

**A Field Guide on
Case Management for Children
With Serious Emotional Disturbances
And Their Families**

**Department of Human Services
Division of Substance Abuse and Mental Health**



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Introduction

This guidebook was written to help prepare you for one of the most important jobs in community mental health today. It will be a study guide as you prepare to take a formal exam required by the State Division of Substance Abuse and Mental Health to become a certified case manager and provider of services. It will be a resource for you at the beginning of your training and a reference you can use later.

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

Today, at least one in five children may have a behavioral, emotional, or mental health problem. At least one in ten may have a serious emotional disturbance (SED) that severely disrupts his or her ability to interact effectively with family, at school and in the community.

A serious emotional disturbance touches every part of a child's life. Therefore, children with SED and their families need many kinds of services from a variety of sources such as schools, community mental health centers, and social service organizations.

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



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Chapter I: System of Care

Overview of Utah's System of Care for Children with Serious Emotional Disturbances and Their Families

Utah System of Care

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

Mental Health Services for Children in Utah

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

Public mental health services are based on these guiding principles:

- Each child is valued as a unique being.
- All of us are responsible for the positive emotional, social, intellectual, and physical development and well being of our children.
- Every child has a right to the services she/he requires to develop physically, emotionally, socially, and intellectually in order to achieve and maintain his/her well being.
- The family is the primary provider, support, and nurturer for each child.
- Collaboration among families, agencies, and communities is necessary and is the basis of all system of care and strategies.
- In order to maximize benefits of care, children and their families need appropriate, consistent, and coordinated support services provided in a child-focused, family-centered, culturally sensitive, and collaborative manner.
- Services are best provided in a comprehensive system of care.

Division of Substance Abuse and Mental Health

The Utah State Division of Substance Abuse and Mental Health (DSAMH) is the mental health authority for the state and is charged with mental health care administration. DHS/DSAMH contracts for the delivery of local mental health services, distributes federal and state funds, and monitors CMHCs to ensure compliance with State Board Policy. The Division shapes the system of care through monitoring, oversight, developing preferred practices of care, policy and funding leadership, interagency coordination, and technical assistance. It also provides leadership and coordination with other state agencies, the state legislature and advocacy groups.

DSAMH has the responsibility to assuring the existence of the mandated services required by contract of the local authorities and conducts on-site visits at least annually, to assure the quality of those services.

Utah State Hospital

The Utah State Hospital provides care for adult, child, adolescent, and geriatric patients who suffer with chronic and severe mental illness. The hospital is part of the state mental health system and admits patients from the thirteen mental health centers throughout the state.

History of Service Delivery in Utah

Since its beginning in 1885, Utah's public mental health system has served children. However, services were not available to the same extent as those to severely mentally ill adults. Prior to 1980, there were few mental health services available in the schools or community. Children who suffered from SED had few community options. Most that needed services were admitted to the Utah State Hospital. While the State Hospital provided quality treatment and a school program, it required that children leave both their family and community, and for many children this was not the most appropriate therapeutic option.

The disparity between children's mental health services and adult mental health services has been gradually diminishing as the community mental health system has developed more options for children in their own community.

- In 1991, three Community Mental Health Centers (CMHCs) piloted a plan with Medicaid to reduce children's psychiatric hospitalizations and to re-route savings into building more community based services. Since then, six other CMHCs have joined in this effort.
- In 1993, a significant milestone occurred: allocation of monies for children's mental health services as a separate budget line item. Legislative appropriations have continued to increase for children's mental health services since the initial \$500,000 allocation. Collaboration with other child-serving agencies and community organizations has also expanded services.
- In 1996, the Utah legislature again passed legislation that impacted the mental health treatment of children. The Commitment and Treatment of Mentally Ill Children legislation now makes it possible to commit children to the mental health system without the parent having to give up custody. Commitment was moved from a state to the community mental health authority function, which allows treatment to begin in the child's community first. The law also provides for more due process for children who are committed, including the use of medication and other treatment procedures.

Utah's public mental health system provides a wide array of quality services through eleven comprehensive CMHCs that serve all 29 Utah counties. Under Utah law, mental health authorities are the service providers. A local mental health authority is generally the governing body of a county and is responsible for a continuum of care sufficient in quality and quantity to ensure that the mental health needs of their citizens are met. The local mental health authorities contract for mental health services with a community mental health center. A number of the community health centers cover more than one county. Four of the CMHCs are private non-profit, and six are under inter-local agreement.

State of Utah Definition of Case Management ¹

Case Management is a service that assists eligible clients to gain access to needed medical, social, educational, and other services. The overall goal of the services is not only to help Medicaid recipients to access needed services, but also to ensure that services are coordinated among all agencies and providers involved.

