

TRAINING MANUAL FOR CASE MANAGEMENT CERTIFICATION

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

FOURTH EDITION

UPDATED & APPROVED

June 2019

TABLE OF CONTENTS

I. INTRODUCTION	1
Why A Case Management Training Manual?	1
What is Case Management?.....	1
Qualified Providers of Case Management Services.....	2
Case Management Training Curriculum.....	2
II. WHO IS ELIGIBLE FOR CASE MANAGEMENT SERVICES	3
Impact of Mental Illness and Substance Use Disorder	3
III. THE CASE MANAGEMENT PROCESS	4
Critical Functions.....	4
The Professional Relationship	6
The Needs Assessment	9
Conducting a Needs Assessment	9
The Assessment Discussion.....	10
The Service Plan	12
Implementing the Service Plan.....	13
Monitoring the Service Plan	14
Public Entitlement Programs	17
Federally Administered Entitlement Programs.....	17
State of Utah Entitlement Programs through the Department of Workforce Services	18
IV. Description of the Levels of Case Management and Caseload Size	19
Description of the Three Levels of Case Management.....	20

V. OTHER CHALLENGES	24
Crisis Intervention	24
Problem Behaviors That May Precipitate a Crisis	24
Illegal Behaviors	24
Alcohol and Street Drug Use	24
Threatening, Violent, or Homicidal Behavior	25
Suicidal Thoughts and Behaviors	25
VI. TAKING CARE OF YOURSELF	26
Time Management	26
Stress Management	27
Recognize the stages of burnout.	27
VII. GLOSSARY.....	28

ACKNOWLEDGEMENTS

These Guidelines have been developed by: The Utah Preferred Practice Consensus Panel under the auspices of the Utah Department of Human Services/Division of Substance Abuse and Mental Health (DHS/DSAMH), the Utah Behavioral Health Care Committee, the State Homeless Coordinating Committee and the Utah Department of Workforce Services/Housing and Community Development Division (DWS/HCDD)

Initial Adoption December 1998

Revised December 2003

2nd Revision January 2012

3rd Revision September 2017

4th Revision June 2019

I. INTRODUCTION

Why a Case Management Training Manual?

This guidebook was written to help prepare you for one of the most important jobs in community behavioral health and homeless services. This training manual will be a study guide as you prepare to take the formal examination required by the Division of Substance Abuse and Mental Health to become certified as a provider of case management services. It will also be a resource manual for you during your training and throughout your career.

This training manual is a companion in your work. Like any new textbook or course of study, this field guide should be considered one of your resources. Providers of case management (hereafter referred to as CM) must also be familiar with the Utah Medicaid's Targeted Case Management Provider Manual(s) and understand how targeted case management services differ from other behavioral health and homeless services such as psychosocial rehabilitative services and personal services.

What is Case Management?

In Utah, the Local Mental Health Authorities are responsible to provide or contract for case management in their local areas as defined by the State of Utah Administrative Code. Homeless service providers are responsible to provide Case Management services to eligible individuals that present at their agency. CMs should be familiar with the State of Utah's Division of Substance Abuse and Mental Health Program Standards, R523-7-4 and the State of Utah's scope of Medicaid-covered mental health services outlined in the Utah Medicaid Provider Manual for Mental Health Centers/Prepaid Mental Health Plans, and the Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness.

Case management services help individuals access needed medical healthcare, behavioral healthcare, basic needs, housing, educational, social, and other services. CMs assess individual needs and develop a service plan designed to help the individual obtain access to a coordinated array of services and to facilitate the achievement of goals. Providers of case management services provide the energy and organization to see that the case management service plan results in real benefits to individuals. Case management services can be provided by one person or a team of providers. The overall goal of case management services is to help individuals to access needed services, and ensure that services are coordinated among all agencies and providers. Case management is usually done in the community as opposed to an office setting. The frequency of contact may be more intensive or less intensive based on the individual's needs.

Individuals that experience homelessness are also eligible for case management services. In this document when referring to the person receiving case management services, the term "individual experiencing homelessness", is defined as: literally homeless persons, those at risk of

homelessness and formerly homeless persons who are housed through homeless programs. Individuals receiving behavioral health and homeless services have the ability to live as productively as possible and to receive the treatment they need with a minimum of interference and a maximum of support. A well-conceived recovery/treatment plan, case management needs assessment, and service plan will match the individual's strengths and needs to specific community resources. For many individuals in Utah, access to behavioral health and homeless case management services can make the difference between isolation and productive community connections.

Qualified Providers of Case Management Services

Qualified Providers of case management services are:

- Licensed behavioral health professional practicing within the scope of their license in accordance with Title 58 of the Utah Code and the Utah Medicaid Provider Manual.
- A non-licensed individual who does not meet the qualifications above under the supervision of a licensed mental health therapist identified in #1. A CM that fits this definition is eligible to bill Medicaid for Targeted Case Management Services.
- A non-licensed individual who will not bill Medicaid for their case management services and does not meet the qualifications above under the supervision of a person who meets one of the following:
 - a Bachelor's Degree in human services or a related field and two years of experience in human services;
 - an Associate's Degree in human services or a related field and three years of experience in human services; or
 - five years of experience in human services.

Supervision of case management providers must be delivered in accordance with the requirements set forth in Title 58 of the Utah Code, and the applicable profession's practice act rule as set forth by the Utah Code.

Case Management Training Curriculum

To meet the State Division of Substance Abuse and Mental Health's (DSAMH) training standards, all non-licensed individuals will be required to:

- Successfully pass a written examination which tests basic knowledge, attitudes, ethics, and case management skills;
- Successfully complete a case management practicum; and
- Successfully complete all requirements outlined in R523-7-4.

II. WHO IS ELIGIBLE TO RECEIVE CASE MANAGEMENT SERVICES?

Any individual with a behavioral health disorder and/or experiencing homelessness may be eligible for case management services. Targeted case management services are contracted through a Local Authority and provided when there is a Serious Mental Illness (SMI), Severe Emotional Disturbance (SED), and/or a Substance Use Disorder (SUD) present.

Targeted case management services must be medically necessary and are eligible for Medicaid billing. Targeted case management services are considered medically necessary when a targeted case management needs assessment documents that the individual requires treatment and there is a reasonable indication that the individuals will only access the needed treatment if assisted by a qualified CM. Treatment services may come from a variety of agencies and providers to meet the documented medical, social, educational and other needs identified in the case management needs assessment.

Individuals experiencing homelessness who have a mental illness, substance use, and/or a possible co-occurring disorder do not require a diagnosis to receive case management services. Case management services for people experiencing homelessness are provided in the community and at local homeless resource centers/shelters. The preferred practice guidelines for homeless service providers can be found on the Department of Workforce Services website at: jobs.utah.gov

Whether or not a CM provides services to people experiencing homelessness, CMs should be familiar with and trained on the Service Prioritization Decision Assistance Tool (SPDAT). The SPDAT tool helps determine the acuity of individuals experiencing homelessness. Homeless service providing communities statewide use the SPDAT to help identify the needs of an individual, determine eligibility for specific programs, and prioritize available housing units.

OrgCode, the agency that developed the SPDAT tool, briefly describes it as, “The SPDAT helps identify who should be recommended for each housing and support intervention, moving the discussion from simply who is eligible for a service intervention to who is eligible and in greatest need of that intervention. While the SPDAT is an assessment tool, the VI-SPDAT is a survey that anyone could complete to help prioritize clients.” For more information on the SPDAT tools, please go to www.orgcode.com

Impact of Mental Illness and Substance Use Disorders

Individuals are generally referred for case management services because mental illness, substance use disorders, and/or homelessness has caused significant disruptive episodes in their life. Their symptoms may have led to one or more hospitalizations, incarceration, homelessness, or may have affected their ability to manage aspects of their life independently. They may require ongoing treatment with psychotropic medications and or substance use medications.

This is referred to as medication assisted treatment (MAT) or Opioid Maintenance Therapy (OMT).

One important function of case management services is providing sufficient monitoring and support of a person's recovery. Through careful monitoring the CM can help the individual access appropriate treatment and services as early as possible and hopefully prevent the episode from becoming so severe that a higher level of care such as residential treatment or hospitalization is needed. It is important that the CM be able to recognize symptoms and report the symptoms to their supervisor and/or the individual's clinician/service provider. However, it is important to remember that CMs do not diagnose.

It is also important to remember that individuals with behavioral health disorders are not symptomatic all the time. If not entirely symptom free, they may have fewer symptoms or be able to manage them in such a way that it does not cause personal distress or a significant disruption in their daily life. Consequently, they may be able to access needed services more independently. The intensity, frequency and duration of targeted case management services may vary as a result.

Providers of case management services are often in a unique position to assist the individual with recognizing early signs that show the individual is showing an increase in symptoms. Therefore, it is important to have some awareness of and knowledge about the various types of behavioral health disorders and systems. For specific questions, it is important to always consult with your supervisor and/or the individual's clinician/service providers.

III. THE CASE MANAGEMENT PROCESS

Critical Functions

Case management can be thought of as filling eight critical functions. These functions are summarized below.

