look to the past.** Effective crisis plans anticipate crises based on past knowledge.
- **Be cautious.** Great crisis plans assume the “worst case” scenario and plan accordingly. As one builds a crisis plan, always research past crises to find out what happened before, during, and after the identified former crisis.
- **Crisis is a process.** Good crisis planning is a process and is not a single event. Crisis plans change over time based on what is known to be effective. Behavioral benchmarks need to change over time to reflect progress as well as the changing capacities and expectations of a child and family.
- **Crisis plans need to be in place as early as possible.** Build crisis plans early so they are in place when a crisis occurs.
- **Use the family as experts.** As the first step in building the crisis plan, be sure to ask the child and family what can go wrong with the plan. They know best what can go wrong.
- **It is not “9 to 5.”** Build crisis plan for 24-hour response.
- **Clearly define roles.** Clearly define the roles of key players. Build roles for family members and natural support people, as they are likely to be most responsive during a crisis. Clarify roles to help the family team remain focused on the overall plan during a crisis.
- **After the crisis, evaluate.** Create time for the family team to assess its management of a crisis about two weeks after the crisis.
- **No knee-jerk responses allowed.** Establish a rule that no major decisions about plan outcomes can be made until at least 72 hours after the crisis has passed. This can keep a family team from overreacting to an event.

Safety Plans for Children

- **Safety plans are not the same as crisis plans. All plans have a crisis plan, but safety plans exist when a safety risk to child, family, or community is present.**
- **When to develop a safety plan.** A safety plan should be developed when solid evidence of

past unsafe behaviors toward self or others by the child exists.

- **Safety plans should be developed** when community concerns over safety are threatening the chances that a child may remain in their community.
- **“Better safe than sorry.”** If a family member or a professional has a sense that safety is an issue, then a safety plan should be developed.
- **Who develops safety plans?** The child and family team consists of the child (as appropriate), family, case management services provider, treatment professional(s), and other supports. They will develop and write a comprehensive safety plan.

Developing a Safety Plan

- **Potential crisis.** The safety plan addresses what to do if some part of the plan breaks down and a crisis occurs. Describe the possible crisis: This should include an assessment of likely events that would threaten the safety of the child, the safety of others, or cause disruption of the plan.
- **Potential outcomes of the identified crisis.** How would the result(s) of the crisis threaten the safety of the child or others, or the stability and progress of the plan?
- **Family/community supports.** Who are the people who are prepared to help in a crisis including caregivers, friends, relatives, and other traditional and non-traditional supports?
- **Crisis phone numbers.** Include back up pager or cell phone numbers if available.
- **Interests and strengths of the youth and family relevant to crisis situations.**
- **Specific effective techniques in resolving crisis.** What has the child responded to in the past? What should be avoided? Who or what supports the caregiver?
- **Situations leading to or antecedents to crisis.** What are things that signal or trigger a crisis?
- **Steps to prevent a crisis.** What are steps to take to respond to the situations or antecedents that lead to the crisis?
- **Steps to address early signs of crisis.** What are things that signal or trigger a crisis? What are signs that a crisis is about to begin?
- **Steps to take to respond to a crisis.**

Problem Behaviors That May Precipitate a Crisis

These are guidelines that can help you respond helpfully and safely to these types of situations. The following sections describe some different categories of problematic behaviors along with suggestions for ways to respond.

Illegal Behaviors

Behaviors that are illegal for one citizen are also against the law for every other citizen. It is not the job of the case management service provider to protect consumers from the consequences of their own behaviors. The motive behind criminal acts is a matter for legal authorities to determine. Please consult with your supervisor to decide if and when illegal behaviors should be reported.

Substance Use

Children and youth are often exposed to alcohol and illegal drug use through a variety of avenues (e.g., media, peers, family members, and the larger community). Talking with children, youth, and their families to inform them of the dangers of alcohol and illegal drug use is important. If children and youth have experimented with, or have developed a more serious addiction with

alcohol and/or substances, refer the child/youth to their therapist, or appropriate treatment programs to assess the situation and prescribe treatment as needed. If you have questions, refer to your supervisor and the policies and procedures for your LMHA/LSAA for support.

Threatening, Violent, or Homicidal Behavior

When someone's life or well-being is threatened, endangered, and/or violated, the case management provider should initiate several actions. First, imminent or immediate threats must be respected for what they are—a potentially dangerous situation. Immediately reduce the threat if possible by withdrawing, leaving, or removing whatever may be causing the anxiety, agitation, or fear.