Qualified Targeted Case Management Providers

Only employees of comprehensive community mental health centers must provide targeted case management for the chronically mentally ill. Qualified targeted case managers include:

- A. Licensed mental health professionals – including licensed physicians, licensed psychologists, licensed clinical social workers, licensed certified social workers, licensed social service workers, licensed advanced practice registered nurses, licensed registered nurses, licensed professional counselors, and licensed marriage and family counselors – who are employed by a comprehensive community mental health center; or
- B. Non-licensed individuals working toward licensure as one of the above and under appropriate supervision; or
- C. Licensed practical nurses or non-licensed individuals who have met the State Division of Mental Health’s training standards for case managers, and who are supervised by one of the licensed mental health professionals identified above.

Targeted Case Management Training Curriculum

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

- A. Successfully pass a written examination which tests basic knowledge, attitudes, and case management skills; and
- B. Successfully complete a 20-hour case management practicum over a two-week time period.

In addition, all case managers must be familiar with Medicaid regulations pertaining to targeted case management.

For more information refer to: Targeted Case Management for the Chronically Mentally Ill, *Utah Medicaid Provider Manual*. Division of Health Care Financing, April 2, 2004, pages 2-14.

¹ Targeted Case Management for the Chronically Mentally Ill from: Utah Medicaid Provider Manual. Division of Health Care Financing. April 2004

Chapter II: Delivery of Services

Basic Value Assumptions

Between 89% and 93% of our children progress normally through childhood and adolescence with developmental and preventive assistance from family, teachers, and community leaders. From time to time, as they grow and mature, they may experience events/feelings that will lead them to seek additional support from mental health professionals, similar to trips to the dentist or doctor. These may be triggered by outside influences such as death, divorce, moving, changing schools, or through the process of maturation.

Between 7% and 11% of our children have been determined to be SED, which requires more intensive treatment and services from mental health professionals in partnership with parents. These services are provided by professionals in Utah's CMHCs and by private providers. As with other disabilities that affect children, early and appropriate mental health services are critical in assisting the child and family in managing the illness, developing a "recovery" plan, gaining stability, and recognizing that multiple periods of care may be required over time.

A Comprehensive Array of Services

Utah law mandates that each CMHC provide a comprehensive array of treatment, prevention, and rehabilitation services in order to receive public funding. Mental health services must be specially designed for children and their families.

The State, by contract with the local mental health authorities and by direction to the State Hospital, shall provide or arrange for a continuum of services including, but not limited to, the following:

- Inpatient care and services
- Residential care and services
- Outpatient care and services
- Twenty-four hour crisis care and services
- Psychotropic medication management
- Psychosocial rehabilitation, including vocational training and skills development
- Case management
- Community supports, including in-home services, housing, family support services, and respite services
- Consultation and education services, including, but not limited to, case consultation, collaboration with other service agencies, public education, and

public information

Ethical Guidelines

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

Case managers who were previously, or may still be clients, may have special problems in clarifying which role is appropriate. The client/case manager can have special understanding and sympathy for the problems of clients, but that very strength might sometimes result in conflicting loyalties and misunderstandings. The client case manager needs to discuss these problems with his/her supervisor and know the specific expectations of the agency.

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

NACM Ethical Guidelines:

As a Case Manager, I:

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

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

Chapter III: The Care Coordination Tool Box

Overview

Case management is the ongoing process of linking children and families to needed treatment and support resources. Families are involved in the formulation of an individualized treatment plan which guides the case manager's efforts. Case management spans a number of service delivery systems and is not limited to the community mental health resources only. Components of this service include the following core activities: assessment of children's needs; development of individualized treatment plans; referral to service providers; monitoring of service provision; coordinating service delivery; the provision of supportive counseling; advocacy; and the documentation and tracking of client progress. The goal of case management is the improved emotional and social functioning of children and their families.

Research reveals the efficacy of case management relative to reduced hospitalizations, fewer hospital days and more days in the community for children with SED (Evans, Armstrong, Dollard, Huz, Kuppinger, & Wood, 1994). Case managers actively coordinate with the family, service providers, and allied agencies to ensure that required services are effectively and efficiently provided. Consistent monitoring and ongoing contact with the child and family members are essential to ensure that services are being provided appropriately. Case managers provide advocacy for the child and family, assess needs and problems identified by the child and family members, plan specific treatment goals and services to achieve desired outcomes, and link children and family members to appropriate services. Varying levels of case management are offered and tailored to the unique needs of the child and family.

Case management assumes the care coordination of a child with SED in collaboration with the child's parents or guardians. Case management is a community-based service. Community settings include the child's home, school, neighborhood, and other natural sites. The frequency of contact between the case manager and the child and family is to be consistent enough to provide for implementation and generalization of mental health treatment services. Case managers provide coordination of care for the child across all systems in which they are involved.