1. Building Rapport

- An integral part of all case management activities is building rapport with the individuals you serve. This can be done by:
 - Developing a supportive relationship with the individuals;
 - Maintaining regular contact with individuals, depending upon individual needs and wherever they reside, i.e., hospital, jail, independent apartment, etc; and
 - Providing case management services to individuals on a continuous basis for as long as medically or clinically necessary.

2. Assessing and Developing a Formal Case Management Needs Assessment

- This is done by assessing the need for any medical (including behavioral health and homeless), educational, social, or other services.

- Assessment activities include:
 - Taking individual history;
 - Identifying the needs with the individual (Needs Assessment);
 - Identifying individual strengths and preferences; and
 - Gathering information from other sources such as family members, medical providers, behavioral health and homeless professionals, other providers, and educators, as available.
3. Planning and Development of a Formal Service Plan
- This is typically done by developing a written, individualized, case management service plan with the individual, based on the information collected through the needs assessment.
 - Setting specific goals related to filling those needs through available resources.
4. Coordination
- Coordination is essential to positive outcomes. In most settings, the CM is responsible to coordinate multiple services and help streamline access to services.
 - The CM should be knowledgeable about the individual's medical providers, medical needs, and other community supports. These resources could be public and private treatment providers, advocacy and self-help groups, low-income housing, employment and training programs, financial benefits and other services.
5. Linking/Assisting Individuals to Access Needed Services
- This involves linking the individuals or family members to:
 - Needed health care services as well as regularly scheduled physical examinations
 - Behavioral health and homeless social services programs
 - Appropriate treatment programs within community
 - Educational programs, employment training and/or work opportunities
 - All benefits for which they are eligible
 - The National Alliance on Mental Illness (NAMI) Utah Chapter, Utah Support Advocates for Recovery Awareness (USARA), Latino Behavioral Health Services (LBHS), Al-Anon, local affiliates and/or family support groups
 - Assisting individuals to:
 - Develop a range of social and natural supports in the community, i.e., community support groups, family, connect with peers and other supports
 - Obtain a satisfactory living situation, including basic living needs
 - Obtain referrals and related activities, including scheduling appointments
6. Monitoring
- Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the case management service plan is effectively implemented and adequately

addresses the needs of the individual (i.e. drug testing results, medication management, etc.)

- Monitoring the individual's progress and continued need for services

7. Documenting

- It is extremely important the provider accurately and carefully documents the services provided to an individual. Providers of targeted case management services must follow the documentation requirements outlined in the Utah Medicaid Provider Manual.
- The targeted case manager (TCM) must also follow the rules in Utah Medicaid Provider Manual for determining the amount of time spent in a day providing targeted case management to an individual. The TCM provider is responsible to ensure amounts of time billed to Medicaid are accurate and fully documented in accordance with Medicaid requirements.

8. Advocating

- Providers of case management services should intercede with and on behalf of the person to ensure access to timely and appropriate services.

The Professional Relationship

A primary factor in providing case management services is the development and maintenance of a professional 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 CM does not attempt to change or judge the individual's beliefs, values or emotions, but works with the individual to access needed services. The CM can help the individual increase skills, gain improved attitudes, and expand the individual's horizons. CMs attempt to bring about solutions to barriers that individuals experience including discrimination or actions that impose on their civil rights. The CM develops a network of community supports for advocacy. Community supports or natural supports are resourceful, caring, and responsible individuals who are committed to the growth and development of the individual. Often these natural supports are family members, friends, neighbors, and community agency personnel. A strong partnership, when it is conscientiously pursued, can assist individuals to succeed in their recovery. The case management relationship, like any other, thrives on consistency, openness, honesty and the careful building of trust.

Familiarity with Trauma Informed Care (TIC) can help with developing a strong partnership. The Substance Abuse and Mental Health Services Administration's (SAMHSA) six key principles of a Trauma Informed Approach are as follows:

- Safety
- Trustworthiness and Transparency
- Peer support
- Collaboration and mutuality

- Empowerment, voice and choice
- Cultural, Historical, and Gender Issues

TIC creates a safe and proactive environment for an individual to grow and recover.

A variety of factors can make development of the professional relationship especially difficult. Sometimes individuals find it difficult to develop this kind of relationship due to the nature of their situation and history of difficulty accessing agencies and institutions. Other obstacles may include housing issues, lack of transportation, and communication problems that prevent anything other than occasional or irregular contacts.

Individuals experiencing symptoms of their mental health or substance use disorder may have trouble separating what is real from what is not real as a result of delusions or hallucinations. These factors can mean that the individual may not accurately interpret their environment and may not know the socially appropriate behaviors that go along with the situation. The CM, parents, and friends can confirm what is real. Individuals may need assistance to understand accurate information about their world. This is especially true for individuals who may hear "voices" competing for attention with real voices and perceptions from the outside world. The CM should consistently provide clear and accurate communications to the individual about what is going on in the environment.

Another important aspect of consistency and reality testing in the case management relationship is that of setting limits and boundaries. It is important that these limits and boundaries be established between the individual and the CM. Some limits originate with the agency's policy and Code of Conduct, Ethical guidelines, and the Department of Human Services Provider Code of Conduct and Division of Occupational and Professional Licensing. These should be studied and understood by each provider. Supervisors and other staff members should be sought out by the provider for appropriate supervision and consultation in establishing and setting appropriate boundaries. See the Utah Department of Human Services Provider Code of Conduct <https://rules.utah.gov/publicat/code/r495/r495-876.htm>.

If CMs should have any reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation they shall immediately notify the nearest peace officer, law enforcement agency, or Adult Protective Services intake worker within the Department of Human Services, Division of Aging and Adult Services. In order to address these situations appropriately, CMs should be familiar with the Utah Code 76-5-111.1.

The case management approach to helping people is anchored in the following values:

- The work of case management focuses on individual strengths and needs using Trauma Informed principles.
- The work of case management is based upon the principle of individual self-determination
- Outreach to the individual is the preferred method of case management
- The community is the primary resource for attaining the goals of the individual

One of the strengths of a CM is the ability to see individuals as people, not "cases". A CM values the individual's skills, abilities, hopes and dreams, and recognizes they may have barriers that prevent them from reaching some of their goals. The CM's job is to help them overcome and adjust to those barriers so that they can meet their goals and live as independently as possible.

When the focus is on abilities rather than disabilities, then the individual is strengthened. The CM must be aware of the danger of confusing their goals with those of the individual. If this happens, the CM and the individual will likely become frustrated and disappointed. Providers of case management services do not impose their values and do not restrict the individual's right to self-determination.

An important concept in the field of behavioral health and serving individuals experiencing homelessness is the idea that people can recover. Guiding principles of recovery include hope, empowerment, meaningful roles in life, and personal responsibility. The individual is able to maintain or regain social roles and activities within their community. It is essential that providers of case management services have an understanding and support these principles of recovery. Recovery often depends on the individual finding someone who believes in them. CMs can be an important part of an individual's recovery capital. SAMHSA explains recovery capital as, "internal and external resources (at personal, family and community levels) that can be mobilized to initiate and sustain long-term recovery." When a CM is able to take that type of supportive and encouraging role with an individual, it is empowering and can be instrumental in that individual's success.

Key Concepts in Recovery

- Hope – Individuals need to feel they can recover.
- Personal Responsibility – Individuals need to feel they can control their own lives and take responsibility for their own care.
- Education – Individuals need information about their illness and treatment options.
- Self-Advocacy – Individuals need support from others, including: family, peers, professionals, and the community.

Recovery is defined by SAMHSA as, "A process of change through which individuals work to improve their own health and wellness, live a self-directed life, and strive to achieve their full potential."

Through the Recovery Support Strategic Initiative, SAMHSA has identified four major dimensions that are essential to a life in recovery:

- Health: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
- Home: a stable and safe place to live;
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and

- Community: relationships and social networks that provide support, friendship, love, and hope

The Needs Assessment

The CM should assess the individual to determine service needs, such as medical, educational, social, or other services. Activities include: taking the individual's history, identifying the needs of the individual and completing related documentation, gathering information from other sources such as family members, medical providers, social workers, other providers and educators, to develop a case management needs assessment.

The Daily Living Assessment (DLA-20) is perhaps the most commonly used needs assessment at Utah's Local Mental Health Authorities. Service plans such as the DLA-20 allow CMs to use hard data examine an individual's progress or lack of progress and to partner with the individual towards recovery. Other examples of service plans include: the SPDAT, VI-SPDAT, American Society of Addiction Medicine (ASAM) Assessment, among others.

The needs assessment documents whether an individual needs assistance in obtaining services from a variety of agencies and providers to meet their documented needs. Once this needs assessment is completed, the CM develops a service plan that outlines short and long-term goals and the objectives that must be taken to achieve those goals.

Conducting a Needs Assessment

There are several areas the CM should assess and document in the Case Management Needs Assessment (CMNA). Formal Needs Assessment tools are available, such as the Daily Living Activities-20 (DLA-20), to ensure that the assessment is systematic and thorough. Individuals are active participants in the CMNA. The CMNA should take into account the behavioral health and/or homeless services being provided through the individual's Recovery/Treatment plan completed by the licensed behavioral health and/or homeless professional. The CMNA identifies assets, strengths, and capacities of individuals to help them maintain a sense of identity, dignity and self-esteem. The assessment procedure should be natural and flexible. Some important principles that apply to all assessment areas are:

- Start with active listening and allow individuals to express their needs and desires.
- A relationship is built on mutual respect and having open and honest conversations.
- Focus on strengths.
- Select a comfortable environment for the needs assessment.
- All of the needs areas should be addressed and prioritized, as per the individual's ability to participate.
- Ask open-ended questions.
- Involve family members and other significant social resources and natural supports in the assessment and case management process, with the individual's signed authorization.