Speak in a normal tone and a calming voice to the consumer. Ask for and provide verbal clarification of the situation. Avoid “trapping,” “backing someone into a corner,” or getting too close to someone if they are frightened unless it is specifically requested. Leave all exits open.

If the danger does not diminish, then physically remove yourself and others from the situation and contact your supervisor and follow your agencies policies and procedures.

Suicidal Thoughts and Behaviors

All suicide threats must be taken seriously. Consult with your supervisor and follow your agencies policy.

Crisis and Safety Planning Tools

Safety is the number one priority during these times. Case management providers should ensure that consumers are aware of the availability of 24-hour crisis services in their area and know how to access these services if/when needed. This information should be reviewed with the child and family, and with the consumer's treatment provider, on a regular basis. Two tools that may be used with proper supervision and training are the Columbia – Suicide Severity Rating Scale (C-SSRS) and the Stanley Brown Safety Plan.

Columbia – Suicide Severity Rating Scale

The C-SSRS is a semi-structured interview meant to assess possible severity and frequency of suicidal ideation and behaviors. The C-SSRS tools are used to better identify any suicidal ideation, suicidal behaviors, monitor changes from one visit to the next, and aide with referral processes when needed⁵. The training and tools can be found at: <http://www.cssrs.columbia.edu/index.html>.

Stanley Brown Safety Plan

One example of a safety plan is the Safety Planning Intervention⁶ developed by Barbara Stanley, Ph.D. and Gregory K. Brown, Ph.D. This safety plan is meant to provide individuals in need with a concrete set of strategies to help decrease the risks of suicidal behaviors. The plan includes the

⁵ Mundt, J. C. et al. (2013). Prediction of suicidal behavior in clinical research by lifetime suicidal ideation and behavior ascertained by the electronic Columbia-Suicide Severity Rating Scale. *Journal of Clinical Psychiatry*, (74), p. e1-e7.

⁶ Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, (19), p. 256-264.

following steps:

- Recognizing suicidal warning signs;
- Utilizing coping skills;
- Having personal contacts to distract from suicidal ideation;
- Using family and friends who can help with the crisis;
- Having mental health professionals/agencies to contact; and
- Means reduction.

The Safety Planning Intervention is may be used in various settings and is only one example of an effective safety planning tool. The Stanley Brown Safety Plan form is located at the following website: http://www.suicidesafetyplan.com/Home_Page.html.

Chapter VIII: Policy, Procedure and Supervision

Policy, Procedure and Supervision

There are situations a case management provider must be aware and cautious of. The LMHA/LSAA has written policy and procedure in place to inform case management providers. The LMHA/LSAA also provides supervisors who are knowledgeable about handling these difficult situations. Supervisors and case management providers meet face-to-face to assure the case management provider has adequate knowledge, skills, ability, and support to handle these and other “sticky situations” including:

- Suspected child abuse and neglect;
- Threats and assaultive behaviors;
- Suicidal thoughts and behaviors;
- Refusal of medications and/or psychotherapy;
- Alcohol and/or substance abuse;
- Illegal behaviors;
- Interagency conflicts with service plan and/or providers;
- Dual roles of the case management provider; and
- Allegations of professional misconduct.

Appendix

Family-Provider Commonly Used Terms and Philosophy

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| <p>Family-Provider Collaboration</p> | <p>Family-provider collaboration in children’s mental health services is the process that participants (including family coordinators and advocates, therapist, administrators, social workers, and case management providers) in systems of care engage in to improve services for children and their families, and requires:</p> <ul style="list-style-type: none"> • Ongoing dialogue on vision and goals; • Attention to how power is shared; • Attention to how responsibilities in planning and decision making are distributed; • Open and honest two-way communication and sharing of information; and • That all participants are seen as mutually respected equals. <p>Collaboration efforts must occur at all levels.</p> |
| <p>System of Care Values and Principals</p> | <p>A comprehensive spectrum of mental health and other support services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances (SED) and their families.</p> |
| <p>Promising Practices in Family-Provider Collaboration</p> | <p>A practice, strategy, or approach that: leads to improved collaboration among family members and providers and ultimately supports family-centered services and improved outcomes for children.</p> |
| <p>Family Advocate Family Member</p> | <p>An individual who is a primary stakeholder in the well-being of children and actively works to improve the delivery of mental health services, and/or to change the mental health service delivery system so that it is family-centered. A primary caregiver or adult (e.g., parents, aunts, uncles, etc.) with substantial and ongoing involvement in the life of a child who have emotional, behavioral, or mental disorders.</p> |
| <p>Family-Centered</p> | <p>A system of care value and principle which:</p> <ul style="list-style-type: none"> • Supports all family members involved with the child’s care • Involves all family members in all aspects of planning and evaluating the service delivery system (including services for themselves and the services for their families). |