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

Case management services begin with an Individualized Service Plan (ISP) that includes addressing the manifesting symptoms of the serious emotional disorder and the psychosocial problems the child and family are experiencing. The problems include, but

are not limited to, transportation; application and attainment of entitlements; acquiring food; clothing; housing; medical care and medications; development of an Individual Education Plan (IEP); successful completion of probation; linkage with Workforce Services; and accessing family support activities, such as respite care.

Individualized Service Planning

Individualized service planning is the cornerstone for children with SED and multiple needs and their families. An ISP will be developed and followed by the core team (also referred to as the family team). Core teams includes parents and, unless clinically inappropriate, the child; the clinician and case manager; educators; and partner agency staff appropriate to the child's and family's needs. Service planning will be ineffective unless the family is involved at every level.

The ISP is based upon a comprehensive assessment, using an ecological perspective, which considers the family's strengths as well as deficits. The ISP will consider eight dimensions: mental health, social, educational, health, vocational, substance abuse, recreational, and operational. In addition, the core team will assess eligibility for financial assistance and services under Federal, State and local programs.

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

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

- Description of the need for services;
- Recognition of existing family strengths;
- Objectives that meet the needs of child and family and which build on existing family's strengths;
- The methodology for meeting these objectives;
- A record of the provision of the services as appropriate, including, for those children 14 years or older who require them, vocational counseling and rehabilitation services, and transition services offered under Individuals with Disabilities Education Act (IDEA)²; and
- Designation of responsibility for case management services to be provided under the plan.
- Review and revision of the appropriateness of services in the ISP when necessary.

² Individuals With Disabilities Education Act aims to strengthen academic expectations and accountability for children with disabilities, and to bridge the gap that has too often existed between what those children learn and the regular curriculum.

Assessment

An assessment is a problem-solving and evaluative service. It is a professional determination of an individual's or family's concerns, taking into consideration factors contributing to the problems as well as the strengths and resources available to the individual or family. It is the basis from which recommendations for treatment and other services are generated. Although typically appropriate at the onset of mental health intervention, an assessment can be conducted at any point during the course of treatment. The assessment is an integral part of the diagnostic and treatment planning process.

Planning for Services: The Strengths Assessment

In order to determine what services the child needs, an evaluation is necessary. This evaluation is called a Strengths Assessment. Once this assessment is made, a service plan is developed which outlines long-term goals and the smaller steps which must be taken to achieve those goals.

Rationale for a Family Strengths Conversation³

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

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

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

What is a Strengths Assessment?

- A tool to obtain and assess the ongoing growth and changing interests of the child;
- An assessment of the child’s situation and circumstances across **Seven Life**

³ Donner, R. Ph.D. *Developing a Comprehensive Strengths Assessment*.

Domains:

- Living Arrangements
- Financial Resources
- Vocational/Educational Involvement
- Social Supports
- Health
- Mental Health Services
- Leisure/Recreational Activities
- Assessment of each life domain based upon:
 - A history of where the child has been
 - The child's current status
 - Stated personal goals
 - Internal and external resources
 - Priority of needs
- A working document that has a beginning, but not end; the assessment is ongoing and is to be updated when the child's status is altered, goals changed or new resources acquired. This will occur at least every 90 days.

The Use of Life Domains

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

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

Conducting a Strengths Conversation

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

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

At a minimum the strengths "conversation" outcomes should include:

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

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

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

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

Prioritizing Needs

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

The Service Plan: Development and Implementation

Once a strengths assessment is complete, the identified goals of the child are recorded in a service plan.

A service plan is a set of action steps designed to achieve one or more of the child's goals as stated during the strengths assessment. The plan contains:

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

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

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

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

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

The service plan consists of an array of flexible, treatment-based, goal-directed support services, which are designed to prevent an out-of-home therapeutic residential placement, or to enable children in such placements to successfully transition home. Wraparound services are dynamic and responsive to the changing needs of children and their families, and are rendered at the frequency, intensity, time periods and locales appropriate to the family.

These services are typically rendered in the child's home or surrounding community, and are available to families on a 24-hour basis. Services include behavior managers, positive role models, transportation, etc. Wraparound services maximize family participation in the treatment process. The CMHC provides many of these services directly, as well as contracts with qualified private providers as the child/family needs dictate.

Goal Setting “*If you can’t measure it, you can’t manage it.*”-George Odiorne⁴

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

The following is a checklist of writing quality action steps:

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

Monitoring the Service Plan

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

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

Case managers are community based, not office bound. To monitor service delivery, the case manager must actively watch, listen and interact with both the child and the service provider. Monitoring must occur while the child is participating in services and programs. Monitoring involves being with the child in his/her natural surroundings. Therefore, the case manager might be at one of many locations. These might include the child’s home, any office of a service provider, a restaurant in the child’s neighborhood, or a clubhouse, to name a few.