Introduction, Exploration, and Engagement: In this initial phase, the CM will introduce themselves to the individual. They will explain the case management process and the goals of this service. The CM will begin to assess the individual'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 individual choice. Individuals 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 CM and must not be used as an "excuse" for under-serving.

The individual is the expert about their own unique strengths, interests, and aspirations. Providers of case management services can positively influence engagement by fostering hope and belief in the individual receiving services. The Needs Assessment should recognize individual's natural supports. This principle allows the individual 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 individual. In this process the CM may respond to the information presented by the individual by restating what they have heard the individual say. The CM should encourage individuals 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."

The Assessment Discussion

The CM responds to the individual by moving in whatever sequence is natural throughout the discussion. It could begin with living arrangements and then move to finances. There is no prescribed sequence in gathering the information. The responses of the individual are used to determine their level of need in the Needs Assessment. It is important to collect and record details regarding individual responses.

An assessment of the individual's situation and circumstances may include but is not limited to:

- Wellness (Medical, psychiatric, substance use)
- Housing/homelessness
- Vocational/educational and productivity
- Family/social support
- Benefits/financial resources
- Leisure/recreational activities
- Legal
- Communication
- Safety
- Time management
- Problem solving
- Tobacco use

- Community resources
- Coping skills (safe and unsafe)
- Instrumental activities of daily living (preparing meals, managing money, shopping, housework, laundry and using a phone)
- Activities of daily living skills (eating, bathing, dressing, toileting, and transferring)

A case management needs assessment of each area is based upon:

- Social history
- Individual's current circumstances
- Stated personal goals
- Internal and external resources
- Priority of needs
- Information from others including family, friends, service providers with individual release of information

The following may help guide the needs assessment process when meeting with the individual:

- Asking what kinds of experiences the individual has had in receiving community and other services up to this time;
- Asking what services are most important now for the individual;
- Reviewing the behavioral health and/or Recovery/Treatment plan
- Asking what resources could help the individual make the desired changes;
- Asking what strengthens or experiences the individual can use to meet the desired goals;
- Asking what steps the individual needs to take to make the changes
- The needs assessment is an ongoing working document and is to be updated when the individual's status is altered, goals change, or new services and resources are needed. Since a needs assessment is ongoing, the CM may stop the needs assessment process at any point to:
 - Respond to an individual's restlessness or unwillingness to continue;
 - Start the prioritization of needs to move into the development of a service plan;
 - Set a continuation date/time to gather further information prior to developing service plan.

After completing the needs assessment, the individual and CM work together to identify which areas should be chosen as priorities for goal setting. Typically these are based primarily on critical survival needs (food, shelter, clothing, medical, and behavioral health and homeless care) and then less critical needs. Once the needs have been prioritized, the individual and CM are ready to develop a service plan to accomplish one or more of the goals.

The Service Plan

Once a needs assessment is completed, the individual's identified goals are recorded in a service plan.

A service plan is a set of action steps designed to achieve one or more of the individual's goals as stated during the needs assessment. It is a plan that contains:

- Measurable short term goals or action steps
- Long term goals
- Parameters of service delivery
- Review date
- Signatures or other indications that show participation of the individual, the CM, and supervisor, if needed.

The Role of the Provider of Case Management Services in Designing a Service Plan:

The role of the CM is to assist the individual to prioritize their needs, establish a goal statement(s) from their needs assessment, identify the necessary action steps to accomplish the goal(s), and to design a plan that will support the individual's progress. Throughout this process the CM educates and reinforces the individual's right and responsibility to identify and make choices.

Each goal must be broken down into a set of action steps. These steps are listed along with whom, how, and when the step will be accomplished. The art of designing a service plan is to develop the sequential steps to help the individual obtain their goals. The following is a checklist for writing quality action steps:

- Are the action steps stated in positive terms?
- Are the action steps realistic, measurable and achievable?
- Are the action steps observable and behavioral?
- Are the action steps stated in specific terms-not global terms?
- Are the action steps individually-oriented?
- Is the initial action step short term with a high probability of success?
- Are the action steps set in sequential order and serve to accomplish the goal?
- Are the number of action steps appropriate to set a direction for the individual?

Once the service plan has been developed the plan needs to be reviewed, approved and signed by a supervisor. The CM and the individual begin the process of implementing the plan. The CM should expect that the service plan will need to be changed and revised from time to time. The CM must formally review the service plan (and update as needed) at least every one hundred and eighty days.

Implementing the Service Plan:

The next step is implementation. The CM will offer both practical support and encouragement throughout this process. The ultimate attainment of individual-based goals rests with the individual, but the CM is critical in helping to overcome barriers to the individual's progress.

Growth and movement are supported by helping an individual attain goals by reviewing goals and being sensitive in offering assistance. The CM's job is to help in a way that strengthens the individual and helps them to become independent. Active outreach to the individual is a cornerstone of case management. The CM should maintain contact with the individual whether or not the individual is in crisis, acute care, or hospitalization.

While it may seem basic, effective coordination is critical to positive outcomes. The CM is responsible to work with the individual and coordinate all needed services, as required on the service plan. The CM coordinates multiple services in such a way that they are not duplicative, nor do they conflict with one another. Coordination with behavioral health, homeless service providers, primary care providers and other service providers can make the critical difference between positive and negative outcomes. CMs must establish a strong collaborative partnership between the individual and other service providers.

The CM must be familiar with the services, resources, and key contact persons within service providers/agencies, because a crucial task of the CM is linking individuals with services and resources.

It will be helpful for the CM to view behavioral health and homeless services on a continuum. The continuum allows an individual to receive services according to their need. If the individual's acuity level is low, they may only need a referral to outpatient services. However, if their acuity level is high, they may need to be referred to more intensive services such as residential support.

The CM must be familiar with the behavioral health and homeless service continuum. The following are the key categories of services:

- Emergency Services
- Inpatient Hospitalization:
 - State institutions
 - Nursing facilities
- Residential Services
- Outpatient services
- Supported Housing and In Home Skills Housing Services
- Permanent supportive housing
- Rapid rehousing
- Sober living homes

Monitoring the Service Plan

Monitoring involves active observation of the service plan to make sure it is being properly implemented and continues to fit the needs of the individual. Monitoring also involves consistent help identifying problems, modifying plans, ensuring the individual has resources to complete goals, and in some cases, monitoring treatment participation of the individual. For example, the CM may identify the need for additional medication management services, housing issues, or a change in service needs.

Case management includes monitoring and follow-up activities, including activities and contacts that are necessary to ensure the case management service plan is effectively implemented and adequately addresses the needs of the individual. These activities may be with the individual, family members, providers or other entities, and conducted as frequently as necessary to help determine: whether services are being furnished in accordance with the individual's case management service plan, whether the services in the case management service plan are adequate, and whether there are changes in the needs or status of the individual. If the needs of the individual change, the CM and the individual will make necessary adjustments in the service plan. The CM will continue to monitor the individual's progress. When the CM is monitoring an individual's progress towards meeting the service plan goals, they will be attempting to answer these questions:

- Is the individual getting the services established by the service plan?
- Are the services provided in such a way that benefits the individual?
- Are the services provided to the individual meeting the objectives of the service plan?
- Are the plan's objectives appropriate to the individual's current needs, skills, and abilities?
- Will meeting the plan's interventions give the individual the ability to live in the community?
- Does the individual need additional services or intervention to be able to continue making progress?

The above questions point to the effectiveness of the service plan. The answers to the questions will lead to the next action. If the current service plan is not helping the individual, a revised assessment and service plan may be in order.

Case management is a fluid activity; providers of case management services are community bound – not office-based. To monitor service delivery, the CM must actively watch, listen and interact with both the individual and all the treatment/service providers.

It is difficult to anticipate all the service needs that might be encountered in case management work but certain issues seem to arise frequently. These include: monitoring medications, behavioral health and homelessness, transportation, money management, hygiene, wellness, medical care, dental care, housing, education, and employment. The individual's Case Management Needs Assessment should assess their strengths, interests, skills and abilities. Services should be identified as goals/objectives in the Case Management Service Plan. Below are some examples of the most common service needs.

For many individuals, medication management may be essential to help alleviate and/or prevent the recurrence of symptoms of mental illness. These medications work to stabilize functioning and help control symptoms.

Many individuals view medications as a benefit and as a necessary part of treatment, and actively engage with their prescriber. Other individuals may not see the benefits of medication.

Medications used to treat mental illness may help individuals in their recovery by stabilizing symptoms which empowers them to live independently in the community and attain their goals.