Youth Involvement Commonly Used Term and Philosophy

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| <p>Youth Involvement</p> | <p>Systems of care are beginning to recognize the value of incorporating a “youth development” approach: engaging youth as partners in program design and implementation, affirming, and drawing on the strength of youth, and involving youth in service delivery.</p> |
| <p>Youth Transitioning to Adulthood</p> | <p>Adolescence is a time of transition, and many youth experience difficulty adjusting to new emotional, social, and biological challenges and demands. The transition from youth to adulthood is often extremely difficult for young people with emotional and behavioral challenges, and for their families or other caregivers. At least 1 in 15 young people in the United States has a SED; but they are the most underserved population by both public and private resources.</p> |
| <p>Transition to Independence Process (TIP) System Guidelines</p> | <ul style="list-style-type: none"> • Person-centered planning is driven by the young person’s interests, strengths, and cultural and familiar values. • Services and supports must be tailored for each youth individually and must encompass all transition domains. • Services and supports need to be coordinated to provide continuity from the young person’s perspective. • An unconditional safety net of support is provided by the young person’s transition team. • Achieving greater independence requires the enhancement of the young person’s competencies. • The TIP system must be outcome driven. |
| <p>Case Managing Day-to-Day</p> | <p>A case management provider brings a ‘unifying’ element to multiple services that may be needed including: monitoring medications, transportation, personal money management, personal hygiene, medical and dental care, and employment training opportunities.</p> |
| <p>Medication Management</p> | <p>As part of the mental health team, a case management provider needs to have a general understanding of the purposes of medication and its effects so they may support the medical aspects of the treatment plan. This may involve discussing uncomfortable side effects with the youth, requesting an unscheduled appointment with the physician, or helping the young person to get prescriptions filled.</p> |
| <p>Personal Money Management</p> | <p>Often a crucial area of case management is helping the young person budget his or her financial resources. Some young people will require a Protective Payee to manage their money. The case management provider may be assigned this task.</p> |

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| Personal Money Management (Cont.) | <p>Here are some additional guidelines if this is the situation:</p> <ul style="list-style-type: none"> • Know your agency policies and procedures about a Protective Payee. • Know the rules and regulations from Social Security about a Protective Payee. • Continuously review the need for Protective Payee. Encourage them to manage their own money as soon as possible. |
| Transportation | <p>Often one of the duties of a case manager will be to transport young people.</p> <ul style="list-style-type: none"> • If you are <i>not</i> able to drive agency vehicles, you may want to check with your own personal insurance company about coverage. You may also want to check with your own personal insurance company about coverage as a driver using an agency vehicle. • Know and follow your agency policies about transporting young people. Discuss these policies with your supervisor. • Do not transport young people alone whom you believe are unstable or unpredictable. • Encourage young people to explore other means of transportation. |
| Hygiene and Grooming | <p>Adequate hygiene and grooming may be problems for young people. Case management providers must carefully assess the possible origins and remedies for these problems. What are some of the reasons behind these problems?</p> |
| Medical and Dental Care | <p>Adequate, timely medical and dental care may be a problem for young people. The case management provider needs to know or find out what medical and dental care can be obtained for each individual young person and from where.</p> |
| Basic Approaches to Vocational Rehabilitation of Youth | <p>Two basic approaches to helping young people engage in working:</p> <ul style="list-style-type: none"> • Adjustment of Disability – This approach adjusts the tasks, length of work time, and compensation to an individual’s presumed capacity for the demands of work. • Adjustment to the Job – The requirements of the anticipated job determine the behavior of the employee. |
| Assistance with Employment Problems | <p>In Utah, you may contact your nearest office of the Utah State Office of Rehabilitation (USOR). They may help with work assessment and training.</p> |