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

- Is the child getting the services established by the service plan?
- Are the services provided in such a ways that the child can benefit from them?
- Are the services provided to the child meeting the objectives of the service plan?

⁴ Harris, Blaine & Charles Coonrad (2001) *The Four Laws of Debt Free Prosperity*, Chequemate International, page 17.

- Are the services provided in manner that is beneficial or usable to the child?
- Are the plan's objectives appropriate to the child's current needs?
- Will meeting the plan's objectives give the child the ability to continue living in the community?
- Does the child need additional services or interventions to be able to continue making progress?

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

Children's Case Management Preferred Practice Guidelines

1. **Child Driven:** Case management services are responsive to the specific needs of the child and family. Services recognize that children are dependent on adults; are served in a highly complex system; are developing at a rapid rate; and have limited experiences, skills and resources.
2. **Family as Partners:** Parents are seen as most knowledgeable about their child and family; as such the case manager and family will partner in all decision making. Services are provided in a manner allowing the family to retain the greatest possible control over their own lives. Families set their own goals and decide what services they will receive, unless in conflict with the child's welfare. Siblings and extended family are included as well.
3. **Developmentally Appropriate:** Case management services assess the child's current level of physical, emotional, intellectual, and social development and design the service plan accordingly. Services the child is linked to will be monitored for meeting his/her developmental needs.
4. **Community Based:** Case management services are delivered in the most natural setting possible (i.e., the child's home, school, neighborhood) and in a way that promotes the development of ongoing linkages with natural social supports for the family once the episode of service ends.
5. **Culturally Competent:** Case management services are sensitive, knowledgeable, and nondiscriminatory regarding the family's racial and cultural heritage. Services are delivered in the primary language of the child and family and appreciate the customs and values of the family's cultural heritage. The family's cultural needs will be considered in the process of matching case manager and family.
6. **Strengths Based:** Case management services should promote the child and family's strengths, interests, and talents in order to support a foundation for recovery and to provide encouragement and hope to the child or child and family.
7. **Collaborative:** Case management service plans are developed through regularly scheduled interagency meetings that include family and all other service providers addressing all of the child and family's life domains in a collaborative partnership. Service coordination is delivered internally and externally to the mental health system.
8. **Comprehensive:** The case management service plan should reflect the complexity of services the child and family needs across the life domains and should emphasize assisting the system to work towards achieving the child's best interest.

9. **Outcome Focused:** Supervision is a central aspect of case management quality assurance. Service evaluation by and for families is a focal point of case management, evaluating for effectiveness and client satisfaction.
10. **Special Needs:** Case management services recognize the differences between functional abilities of children and mold services to accommodate these differences.
11. **Acuity Driven:** Case management services are designed to match the child's mental health acuity and service levels meet the intensity of the child and family needs.

Indicators of Effective Case Management Service Planning and Implementation:

- The service plan is based on an ongoing assessment that considers the child and family needs across all life domains.
- The case manager has linked the family to all necessary services.
- The case manager has organized all services for the child and family in a coordinated manner.
- The case manager is overseeing all relevant services to assure they are meeting the stated needs.
- The case manager meets the requirement for family, school and community contacts according to the level of case management required.
- The case manager has invited the family to participate in the service planning and design and has given them a copy of the signed service plan.
- The case management service plan is specific as to what activities need to be done by whom and when they need to be done to accomplish stated goals and objectives.
- The case manager has consistently documented their activities, other services provided, and the child and family's response to the services.

Criteria for Case Management Discharge

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

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

- Services have been accessed, utilized, and effective and no longer need significant coordination,
- The child and family have gained new coping skills and are staying linked with other appropriate services,
- Manifestations of the SED are managed and minimized,
- The child and family have developed and maintained some natural supports,
- The family and the child are understanding of the risks for relapse and have a plan to engage in when symptoms resurface before significant regression occurs.

Chapter IV: Family & Professional Partnership

Family participation in an integrated service delivery system for children and their families is increasingly the norm around the nation. Children experience improved educational outcomes and well-being, and reduced length of stay in out-of-home placements and residential settings when their parents are involved. Young people with behavior problems whose parents participated in a program of intensive family support and intervention in their alternative school showed improvements in behavior, grade point average, attendance, and drop out rates. Family partnership also appears to reduce the length of stay in foster care, residential treatment, and psychiatric hospitals.⁵

Mental health of children depends on family involvement. A broad definition of family should be considered in who may be a resource to the child with SED: “A primary caregiver or adult with substantial and ongoing involvement in the life of a child who has (or lives of children who have) emotional, behavioral, or mental disorders. This could include anyone who functions in the role of a family member, including parents, aunts, uncles, grandparents, siblings, foster parents, guardians . . .” (System of Care, Promising Practices for Children).