The role of the CM may include monitoring and supporting an individual in their medication treatment. The decision to use medications is carefully considered between the individual and the prescriber. The CM can be supportive in that decision. The CMs may collaborate with the individual and the prescriber to communicate any of the individual's concerns and/or observations with medications, and may discuss the need for medication, its effects and possible side effects with each individual. This responsibility may also include requesting a routine appointment or an urgent appointment with the prescriber and helping the individual fill prescriptions. The prescriber, and not the CM, is responsible for the assessment, prescription and monitoring of psychiatric medicine when prescribed for individuals.

CMs should also be familiar with Naloxone, or Narcan. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "Naloxone is a medication approved by the Food and Drug Administration (FDA) to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection." More information and training on the use of Naloxone kits can be found at <http://www.utahnaloxone.org/>

A basic knowledge of psychiatric medicines and their proposed benefits and possible side effects will help the CM monitor the individual's behavioral health status. Providers of case management services should consult with their supervisor, the prescriber and other treatment team members.

One of your duties may be to transport individuals. Some points to keep in mind are:

- Know and follow your agency policies about transporting individuals. Discuss these policies with your supervisor.
- Transportation by itself is not billable to Medicaid. In order to bill Medicaid for transportation, a billable service must be concurrently provided.
- If you are able to drive personal vehicles for case management, check with your agency and your own personal insurance company to ensure proper coverage.
- DO NOT transport individuals alone when their behaviors appear unstable or unpredictable.

Providers of case management services must carefully assess hygiene needs being careful to not push their own values on individuals. A nonjudgmental and thoughtful assessment of the

possible reasons for poor hygiene and grooming should be made. Hygiene and grooming issues may be the result of financial barriers, or symptoms of medical or behavioral health needs and/or homelessness.

Adequate, timely medical and dental care may be a problem for individuals. Providers of case management services should be familiar with what medical and dental care can be obtained for the individual. For individuals with Medicaid and/or other insurance benefits, the CM must understand the details of the plan the individual is on and whether they are enrolled in a physical health plan for their medical care. For individuals who do not have insurance, sometimes low-cost or no-cost services can be obtained from local professionals or service organizations.

The CM must ensure that an authorization to release information is signed by the individual before approaching and including family members or other natural supports. Natural supports may know the individual's history of mental and physical health problems, the treatments that have been received, and the responses to treatment. They can be a resource in managing the needs of the individual, and are encouraged to work with the individual and treatment team, when it is appropriate.

Education may be suitable for individuals. Providers of case management should assess an individual's desire to reach educational goals. If there is a desire for education, the provider of case management should link individuals to services and resources to pursue educational opportunities, including supported education programs.

Individuals may have a desire to gain employment. Some key questions for individuals and CM are:

- Has the individual expressed a desire to work?
- How can they acquire skills, abilities, and learn to apply them in a work setting?
- How can the individual minimize barriers?
- Where can the individual get a job in a competitive 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 individual's desire, skills and strengths, and the availability of work.

Individuals who desire to be employed may benefit from transitional employment (TE), Supported Employed (SE), and Individual Placement and Support (IPS). TE, SE, and IPS models offer social, educational, pre-vocational, and vocational opportunities to individuals. Full-time, part-time, and volunteer work may provide significant benefits to individuals. The CM can assist the individual by linking them to employment specialists within their agency or, as necessary, linking the individual to Utah State Office of Rehabilitation (USOR). USOR can also link individuals to a Benefits Specialist, to provide education on how employment may impact benefits that they are already receiving or have applied for.

Public Entitlement Programs

Individuals may need case management to obtain entitlements. The most important kinds of assistance available are income support (SSI, SSDI- GA or TANF) and special services for people without money or insurance, such as donated medical or legal assistance. In most communities, the public and private social welfare system is characterized by complex intake and reporting procedures. A CM can assist the individual to gain access to public entitlements. It is also the CM's responsibility to develop the expertise and understand the eligibility process.

Applications for Social Security benefits may be turned down; however, often times individuals are eligible to appeal. It is the CM responsibility to inform the individual 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 tribal or church record of birth
- Picture identification (Driver's License or Utah State ID Card)
- Social Security Card
- Other documentation as required (refer to Social Security Administration's website for details)

Federally Administered Entitlement Programs:

Medicare - Medicare is a federal health insurance program. Turning 65 is one way you can be eligible for Medicare. You can also be under 65 years old and still qualify for Medicare because you are receiving Social Security Disability Insurance (SSDI). In most cases, you qualify for Medicare due to a disability if you have been receiving SSDI checks for more than 24 months.

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.

Supplemental 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 CM to inform the individual of the appeal process with any findings of ineligibility, particularly at the first step. When awarded, entitlements are retroactive to the original date of application.

State of Utah Entitlement Programs through the Department of Workforce Services

Medicaid - This is a federal program that assists low-income citizens with disabilities obtain medical care. Individuals who qualify for SSI will qualify for Medicaid, but they must apply for each program separately. Not all providers of medical services accept Medicaid, so you will need to become familiar with the providers in your area who accept this insurance. It is important to remember that only Targeted Case Management services are billable to Medicaid.

If an individual earns money or receives SSDI, they may qualify for Medicaid; however, they may have to pay for this benefit, called a spend-down, depending on their income. CMs must become familiar with the regulations regarding spend-down as the amount of the spend-down varies depending on the individual's income. In addition, Targeted Case Management services can NOT be billed when assisting the client to establish and maintain eligibility for Medicaid.

General Assistance (GA) - This is financial assistance for individuals who have not qualified for federal assistance programs such as Social Security and/or who have a short-term disability. Applicants must provide a completed medical form from a physician that describes the extent, duration and medical diagnosis of the applicant's claimed disability.

Supplemental Nutrition Assistance Program, SNAP (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.

Temporary Assistance to Needy Families (TANF) - This program is designed to meet the minimal 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 SNAP program. Individuals have the right to special assistance, foreign language translators, and sign language assistance to complete the application process.

Unemployment Benefits: Unemployment insurance is a temporary assistance for people who are unemployed through no fault of their own while they are seeking other work. It is a partial, short-term replacement of lost wages and is not intended to be a permanent source of income. Benefits are not based on financial need.

Day Care: The State of Utah is responsible to license day care providers who offer childcare to eligible parents. Many times, individuals will be eligible to use these services while they receive treatment, participate in vocational training, and/or participate in other services.

Community Resources: Aside from the behavioral health and homeless services an individual may need, each community has a variety of other services that will be crucial in assisting the individual in fulfilling their goals. Providers of case management services are responsible to know about the services, service providers, and resources in their community.

IV. Description of the Levels of Case Management and Caseload Size

These guidelines present three levels of case management which were developed in collaboration with individuals, providers, and the National Association of Case Management (NACM) and acknowledge the great variability of behavioral illness, homelessness, and associated periods of need. Level I CM provides extensive supports for those whose present need and disability are the greatest. Level II CM provides an intensity of case management focused on recovery and rehabilitation. Level III case management provides a basic linking and crisis prevention service for people who are largely able to self-manage their lives, or who do not choose to be presently involved in a more intensive service. While formal assessment findings and individual choice are key indicators for case management assignment, there are many factors to be considered in the selection of the level of case management for each individual. Among these considerations are:

- Individual choice must be a primary factor in the assignment decision. Choices may be related to determining the level of case management as well as selecting the case management site (if services are available at more than one site). Once there is agreement about the assignment to case management, there is a continuing need for sensitivity to individual choice about the intensity of service and privacy.
- Willingness is closely associated with individual choice. Individuals 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 under-serving. It is important to note that providers of case management services can positively influence willingness through demonstration of hope and belief in the individual, while working to enable the individual to have the ability to manage themselves and live successfully in the community.
- Social resources and natural supports available to individuals are a very important factor in a decision about the intensity of case management. Individuals who are living in supervised housing/group homes or residences associated with psychosocial rehabilitation and/or attending Clubhouses may well require a less intensive case management service. Individuals 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” CM.
- 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. Providers of case management services should always work with their supervisor and follow agency policy when safety may be an issue.
- Culture is also a critical determinant for case management. All providers of case management services must be aware of the ethnicity and heritage of the individuals they serve. Agencies are encouraged to employ case managers who are representative of the various cultures in the service area, to help ensure culturally sensitive case management services. Specific training in cultural competence should be required for all providers. When working with individuals with Limited English Proficiency, agencies must provide

access to interpreter services. Family members should not be used as interpreters, if at all possible.

- Co-occurring conditions or situations will also affect assignment. Individuals with a mental illness and a co-occurring substance use disorder problem should work with providers who are trained in the provision of substance use disorder services to ensure comprehensive care is provided. Individuals who live with mental illness, older adults, physically or developmentally disabled, experience homelessness and/or are involved with the criminal justice system may require specialized services.
- Legal issues are a factor in the selection of case management intensity. Individuals with guardians or those who are involuntarily committed should be assigned a level of case management intensity that reflects acuity and presence of a support system. Individuals with involvement in the criminal justice system require case management coordination with that system.