CASE MANAGER PROVIDING BILLABLE “TARGETED CASE MANAGEMENT”

| Service: ASSESSING, LINKING AND MONITORING all related to accessing services for the identified NEEDS. | Billing code | Deliverable paperwork | EMR entry | Scanned into attachments | Family binder | Copy for family |
|--|---|--|--------------|--------------------------------|------------------|-----------------------|
| Going over the Acuity Needs Assessment with the family | TCM: Assessing | Acuity scale Progress note: referencing the scanned Acuity scale. | X | X | | |
| Writing the TCM service plan based on the information in the ANA | TCM: Assessing | Service plan: Progress note: referencing the Service Plan or pasting the Service plan in the note. | | | | |
| Face to face or Telephone calls to get information= Linking and possibly Referring. Examples: Housing, CHIP, Aquatic center, HEAT, WeeCare, Midtown, IHC, Food bank, NAMI, CHADD, AA, WIC, Headstart, Early intervention, Center for Grieving, Family Law center, Disability law center, DSPD, Safe Harbor, Legal Aid, Family Connection center, | TCM: Linking/Referring the family to services for identified needs. | Progress note. | X | | | |
| Face to face or telephone calls to check on follow through of agency or family for services= Monitoring. Examples: Housing, CHIP, Aquatic center, HEAT, WeeCare, Midtown, IHC, Food bank, NAMI, CHADD, AA, WIC, Headstart, Early intervention, Center for Grieving, Family Law center, Disability law center, | TCM: Monitoring and follow up to: Ensure the TCM service plan is effectively implemented and adequately addressing the needs. To see if there are changes in the needs or status of the client, need for adjustment in the plan and service | Progress note. | | | | |

| | | | | | | |
|--|--|-----------------------|--|--|--|--|
| DSPD, Safe Harbor, Legal Aid, Family Connection center, | arrangements. | | | | | |
| (With ROI in place) Talking face to face or telephone to grandma, teacher, neighbor, bishop, pastor, to identify child and family needs. | TCM: Assessing to determine service needs. | Progress note. | | | | |

CASE MANAGER PROVIDING INDIVIDUAL SKILL DEVELOPMENT, PERSONAL SERVICES, RESPITE.

| Service: Individual Skill Development: Techniques of <i>cueing, modeling and role modeling for appropriate life skills</i> | Purpose: | Billing code | Deliverable paperwork | EMR entry | Scanned in attachment |
|---|--|------------------------------|-----------------------|-----------|-----------------------|
| Introducing a BEHAVIOR chart to the CHILD and family. CHORE chart. REWARD system. | ~To decrease the negative routines at home and develop effective behaviors; ~OR to develop appropriate interactions at home. ~OR: To regain or improve basic living skills so that Jem can remain at home rather than the consideration of a more restrictive environment. Same as above | Individual skill development | Progress note | X | |
| Introducing a BEHAVIOR plan (CHORE CHART ETC) with the parent only. | | Individual skill dev. | Progress note | X | |
| Organizing child's room WITH the child or parent/family. | ~Cueing and role modeling for basic living skills. ~Role modeling for Jem to experience the feeling of accomplishment so that he will be motivated for further successful behavior changes at home. | Individual skill development | Progress note | X | |
| Transporting client or family to get groceries/school supplies. | To assist with the instrumental activities of daily living to live successfully in the community. | Personal services | Progress note | X | |
| Helping client put ad in the newspaper. | | | Progress note | X | |
| Help client rearrange bedroom so that each child can have his own space. | | | Progress note | X | |
| Apartment hunting | | | Progress note | X | |
| Service: Individual Skill Development: Techniques of | Purpose: | Billing code | Deliverable paperwork | EMR entry | Scanned in attachment |

| <i>cueing, modeling and role modeling for appropriate life skills</i> | | | | | |
|--|---|-------------------|---------------|---|--|
| Assisting with a budget | To assist with the instrumental activities of daily living to live successfully in the community. | Personal services | Progress note | X | |
| Helping cook a meal | | | Progress note | X | |
| Help a client to move | | | Progress note | X | |
| Shopping with a client or family member | | | Progress note | X | |
| Directly assisting with personal care. Teaching hygiene. | | | Progress note | X | |
| Recreational activity | For temporary relief from the stresses related to Jem's SED and behavior. | RESPITE | Progress note | X | |
| | To allow time for mom to spend with Jem's brother Dill. | RESPITE | Progress note | X | |
| | To avoid parent burn out from the stress related to Jem's SED and behaviors. | RESPITE | Progress note | X | |
| Supervision of child or siblings at their home. (Child care) | Same as above | RESPITE | Progress note | X | |

These services are aimed at maximizing the client's social and behavioral skills in order to prevent the need for more restrictive levels of care. (1) Eliminating or reducing symptomatology related to their diagnosis. (2) Increase medication compliance. (3) avoid psychiatric hospitalizations (4) eliminate or reduce maladaptive or hazardous behaviors and develop effective behaviors; (5) improve personal motivation and enhance self-esteem (6) develop appropriate communication and social and personal interactions (7) regain or enhance the basic living skills for living in the least restrictive environment possible.