It is critical for professionals to create an environment for partnering with families at the service plan and the system development levels. Case managers play a very important role in facilitating both. Allies with Families in North Salt Lake, Utah in collaboration with Dr. Mary McCormack, Dakota Enterprises, developed the “Family Perception of Care Scale.” This scale provides immediate feedback to the mental health provider about the quality of the family’s experience in accessing and receiving services for their child with a serious emotional disorder. Based on the findings using this scale in Utah, assertive case management powerfully impacts the family’s ability in:

- Accessing services
- Maintaining parental employment during child’s difficulties
- Successfully transitioning from one service to another
- Collaborating with other professionals to reach service plan goals
- Improving the quality of family life since service inception
- Accessing entitlements to avoid severe family debt
- Being included in the educational planning for the child with SED
- Having advocates for both the child and the family, and
- Developing positive social/recreational activities.

Families as Effective Participants in System Development

For family members to participate actively as partners they must be informed, educated, and persistent. Participation is a right of all parents, not only those who have these qualities. Providers may support families’ participation by:

⁵ Family Participation in Systems of Care: Frequently Asked Questions and Some Answers. CWTAC Updates. Series on Family and Professional Partnerships. January/February 2002. Vol. 5, Issue 1, pp. 1-2

- Developing and maintaining a climate that is respectful of parents and supportive of participation.
- Offering real opportunities for participation.
- Sharing information.
- Providing training so that families are able to be full participants.
- Offering concrete assistance, such as childcare, transportation, and reimbursement for expenses and time taken off work.⁶

What Families Bring to the Case Management Relationship

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

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

What Families Need in Partner with Professionals

Family members find that the term “case manager” depersonalizes them and distances them from addressing their real needs. Family members prefer the term “service coordinator” to describe the person who works closely with their family to help them

⁶ Friesen, B.J. & Koroloff, N.M. (1990). Family –centered services: Implication for mental health administration and research. *Journal of Mental Health Administration*, 17 (Spring), 13-25.

negotiate the system of care, take responsibility for themselves in caring for their children, and establish networks of contacts with the system.⁷

There are some basic things that families need from professionals to better facilitate their ability to develop partnerships at all levels. These are:

- Non-dominant help, information on SED and the system of care, and training on family advocacy,
- Information in a timely, straightforward, and accessible fashion, free of jargon and acronyms,
- Opportunities to exercise their management skills,
- Safety, closeness, and appreciation,
- Expressions of opinions and emotion,
- Acceptance of their differences,
- Access to appropriate services,
- Voice in and ownership of service plan development,
- Freedom from labels such as ‘dysfunctional’, etc.

The Continuum of Family/Professional Relationships

This is the continuum of how systems view and work with families. Professionals seeking to partnership with families will find this useful as a self-evaluation tool. Mental health agencies benefit from using this kind of thinking about the professional and family role in service design and in developing win-win partnerships.

Team Centered	Family Driven	Family Allied	Family Focused	Professional Centered
<ul style="list-style-type: none"> • Wraparound model • Team makes decisions • Team includes family, provider, child and others 	<ul style="list-style-type: none"> • Professionals are one down to families • Parents know best • Professional’s role is to support families to help their child 	<ul style="list-style-type: none"> • Families are customer • Family caregiver an equal • Family and professional work collaboratively to address mutually agreed upon goals 	<ul style="list-style-type: none"> • Families are helpers and allies • Caregiver is one down • Professional is the expert 	<ul style="list-style-type: none"> • Adversarial Professional-parental relationship • Professional is the expert • Parent is the problem

⁷ Osher, T., deFur, E., Nava, C., Spencer, S., Toth-Dennis, D. (1998). New Roles for Families in Systems of Care. *Systems of Care Promising Practices in Children’s Mental Health*. (1), p. 27.

Team Centered

The wraparound model centers decision making with the team. Team strengths and resources (which include those of the provider as well as family and child) are collected and used to select the interventions most likely to work. Both planning and interventions rest on the combined skills and flexible resources of a diversified, committed team. Responsibility for decisions rests with the team as a whole, working together and supporting each other as well as supporting the family.

Family Driven

Practice at this level of the continuum puts professionals “one-down” to the family caregiver. The philosophy is that parents know what is best for themselves and their children. The philosophy is that professionals’ services exist to support parents as the primary agent in helping the child achieve his or her goals.