Description of the Three Levels of Case Management

(Case Management Services allow for Blended Caseloads of Level I, II, and III)

	Level I CM	Level II CM	Level III CM
Description	<p>Level I CM is the most intensive level of support.</p> <p>Through frequent, comprehensive CM, support is given to the most severely disabled adults. Crisis coverage is accessible 24 hours per day, seven days per week. (Crisis services may be provided by other behavioral health and homeless service providers.)</p>	<p>Level II CM provides a moderate level of support.</p> <p>This adult population has symptoms which are at least partially controlled. Crisis coverage is accessible 24 hours per day, seven days per week. (Crisis services may be provided by other MH providers).</p>	<p>Level III CM is the least intensive level mode of support.</p> <p>This adult population is somewhat satisfied with their life situation, or are largely able to self-manage much of their progress. Services are provided pending the individual’s needs with on-call crisis intervention, or other crisis intervention arrangements.</p>

<p>Admission - Meets State Case Management eligibility for behavioral health and/or homeless services (found in Part II).</p>	<p><u>Severity:</u> Past hospitalization and recent major crisis activity</p> <p><u>Assessment:</u> Will show severe deficits in skills and resources needed for community living.</p>	<p><u>Severity:</u> Past hospitalizations, but no recent major crisis activity or hospitalization. Symptoms are partially controlled.</p> <p><u>Assessment:</u> Will show skill and resource deficits which somewhat impair the person's ability to achieve personal goals independently.</p>	<p><u>Severity:</u> Extended period with no hospitalizations or major crisis episodes. Largely able to independently manage symptoms and medication. Some satisfaction with current life and able to make significant progress towards goals with occasional assistance.</p> <p><u>Assessment:</u> May show moderate dysfunction.</p>
	<p><u>Level I CM</u></p>	<p><u>Level II CM</u></p>	<p><u>Level III CM</u></p>
<p>Focus/Activities</p>	<p><u>Focuses on linking the individual to agencies that provide basic human needs and supports; monitor symptoms and side effects of medication; encouraging periods of independence; building support networks; minimizing or eliminating periods of crisis. Advocate for individuals to re-establish sense of self and personal aspirations.</u></p>	<p><u>Focuses on obtaining recovery outcomes and maximizing strengths by implementing and coordinating services and resources to meet their needs; teaches independent living skills.</u></p>	<p><u>Focuses on maintaining stability and independence by providing a link to services and interface with psychiatric and medication services, crisis prevention and intervention.</u></p>

<p>Caseload</p>	<p><u>Recommended average of 15 persons per caseload. Depending on the needs of persons served and team availability, the range could be from 5 to 15 persons per caseload except in rural areas, due to transportation limitations. Teams provide 24-hour coverage with mutual support caseloads. Assisted Outpatient Treatment (AOT), ACT and ACOT teams are evidence-based practices and ideal at this level. Utah ACOT guidelines can be found here.</u></p> <p><u>A face-to-face assessment of needs should be conducted a minimum of four times per week, with at least once weekly contact at place of residence.</u></p>	<p><u>Recommended average of 24 persons per caseload. Depending on the needs of persons served and team availability, the range could be from 15 to 30 persons per case manager, except in rural areas. Caseloads can be carried by an individual or a team. Best Practice includes access to nursing services and a psychiatric prescriber, a job specialist and a housing specialist.</u></p> <p><u>A face-to-face assessment of needs should be conducted at least once monthly.</u></p>	<p><u>Recommended average of 50 persons per caseload. Depending on the needs of persons served and team availability, the range could be from 30 to 80 persons per case manager. Usually this involves individual practice in office with some team features. The CM will collaborate with medication service. Available crisis prevention/ intervention Monday through Friday, 8:00 a.m. to 5:00 p.m., with back up arrangements at other times. A face-to-face assessment of needs should be conducted at least one time every 90 days. Additionally, at least two face-to-face and eight telephone contacts should be conducted each year.</u></p>
-----------------	--	---	---

	Level I CM	Level II CM	Level III CM
Internal Review of Services For Medicaid Reimbursement	Reauthorization in 180-day intervals. Continued CM at Level I is based on degree of symptoms, crisis reduction and/or positive progress	Reauthorization in 180- day intervals. Continued CM at Level II is based on progress with rehabilitation goals and desire for further services	Reauthorization in 180 days, and thereafter as person chooses to have continued CM linkage to behavioral health and/or homeless systems.
Expected Outcomes	<p>Increased:</p> <ul style="list-style-type: none"> -community tenure and reductions in the frequency or length of crisis or hospital services; -housing stability; increased social integration; -individual satisfaction; -independence or semi-independent living arrangement. <p>Decreased:</p> <ul style="list-style-type: none"> - symptoms and medication side effects; - impairment from substance use; - decrease in level of care needed; and -episodes of homelessness. 	<p>Increased:</p> <ul style="list-style-type: none"> - community tenure; -time spent employed or in school; -social contacts; -independence or semi- independent living arrangement; and -individual satisfaction. <p>Decreased:</p> <ul style="list-style-type: none"> -crisis episodes; and-impairment from substance use; and -episodes of homelessness. 	<p>Increased:</p> <ul style="list-style-type: none"> -individual satisfaction with personal life domains; -personal independence in any life domain. -stability as measured by rare, brief, hospitalizations; and -episodes of recovery from mental health and substance use. <p>Decreased:</p> <ul style="list-style-type: none"> - frequency and duration of crisis episodes;

V. OTHER CHALLENGES

Crisis Intervention

A crisis intervention is a planned response to a variety of situations, which can range from suicidal ideations to non-lethal problems such as eviction, divorce, or death of a loved one. A crisis is not necessarily always negative and the CM can help the individual 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 individual to learn and grow. The CM should consult with their supervisor and other team members to plan appropriate interventions when encountering a crisis situation.

Behaviors That May Precipitate Violence

Popular culture and the media have helped to portray individuals with mental illness and/or experiencing homelessness as violent and unpredictable. These false images perpetuate stigma. However, individuals experiencing mental illness and/or homelessness are responsible for no more than 5% of violent episodes in the United States. In fact, people with mental illness and those experiencing homelessness are more likely to be the victims of violence than to be the perpetrator, and are citizens who share the predominant values of their home communities. Some factors that may increase the likelihood of violence include substance use, difficulty maintaining consistent medication management, financial stressors, trauma, and low insight into their illness.

Illegal Behaviors

Most individuals with behavioral disorders and those experiencing homelessness are law abiding citizens, although some individuals may act against property, other people, or themselves. This may involve law breaking, or impulsive reactions to stressful situations or to their own thoughts and feelings. It is impossible for anyone, including behavioral health and homeless service providers, to reliably predict how someone else is going to behave. It is not the CM's job to protect individuals from the consequences of their illegal behavior. The motives behind illegal behaviors, whether deliberate or not, are a matter for legal authorities to determine. The CM should consult their supervisor before reporting illegal behaviors to ensure privacy laws are protected. All abuse of vulnerable persons must be reported.

Alcohol and Street Drug Use

Individuals will sometimes choose to use alcohol and/or street drugs for a variety of reasons. Individuals are free to use alcohol in accordance with applicable laws in their communities. However, they should be informed of the dangers associated with both drug and alcohol use, along with the possibility of dangerous interactions that these substances may have with

psychiatric medications. Individuals will sometimes stop taking their medication and prefer to “self-medicate” with alcohol or street drugs to relieve their symptoms. The CM can monitor and assess individuals for substance use. The prescriber and treatment team should be notified, and all should work with the individual to address the individual’s alcohol and/or street drug use. Remember that a release of information is required before disclosing substance use to anyone outside of the individual’s treatment team and/or agency.

The individual can be linked to public and private treatment programs and facilities when appropriate. A list of treatment programs for Substance Abuse is maintained by the Utah Division of Substance Abuse and Mental Health and can be accessed online at <https://hslic.utah.gov/db-search>

Threatening, Violent, or Homicidal Behavior

When someone’s life or well-being is threatened, endangered, or violated, the CM 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 anxiety, agitation, or fear. Speak in a normal tone and a calming voice to the individual. Ask for and provide verbal clarification of the situation. Avoid trapping or backing someone into a corner, or getting too close to someone. Leave all exits open. If the danger does not diminish, physically remove yourself and others from the situation and contact the police.

The law (Tarasoff Law) requires that CMs inform anyone who has been threatened by another that his or her safety is jeopardized and by whom. The threat must be a credible threat of bodily harm. Utah state law also specifically requires all behavioral health and homeless service providers to report known or suspected situations of child abuse to Child Protective Services or to the police, and known or suspected situations of abuse to a vulnerable adult to Adult Protective Services. You should never hesitate to call the police for assistance when you perceive an immediate threat to the physical safety of an individual. It is the job of the police, not yours, to physically restrain people who are out of control.

Situations involving potential harm to individuals or property should always be discussed with your supervisor at the earliest possible time so that plans can be implemented to protect the safety of the individual, the CM, and others in the community. These types of situations should also be carefully documented.

Suicidal Thoughts and Behaviors

Suicidal thoughts and behaviors can occur with individuals who are struggling with the symptoms of their mental illness and who may also lack the connections of work, family, and friends to provide support during the difficult time. Thoughts of suicide may arise from desperation and discouragement or more rarely may result from “command hallucinations.”

Command hallucinations are “voices” instructing the individual to harm themselves (or others) or take their own life during a psychotic episode.

All suicide threats must be taken seriously. It is essential that you consult with and remain in close contact with your supervisor throughout the period when there is a danger. Safety is the number one priority during these times. CMs should ensure that individuals are aware of the availability of 24-hour Crisis Services in their area and how to access these services when needed; this information is reviewed with the individual on a regular basis.

In general, suicidal risk is higher when: there is a specific and detailed plan for committing suicide, the chosen method is lethal, and the method of suicide is available. For example, the individual who is discussing suicide, has access to a loaded gun, and intends to use it tonight, is generally in more immediate danger than another person who has declared plans to starve her/himself or swallow pills soon. All suicidal thoughts and behaviors should be carefully documented. Never hesitate to involve your supervisor, crisis services, or the police when there is an immediate threat to the physical well-being of somebody.

VI. TAKING CARE OF YOURSELF

Working with people can sometimes be stressful. It is important to take care of yourself – physically, emotionally, and socially. Utilize opportunities to attend time management and stress management workshops as this may be helpful in coping with the challenges of your job.

Time Management

- Make a daily plan of tasks.
- Prioritize the list. Identify those tasks that have to be done today (A’s), from those which should be done, but could be done tomorrow (B’s), and those which are not that important (C’s). You will find that you often have to adapt and revise your list. There may also be times when reviewing your list with your supervisor is beneficial.
- Be sure to do your “A” tasks first.
- Keep lists simple and realistic.
- Carry your list with you – consult it often.
- Let your list be your guide.
- Let individuals know when you will have time to provide case management services for them. Set appointments with them and stick with it. If they are not there for the appointment, make another appointment for another time. They will soon know they can rely on you if they will make their appointment times with you.
- Be on time. Treat individuals the way you want to be treated.
- Always ask “what is the best use of my time right now?”
- Do not always work on other peoples “A” tasks at the expense of your own.

Stress Management

- Talk with staff and your supervisor about your experiences and feelings. Sharing with others helps to reduce the tension and find humor in difficult situations.
- Learn how to use relaxation exercises.
- Use humor appropriately.

Recognize the stages of burnout.

- Stage I – Early Warning Signs: vague anxiety, constant fatigue, feelings of depression, boredom with one’s job, apathy
- Stage II – Initial Burnout: lowered emotional control, increasing anxiety, sleep disturbances, headaches, diffuse back and muscle aches, loss of energy, hyperactivity, excessive fatigue, and moderate withdrawal from social contact
- Stage III – Burnout: skin rashes, generalized physical weakness, strong feelings of depression, increased alcohol intake, increased smoking, high blood pressure, ulcers, migraines, severe withdrawal, loss of appetite for food, loss of sexual appetite, excessive irritability, emotional outbursts, irrational fears (phobias), rigid thinking
- Stage IV – Burnout: asthma, coronary artery disease, diabetes, cancer, heart attacks, severe depression, lowered self-esteem, inability to function on the job and personally, severe withdrawal, uncontrolled crying spells, suicidal thoughts, muscle tremors, severe fatigue, over-reaction to emotional stimuli, agitation, constant tension, accident proneness and carelessness, feelings of hostility
- Take action to deal with your burnout if you recognize it.
- Talk to your supervisor for assistance.
- Take time-outs. These can be mini time-outs, such as taking the afternoon off, or longer vacations.
- It is okay to say you are having a difficult time. We all do at times. It is not okay to ignore the stress symptoms and do nothing about them.
- Cultivate pleasurable activities and hobbies that will offer you balance and peace.
- Develop a positive, nurturing support system.
- Set limits with yourself and others. Know your own boundaries.
- Exercise regularly.

“Often the person who identifies himself as the curer or fixer-type healer is vulnerable to burnout.” (Rachel Naomi Remen, M.D.)

“Perhaps the most important thing I have learned from my work is that I can be a friend and supporter of healing; I can be a guide to people; but it is not I who does the healing. I try to heal by creating situations that seem to allow or foster healing – calmness, faith, hope, enthusiasm – and sometimes just the idea that healing is a possibility.” (Martin Rossman, M.D.)

VII. GLOSSARY

Acute phase of illness: A period of time during which the person suffers increased intensity of symptoms. It may last from a few days to several weeks.

Assertive Community Treatment (ACT) Team: A multidisciplinary team acting as the primary provider individualized treatment, rehabilitation, and support services to an identified population of high risk individuals with Serious and Persistent Mental Illness (SPMI) to assist those persons live successfully in the community.

Assertive Community Outreach Treatment (ACOT) Team: ACOT teams provide time unlimited services to individuals who have SPMI, SUD, or co-occurring SPMI/SUD. Services are delivered by a group of multidisciplinary staff that operates as a team that shares (by assignment) in the provision of individually tailored treatment, rehabilitation, and support services each client needs per each client's comprehensive assessment and individualized treatment plan.

Addiction: Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Adjustment disorder: A poorly suited response to life stress that usually disappears when the stress stops.

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

Affect (flat): Absence of the common signs of normal emotions, such as smiling, laughing, etc.

Affect (inappropriate): Display of emotion that is out of place and does not relate to events.

Affect (labile): Abrupt, unpredictable shifts of emotion.

Akathisia: Common, unpleasant side effects of major tranquilizers that make a person feel jittery and agitated.

Alogia: Poverty (reduction in quantity) of thinking evidenced either by poverty of speech or by poverty of content of speech. (See also mutism)

Alzheimer's Disease: A common and irreversible form of dementia in which the brain atrophies. Death usually follows in six to ten years.

Ambivalence: The presence of strong opposing feelings that make it difficult for a person to reach a decision.

AMI: Alliance for the Mentally Ill (National)

Amphetamine: A stimulant drug with effects similar to cocaine.

Analgesics: A group of medications that reduce pain.

Anorexia nervosa: A common and serious eating disorder generally found in young women in which they gradually decrease the amount of food they eat until their weight becomes dangerously low.

Anti-anxiety drugs: Medications used to help relieve tension and feelings of nervousness.

Antidepressant drugs: Medications used to treat serious depression.

Antipsychotic drugs: Medications used to treat schizophrenia and other psychotic disorders.

Antisocial personality disorder: A diagnosis generally applied to individuals with long histories of continuous and chronic antisocial behavior, such as disregard for and violation of the rights of others.

Atypical psychosis: A diagnosis sometimes used when psychosis is observed but its causes are not understood.

Avoidant Personality Disorder: Characterized by hypersensitivity to rejection, and feelings of inadequacy and low self-esteem.

Avolition: Absence of initiative or motivation to begin and maintain behavior in pursuit of a goal.

Barbiturate: A type of central nervous system (CNS) depressant often prescribed to promote sleep.

Bath salts: An emerging family of drugs containing one or more synthetic chemicals related to cathinone, an amphetamine-like stimulant found naturally in the khat plant

Benzodiazepine: A type of Central Nervous System (CNS) depressant often prescribed to relieve anxiety. Valium and Xanax are among the most widely prescribed benzodiazepine medications.

Bipolar Disorder: A mood disorder in which a person experiences episodes of intense feelings of euphoria, and excitement, or irritability, followed by episodes of depression

Borderline Personality: A personality disorder characterized by instability of personal relationships, self-image, moods, and impulsivity.

Bulimia: Binge eating often accompanied by vomiting caused by concern over appearance and weight. This problem is related to anorexia nervosa and, in its severe form, can be life threatening.

Buprenorphine: Medication approved by the U.S. Food and Drug Administration in October 2002 for the treatment of opioid addiction.

Cannabidiol (CBD): A non-psychoactive cannabinoid that may be useful in reducing pain and inflammation and in controlling epileptic seizures.

Cannabinoid receptor: The receptor in the brain that recognizes and binds cannabinoids that are produced in the brain (anandamide) or outside the body (for example, Tetrahydrocannabinol/THC and cannabidiol).

Cannabinoids: Chemicals that bind to cannabinoid receptors in the brain. They are found naturally in the brain (anandamide) and are also chemicals found in marijuana (for example, THC and CBD). They are involved in a variety of mental and physical processes, including memory, thinking, concentration, movement, pain regulation, food intake, and reward.

Cannabis: The botanical name for the plant that produces marijuana.

Carcinogen: A substance that may cause cancer.

Cardiovascular system: The heart and blood vessels.

Catatonic schizophrenia: A type of schizophrenia characterized by pronounced motor symptoms ranging from rigid immobility to extreme excitement and excessive motor activity.

Central nervous system (CNS): The brain and spinal cord

Chronic phase of illness: Refers to the persistence of illness or symptoms over a long period of time.

Civil Commitment (also called involuntary commitment): A judicial process whereby someone may be committed to a hospital or Local Mental Health Authority against their will if the person is judged to be mentally ill and one or more of the following conditions also applies: 1) danger to self, 2) danger to others, 3) there is no less restrictive treatment available. Additional information on civil commitment in Utah can be found [here](#).

Clinical case management – a more intensive form of case management that may include clinical interventions. Clinical case management meets the required activities of case management, with the additional specialization of provide clinical services.

Clubhouse: May refer to individual self-help clubs developed and organized by individuals themselves, or psychosocial clubs such as Alliance House in Salt Lake City, which are program components of community mental health centers. As the term implies, a club emphasizes belonging, social connections and common purposes.