Family Allied

Families are viewed as the customer in the service delivery system. Professionals strive to attune the services to the needs and desires of the family which is their customer. Providers see the family’s caregiver as an equal colleague, one who has expertise, knowledge and choice. Professionals and caregivers work collaboratively to address mutually agreed upon goals.

Family Focused

The professional philosophy views the professional as expert with families as helpers and allies to the professional. The professional knows best and the relationship to the parent is one of getting the family caregiver to become a partner in helping the professional. The caregiver is “one-down” because the professional decides the rules and roles, and the caregiver is merely an agent of the professional.

Professional Centered

The professional stance that considers the professional to be the expert and views the family as a hostile resistive force in the way of achieving professional goals. The professional-parent relationship is unfriendly, viewed as adversarial with the parent as the problem. This attitude results in the view of the family caregiver as someone who can be “taught or treated.” The parent must adapt to the professional’s service values.

Family-Provider Definitions

Family-Provider Collaboration

Family-provider collaboration in children's mental health services is the process that participants (including family coordinators and advocates, therapist, administrators, social workers, and case managers) in systems of care reengage in to improve services for children and their families, and requires:

- Ongoing dialogue on vision and goals
- Attention to how power is shared
- Attention to how responsibilities in planning and decision making are distributed
- Open and honest two-way communication and sharing of information
- That all participants in system of care are seen as mutually respected equals

Efforts at collaboration must occur at all levels of the system of care, including evaluation, program design and implementation, and delivery of services.

Traditional Mental Health Services

Include services that are usually: (1) limited to outpatient, day treatment and in-patient services; (2) prescribed by a professional with little or no family participation; and (3) categorically funded.

Participants in Systems of Care

Anyone who supports the development, evaluation, or delivery of services to children with emotional, behavioral and mental disorders and their families; including family members, social workers, providers, site directors, and case managers. Support is broadly understood and includes education, advocacy, respite, identification and referral, assessment, development and evaluation of services.

System of Care

A comprehensive spectrum of mental health and other support services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families.

Professional

People within a system of care who have had specific educational training concerning the delivery of services to children with emotional, behavioral, and mental disorders and their families.

Promising Practices in Family-Provider Collaboration

A practice, strategy, or approach that participants in children’s mental health systems or care have developed that: (1) leads to improved collaboration among family members and providers and that (2) ultimately supports family-centered services and improved outcomes for children. Promising practices are examples of collaborative processes that participants in systems of care are developing.

Family Member

A primary caregiver or adult with substantial and ongoing involvement in the life of a child or the lives of children who have emotional, behavioral, or mental disorders. This could include anyone who functions in the role of a family member, including parents, aunts, uncles, grandparents, sibling, etc.

Family Advocate

An individual who is a primary stakeholder in the well-being of children and who actively works to improve the delivery of mental health services to an individual family and their child (or children), and/or to change the mental health service delivery system so that it is family-centered.

Family-Centered

A system of care which is family-centered:

- Supports all family members involved with the child’s care
- Involves all family members in all aspects of planning and evaluating the service delivery system (including services for themselves and the services for their families.)

Values and Family-Centered Principles:

- A family is a constant in a child’s life but the service system and professionals in the systems change.
- Information should be shared in an on-going, unbiased, and supportive way.
- All families have strengths and different ways of coping that need to be recognized and respected.
- Policies and programs should be comprehensive and provide emotional and other forms of support to the family.
- Services and supports should be incorporated into existing community services.
- Parent-to-Parent support should be encouraged and made possible by agencies.
- Services and supports need to be affordable, flexible, accessible, and responsive to a family’s needs at a given time.
- Professionals must be culturally competent and respect diversity among families.
- Collaboration is the foundation of family-centered programs; a collaborative spirit is the key to a sound family-professional partnership.

9 Elements of Collaboration with Families

- Mutual respect for knowledge and skills
- Honest and clear communication
- Understanding and empathy
- Mutually agreed upon goals
- Shared planning and decision-making
- Open and two-way sharing of information
- Accessibility and responsiveness
- Joint evaluation of progress
- Absence of labeling and blaming

Strategies for Involving Families

- Involve multiple family members.
- Make sure that the group is diverse; be sensitive to ethnic, gender, geographic and disability factors.
- Compensate families for time, child care, transportation, and other costs related to the meeting; professionals are paid for attending, and families should be paid, too.
- Give families meaningful roles; from the outset they should actively work on the planning, design, implementation, and evaluation of programs, supports, policies, and services.
- Respect families' choices, ideas, and opinions.
- Make sure that families have access to all information given to other board or committee members.
- Make sure that the invited family members truly represent the needs of the working group.
- Conduct meetings at mutually convenient times; ask families for "best" and "worst" times before scheduling during the workday.
- Provide families for opportunities to assume leadership roles within the group; have the chairperson rotate or have co-chairpersons.
- Provide families with opportunities for taking part in retreats, conferences, and other special events usually attended by professionals only.
- Offer families honoraria for speaking, writing articles, and taking on other board-related roles for which consultants would receive honoraria.

Chapter V: Education and Case Management

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

Case Managers, Students, and Schools

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

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

Special Education: IDEA

The Individuals with Disabilities Education Act Amendments (IDEA) of 1997 brought changes to the law initially passed in 1975. Since that date, this law has guaranteed that eligible children with disabilities have available to them a free appropriate public education (FAPE) in the least restrictive environment appropriate, based on an IEP designed to meet their unique educational needs as determined by a multi-disciplinary team including parents and other service providers as appropriate. IDEA not only applies to children of school-age but includes infants, toddlers, and preschoolers, as well. Beginning with referral for eligibility determination, procedural safeguards offer protections for child and parental rights. The newest amendments address changes in evaluation, parental participation in eligibility and placement decisions, IEP requirements including addressing special factors such as behavior strategies and supports if the child’s behavior impedes his/her learning or that of others, transition services, mediation, and discipline of children with disabilities.

Six Major Provisions of the IDEA.

1) *Zero Reject.* No child in need of and eligible for special education will be excluded from receiving services—even those children with the most severe disabilities.

2) *Non-discriminatory evaluation.* Children will be evaluated to determine if they need special education services and meet eligibility requirements. Before they can be found eligible or placed into a special education program, they must be evaluated by a team of professionals. The law requires that the instruments used evaluate both strengths and weaknesses; that the process is non-discriminatory, that all tests and other materials are given to children in their own language and in such a manner that their abilities and disabilities are reflected accurately; and that eligibility is not based on a single test or test score but upon results obtained from several tests, including observations and interviews.

3) *Free, appropriate public education.* Each child determined eligible for special education services will have access to a full range of services that may include related services such as psychological or psychiatric services, counseling, speech/language therapy, or other services to assist him/her to benefit from special education. These services and their appropriateness will be determined through the Individual Education Plan (IEP), which is developed by a team including family members and educators.

4) *Least restrictive environment.* Children with disabilities will be educated to the extent possible with children who do not have disabilities. When the IEP is written, a determination is made regarding the amount of time each student with disabilities will spend with students who are not disabled both in the classroom setting and other school activities. Students are educated in separated programs, classrooms, or schools only when the nature and severity of their disabilities are such that such a setting is required to meet their educational needs in a less restrictive environment.

5) *Due process safeguards.* Parents have the right to challenge decisions made about their child including evaluation, inclusion or exclusion, appropriateness of the IEP, or the placement. Provisions are made for settlement of disputes by a third party. In addition, parents must be notified of this right and of “notice”. Whenever any change is made with regard to their child’s evaluation, entrance or exit from services, the parent must be notified in advance. Consent of the parents prior to such changes is required in some situations.

6) *Family participation and informed written parental consent.* Informed written consent by parent(s) is required prior for initial evaluation and placement. Parents are involved in the IEP development and review and provide written approval or disapproval. Parents have the right of access to their child’s education records for review and must provide written consent prior to the release of personal identifiable information.

Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 provides that “No otherwise qualified individual with a disability...shall solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance”. 29 U.S.C. 794(a).

A person is considered to be “disabled” under Section 504 when s/he “has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment. 29 U.S.C. 706(8XB).

Section 504 requires that programs receiving federal funds be accessible to individuals with disabilities. Accessibility requirements mean that students with disabilities cannot be denied access to programs due to architectural barriers, admission practices, or because they require related services or auxiliary aids.

Section 504 requires reasonable accommodations. This means that the accommodations do not change the essential components of the program, rather that they provide the opportunity for the student who is otherwise qualified to participate.

Some examples of adaptation and modification in school settings include:

- modifying instructional equipment,
- modifying or adapting the way in which course work is offered such as providing a tape of the course,
- recording of written materials,
- providing related services such as transportation,
- counseling,
- physical therapy,
- making academic adjustments which will allow the student the opportunity to participate, including modifying academic requirements,
- adapting tests or testing procedures;
- providing auxiliary aids such as interpreters,
- adapted equipment, language boards, and taped textbooks,
- evaluation.

Americans with Disabilities Act (ADA)

The ADA expands anti-discrimination protections for persons with disabilities. Passed in 1990, the ADA provides individuals with disabilities similar civil rights protections provided to all individuals on the basis of race, sex, national origin, and religion. Similar to the Rehabilitation Act of 1975, ADA provides equal opportunity for individuals with disabilities in employment, public accommodations, transportation, state and local government services, and telecommunications.

There are 5 major components of ADA: I. Employment, II. Public Services, III. Public Accommodations, IV. Telecommunications, and V. Miscellaneous Provisions. Each of these components has implications for case managers working across school and community settings.