Central Nervous System (CNS) depressants: A class of drugs (also called sedatives and tranquilizers) that slow CNS function; some are used to treat anxiety and sleep disorders (includes barbiturates and benzodiazepines).

Coca: The plant, Erythroxylon, from which cocaine is derived. Also refers to the leaves of this plant.

Cocaine: A highly addictive stimulant drug derived from the coca plant that produces profound feelings of pleasure.

Cognitive-behavioral treatments: A set of treatments that focus on modifying thinking, motivation, coping mechanisms, and/or choices made by people.

Community Mental Health Centers (CMHC): Organizations located in communities throughout the state that assist individuals to live as productively and satisfactorily as possible by providing individualized treatment for mental illness and/or substance use disorders.

Community Support Projects Programs: The range of programs, agencies and services in any given geographic area which may be utilized by individuals to live as comfortably and productively as possible in the community. This includes traditional behavioral health and homeless agencies and other services.

Confidentiality: A principle of medical practice that requires behavioral health and homeless treatment providers to keep private treatment matters confidential (not discuss with other people) without authorization from the individual involved.

Counseling: Listed as an eligible activity under case management for some Department of Housing and Urban Development (HUD) programs, it needs to be clarified that counseling provided by case managers does not include any form of specialized counseling, which should only be exercised by licensed professionals.

Delusion: A false belief, which dominates a person's thinking despite evidence to the contrary.

Delusional Disorder: A disorder characterized by a system of non-bizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease).

Dependent Personality Disorder: Characterized by an excessive need to be taken care of and submissive and clinging behavior, as well as feelings of panic or discomfort at having to be alone.

Dependence: A physiological state that can occur with regular drug use and results in withdrawal symptoms when drug use is abruptly discontinued.

Depression: An emotional state characterized by extreme sadness, feelings of low self-worth and may include thoughts of death and suicide.

Depressants: Drugs that relieve anxiety and promote sleep. Depressants include barbiturates, benzodiazepines, and alcohol.

Detoxification (“Detox”): A process that enables the body to rid itself of a drug. Medically assisted detoxification may be needed to help manage an individual’s withdrawal symptoms. Detoxification alone is not treatment but is often the first step in a drug treatment program.

Diagnosis: The assignment of a specific illness based on standardized symptoms assessed by a doctor, licensed behavioral health and homeless provider, or other qualified personnel.

Disability Law Center (DLC): A private non-profit organization to protect the rights of people with disabilities in Utah.

Disorganized Type Schizophrenia: A type of Schizophrenia characterized by a prominence of disorganized speech, disorganized behavior, and inappropriate affect.

Dopamine: A brain chemical, classified as a neurotransmitter, found in regions of the brain that regulate movement, emotion, motivation, and pleasure.

Diagnostic and Statistical Manual for Mental Disorders (DSM): Provides a definition of all recognized mental disorders.

Due process: A legal term meaning the right to an official court hearing before an individual's freedom is restricted in any way, such as before involuntary hospitalization or treatment of any kind.

Ecstasy (3,4-methylenedioxy-methamphetamine, MDMA): A mood- and perception-altering drug that is chemically similar to hallucinogens and stimulants.

Food stamps: Public welfare program administered by the State Department of Human Services offices in Utah also referred to as Supplemental Nutrition Assistance Program (SNAP).

General Assistance (GA): Public welfare, available to those who meet requirements.

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.

Hallucinations: A perception in which things are seen or heard that are not real or present. Hallucinations usually arise from a disorder of the nervous system or as an effect of a hallucinogenic drug, such as lysergic acid diethylamide (LSD).

Hallucinogens: A diverse group of drugs that alter perceptions, thoughts, and feelings. Hallucinogenic drugs include lysergic acid diethylamide (LSD), mescaline, phencyclidine (PCP), and psilocybin (magic mushrooms).

Health Plan: A federally defined plan under contract with the Utah Department of Health to provide specified physical health care services to a specific group of Medicaid enrollees.

Home Energy Assistance Training (H.E.A.T.): Federally funded program that helps qualified, low-income individuals pay the high cost of winter heating bills.

Heroin: A synthetic opioid related to morphine. It is more potent than morphine and is highly addictive.

HHS: Department of Health and Human Services (federal government).

Histrionic Personality Disorder: Characterized by excessive attention seeking behavior and emotional instability.

HUD: Department of Housing and Urban Development (federal government).

ID/RC: Intellectual Disability/Related Condition

Inhalant: Any drug administered by breathing in its vapors. Inhalants are commonly organic solvents, such as glue and paint thinner, or anesthetic gases, such as nitrous oxide.

Inhalation: Taking air or a substance into the lungs by breathing it in through the nose or mouth. Nicotine in tobacco smoke enters the body by inhalation.

Injection: Taking a substance into the skin, subcutaneous tissue, muscle, blood vessels, or body cavities - usually by means of a needle.

Injection drug use: Taking drugs directly into blood vessels using a hypodermic needle and syringe. Also called intravenous drug use.

Informed consent: The informed, conscious and willful agreement of an individual. A behavioral health and homeless professional cannot assume that an individual has given informed consent unless the individual has been provided a full and complete explanation of the situation and their legal rights.

Inpatient: Refers to a treatment status of a person within a hospital or other medical facility.

Kratom: A tropical tree native to Southeast Asia, with leaves that contain compounds that can have psychotropic (mind-altering) effects.

Limbic system: Area of the brain that is involved with feelings, emotions, and motivations. It is also important for learning and memory.

LSD (lysergic acid diethylamide): A hallucinogenic drug that acts on the serotonin receptor.

Manic Depressive Illness (MDI): See bipolar disorder.

Marijuana: A psychoactive drug, usually smoked but sometimes vaporized or ingested, that is typically made from the flowers, leaves, and stems of the female cannabis plant. The main psychoactive ingredient is THC.

Medicaid: A health insurance program for low income people. It pays medical costs for eligible individuals who cannot afford the cost of health care. People who qualify for Supplemental Security Income (SSI) may be eligible for Medicaid.

Medical case management – a collaborative process that facilitates recommended treatment plans to ensure that appropriate medical care is provided to disabled, ill or injured individuals. A medical case manager meets the required activities of case management, with the additional specialization of working closely with medical providers to provide a full range of health, medical and social services to those individuals identified as needing specialized and resource-intensive services. Medical case managers focus on “patient-centered care” that incorporates the individual’s active participation in their health care.

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

Medication: A drug that is used to treat an illness or disease according to established medical guidelines. If the medication contains one or more controlled substances, it must be prescribed by a licensed physician.

Medication, Psychiatric: Medicines prescribed by psychiatrists for the control of symptoms of various kinds.

Mental illness: A condition in which an individual's mental processes, including thoughts, feelings, and perceptions, are disrupted or dysfunctional in helping the person to adapt to his surroundings.

Methadone: A long-acting synthetic opioid medication that is effective in treating pain and opioid addiction.

Methamphetamine: An addictive, potent stimulant drug that is part of the larger class of amphetamines.

Methylphenidate (Ritalin/Concerta): A CNS stimulant that has effects similar to, but more potent than, caffeine and less potent than amphetamines. It has a notably calming and "focusing" effect on patients with ADHD, particularly children.

Mood Disorders: Disorders in which the primary feature is an intense disturbance in mood.

Mutism: Refusal or failure to speak when speech is expected or demanded.

NAMI: National Alliance for Mental Illness

Narcissistic Personality Disorder: Characterized by grandiosity, need for admiration, and lack of empathy.

Needs assessment: A tool to obtain and represent the ongoing growth and changing needs of the individual.

Negative symptoms: These symptoms involve the absence of normal behaviors. They include affective flattening, alogia, apathy, avolition and social withdrawal.

Neuron (nerve cell): A unique type of cell found in the brain and throughout the body that specializes in the transmission and processing of information.

Neurotransmitter: A chemical produced by neurons to carry messages to adjacent neurons.

Nicotine: The addictive drug in tobacco. Nicotine activates a specific type of acetylcholine receptor.

NIMH: National Institute of Mental Health

Noradrenaline: A neurotransmitter that is made in the brain and influences, among other things, the function of the heart.

Nucleus accumbens: A part of the brain reward system, located in the limbic system, that processes information related to motivation and reward. Nearly all addictive drugs act directly or indirectly on the nucleus accumbens to reinforce drug taking.

Obsessive Compulsive Personality Disorder (OCD): Characterized by excessive concern with maintaining order, control, perfectionism and adherence to rules.

Outpatient: Refers to a treatment status or a person receiving treatment in the community and outside of a mental hospital or other medical facility.

Outreach – to attempt to engage and enroll persons not currently accessing services.

Opioids (or opiates): Controlled substances most often prescribed for the management of pain. They are natural or synthetic chemicals similar to morphine that work by mimicking the actions of enkephalin and endorphin (endogenous opioids or pain-relieving chemicals produced in the body).

Paranoid Type Schizophrenia: A type of Schizophrenia characterized by a preoccupation with one or more delusions or frequent auditory hallucinations, which are often experienced as threatening to the person. Does not include prominent symptoms of disorganized speech, behavior or inappropriate affect.

Paranoid Personality Disorder: A pervasive distrust and suspiciousness of others.

Personality disorder: Refers to patterns of maladaptation, inflexibility, or impairment in an individual's basic pattern of perceiving and relation to others.

Positive symptoms: These prominent or added symptoms include delusions, hallucinations, thought disorder, and aberrant behaviors.

Prepaid Mental Health plan: (PMHP) means the Department of Health's mental health freedom-of-choice waiver approved by CMS that allows the Department to require Medicaid Eligible Individuals in certain counties of the state to obtain Covered Services from specified contractors. PMHP contractors are responsible to provide covered inpatient and outpatient mental health services to Medicaid eligible individuals.

Prevocational services: Activities intended to help an individual prepare for employment by teaching work related skills.

Preferred Practice Guidelines: Uniform and consistent guidelines for people with mental illness

Prefrontal cortex: Located in the frontal lobe (one of the four divisions of each cerebral hemisphere) of the brain. This area is important for decision making, planning, and judgment.

Prescription drug abuse: The use of a medication by someone other than for whom it is prescribed, in ways or amounts other than intended by a doctor, or for the experience or feeling it causes.

Primary therapist: The person in a behavioral health and/or homeless center who has primary responsibility for providing treatment and managing the individuals file.

Provider of case management services: A behavioral health and/or homeless service provider who assists individuals access various resources and assistance to meet their needs and live as independently as possible. Referred to in this document as CM.

Psychedelic drug: A drug that distorts perception, thought, and feeling. This term is typically used to refer to drugs with hallucinogenic effects like those of LSD.

Psychoactive: Having a specific effect on the brain.

Psychological Screening: The use of psychological procedures or tests to detect psychological problems.

Psychopharmacological drugs: Drugs used in the treatment of mental disorders.

Psychosis: A term that is used to describe major distortions or interpretations of reality. For example, the notion that one can control others or be controlled through brainwaves transmitted via radio receivers.

Psychosocial Rehabilitation Services (also called PRS or SDS): Psychosocial rehabilitative services are medical or remedial services designed to reduce the individual's mental health symptoms and restore the individual's maximum functional level, through the use of face-to-face interventions such as cueing, modeling and role modeling of appropriate life skills. These services are aimed at maximizing the individual's social and behavioral skills in order to prevent the need for more restrictive levels of care and include services to: (1) eliminate or reduce symptomatology related to the individual's diagnosis; (2) increase compliance with the medication regimen, as applicable; (3) avoid psychiatric hospitalization; (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; and (7) regain or enhance the basic living skills necessary for living in the least restrictive environment possible. Services are provided in either an individual or group setting.

Psychotherapeutics: Therapeutic drugs that have an effect on brain function; some are used to treat psychiatric disorders. They include antidepressants, mood stabilizers, CNS depressants, stimulants, and opioids.

Psychotherapy: Treatment of mental disorders using psychological methods.

Rapport: Interpersonal relationship developed and characterized by a spirit of cooperation, confidence, and harmony.

Rationalization: Mechanism created by an individual to justify his or her actions.

Recovery – is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a process of change through which individuals work to improve their own health and well-being, live a self-directed life and strive to achieve their full potential. Through the Recovery Support Strategic Initiative, SAMHSA has defined the following four major dimensions that are essential to a life in recovery: Health: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way Home: a stable and safe place to live Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income and resources to participate in society Community: relationships and social networks that provide support, friendship, love and hope.

Psychotherapeutics: Therapeutic drugs that have an effect on brain function; some are used to treat psychiatric disorders. They include antidepressants, mood stabilizers, CNS depressants, stimulants, and opioids.

Remission of symptoms: The reduction or disappearance of symptoms of an illness.

Residual Type Schizophrenia: A type of schizophrenia that often follows the acute phase. Residual symptoms may include social isolation or withdrawal, major impairment in daily work roles, an apparent lack of feelings or expressiveness, or peculiar and strange ideas.

Resistive to treatment: From the point of view of a treatment provider, the characteristic of someone who directly or indirectly refuses treatment. In spite of this viewpoint, individuals have the right to willfully choose or not choose treatments, except and unless that right is altered by a court of law.

Reward: The process that reinforces behavior or increases its likelihood of recurrence. It is mediated, at least in part, by the release of dopamine into the nucleus accumbens. Human subjects report that reward is associated with feelings of pleasure.

Reward system (or brain reward system): A brain circuit that, when activated, reinforces behaviors. The circuit includes the dopamine-containing neurons of the ventral tegmental area, the nucleus accumbens, and part of the prefrontal cortex.

Route of administration: The way a drug is taken into the body. Drugs are most commonly taken by eating, drinking, inhaling, injecting, snorting, or smoking.

Rush: A surge of pleasure (euphoria) that rapidly follows the administration of some drugs.

Salvia: An herb in the mint family native to southern Mexico that is used to produce hallucinogenic experiences.

Schizoaffective disorder: Mental disorder characterized by a person's experiencing severe but highly episodic disturbances of psychological functioning, such as mood-incongruent delusions and hallucinations.

Schizoid personality disorder: Personality disorder characterized by shyness, seclusiveness, over sensitivity, and eccentricity.

Schizophrenia: A serious and sometimes disabling mental illness. Symptoms include so-called *positive symptoms*, such as hearing voices and developing false, unconfirmed ideas as well as *negative symptoms*, like withdrawing from friends and family.

Schizotypal Personality Disorder: A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for close relationships and well as by cognitive or perceptual distortions and eccentricities of behavior.

Sedatives: Drugs that promote sleep, suppress anxiety, and relax muscles; the National Survey on Drug Use and Health (NSDUH) classification includes benzodiazepines, barbiturates, and other types of CNS depressants.

Serotonin: A neurotransmitter that regulates many functions, including mood, appetite, and sensory perception.

Severe Emotional Disturbance (SED): The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Self-esteem: Overall feeling of self-worth.

Self-identity: An individual's delineation and awareness of his or her continuing identity as a person.

Self-monitoring: The observation and recording of one's own behavior.

Serotonin: A neurotransmitter that regulates many functions, including mood, appetite, and sensory perception.

Service Plan: A formal agreed upon plan for support and assistance provided to individuals.

Serious Mental Illness (SMI): A diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

Social Security Administration: The federal organization that administers SSA-DI, SSI and Medicare. These are all referred to as entitlement programs.

Somatic: Pertaining to one's body.

Spice: Dried plant material containing synthetic (or designer) cannabinoid compounds that produce mind-altering effects as well as other compounds that vary from product to product.

SSA-DI: Social Security Administration Disability Insurance

SSI: Supplemental Security Income

State Vocational Rehabilitation: A state government organization mandated to serve those who are unemployed by reason of some handicapping condition. Traditionally, "voc rehab" has served mainly physical disabilities, but some individual voc rehab counselors (VRCs) may have a special interest in assisting individuals recovering from mental illness.

Stimulants: A class of drugs that elevates mood, increases feelings of well-being, and increases energy and alertness. Some stimulants, such as cocaine and methamphetamine, produce euphoria and are powerfully rewarding. Other stimulants, such as methylphenidate

(Ritalin and Concerta) or Adderall (a mix of amphetamine salts), are often prescribed to treat ADHD.

Stress: Internal responses caused by the application of a stressor.

Substance use disorder: Patterns of maladaptive behaviors centered around the regular and consistent use of the substance(s) involved.

Symptom: Particular evidence of illness, such as hallucinations, sleeplessness or changes in personality.

TANF: See Temporary Assistance for Needy Families

Targeted Case Management (TCM): Targeted case management is a service that assists eligible Medicaid recipients with serious mental illness to gain access to needed medical, social, educational, vocational and other services.

Temporary Assistance for Needy Families (TANF): A federal block grant administered by states in ways to assist needy families.

Tetrahydrocannabinol: See “THC.”

Thalamus: The key relay station for sensory information flowing to the cortex, which is located deep within the brain. It filters important messages out from the background noise, produced by the many signals entering the brain.

THC: Delta-9-tetrahydrocannabinol; the main psychoactive ingredient in marijuana, which acts on the brain to produce marijuana’s psychoactive effects.

Tobacco: A plant widely cultivated for its leaves, which are used primarily for smoking; the tabacum species is the major source of tobacco products.

Tolerance: A condition in which higher doses of a drug are required to produce the same effect achieved during initial use, which often leads to dependence.

Transference: The process whereby an individual projects attitudes and emotions applicable to another significant person onto the therapist; emphasized in psychoanalytic therapy.

Undifferentiated Type Schizophrenia: A type of Schizophrenia in which the major symptoms are present but criteria for paranoid, disorganized, or catatonic types are not present.

USARA: Utah Support Advocates for Recovery Awareness

Ventral tegmental area: The group of dopamine-containing neurons that make up a key part of the brain reward system. This region is part of the brain reward pathways that also include the nucleus accumbens and prefrontal cortex.

VRC: Vocational Rehabilitation Counselor

Vulnerable Adult: An adult (18 years of age and older) who is or may be in need of community care services by reason of disability, age or illness; and is or may be unable to take care of unable to protect him or herself against significant harm or exploitation.

Withdrawal: Symptoms that occur after regular use of a drug has been abruptly reduced or stopped. Symptom severity depends on the type of drug, the dosage, and how long and how frequently it has been taken.