Case Managers Can Help Families through the Educational Process

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

Chapter VI: Youth Involvement

Many of the same points made about family involvement pertain to youth involvement. Systems of care are beginning to recognize the value of incorporating a “youth development” approach, that is, engaging youth as partners in program design and implementation, affirming, and drawing on the strength of youth, and involving youth in service delivery.

Youth Transitioning to Adulthood

Adolescence is a time of transition, and many youth experience difficulty adjusting to new emotional, social, and biological challenges and demands. It is not surprising that mental health and substance use problems intensify for people in this stage of life. It is also during this time in life that people are least likely to have health insurance and most likely to experience residential changes.

The transition from youth to adulthood is stressful for almost everyone. However, transition to independent living is often extremely difficult for young people with emotional and behavioral challenges, and for their families or other caregivers.

Adolescence is a crucial time for mental health intervention because several behavioral and emotional difficulties (e.g. suicide, delinquency, substance abuse, depression) increase from childhood to adolescence to adulthood. At least one in fifteen young people in the United States has a serious emotional disturbance (SED)⁸. Yet, despite the needs of young adults with SED, they are the most underserved population by both public and private resources.

Through interdependent relationships with family and friends, community, and connections with competent and caring adults, transitioning youth will have the resources and support to succeed in all of the important areas, or domains, of their lives: employment and career development, educational opportunities, living situations, and community life functioning.

Transition to Independence Process (TIP) System Guidelines

Six guidelines of transition programs drive the successful development and operation of quality transition systems:⁹

- **Person-centered planning is driven by the young person’s interests, strengths, and cultural and familiar values.** Improved community outcomes for young people in transition stem from an informal and flexible planning process driven by the young person’s interests, strengths, and cultural and familial values, allowing for the formulation of the individual’s goals.

⁸ U.S. Department of Health and Humans Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1997.

⁹ Clark, H.B., Deschenes, N., (2001) Best Practices in Transition Programs for Youth with Emotional and Behavioral Difficulties. In *Focal Point*, A National Bulletin on Family Support and Children’s Mental Health. Spring 2001, Vol. 14, No. 1, pages 14-17

- **Services and supports must be tailored for each youth individually and must encompass all transition domains.** An array of individualized services and supports is essential during the transition from school to the world of employment and independent community living.
- **Services and supports need to be coordinated to provide continuity from the young person’s perspective.** Continuity of supports across child and adult systems is essential during the transition to adult living, especially when a young person turns 18 and begins to access adult services. To ensure access to required community resources and the creation of opportunities across all of the transition domains, collaborative linkages must be established at the young person’s level and at the system level.
- **An unconditional safety net of support is provided by the young person’s transition team.** Unconditional commitment to transitional youth by accepting referrals based on the community’s determination of who is to be admitted, and adjusting services and supports based on the current and future changing needs of each young person. Services are never denied to young people and never rejected under any circumstances.
- **Achieving greater independence requires the enhancement of the young person’s competencies.** Community life skills are necessary to successful transition into independent adult living. Such skills include problem solving, communication, daily living, money management, recreation, personal hygiene, housekeeping, emotional/behavioral self-management, and social development.
- **The TIP system must be outcome driven.** Outcomes need to focus on three features: youth outcomes, system responsiveness, and system effectiveness.

Case Managing Day-to-Day

It’s impossible to anticipate all the problems that one might encounter in case management with young people; however, certain problems seem to arise frequently. These include monitoring medications, transportation, personal money management, personal hygiene, medical and dental care, and employment training opportunities.

The primary activities of a case manager are activities that provide the ‘unifying’ element to multiple services that young people with SED often need. These activities are billable to Medicaid and other third party payers, if medically necessary and documented appropriately.

Medication Management: For many young people, a medical evaluation and prescription management are essential in preventing the recurrence of primary symptoms of mental illness, such as auditory hallucinations or “voices.” These medications, also called psychiatric medications or psychotropic medications, work to stabilize brain functioning, diminish anxiety and reduce the flood of disturbing mental messages that

children can experience. These medicines do not “cure” mental illness; however, they can help control symptoms.

Many young people view medication as help; however, they are anxious to collaborate with medical staff to maximize the most effective use of medication. Others resist the use of medication, some forget to take their medications, and some stop because they feel better without it or dislike uncomfortable side effects.

Psychotropic medications are powerful medications. They can mean the difference between a person’s ability to live in the community or need to return to the hospital. They do not substitute for housing, income or social and work connections in the community. But often, psychotropic medications suppress or eliminate the symptoms of mental dysfunction, which would otherwise interfere with the individual’s opportunities for more normal daily living.

The evaluation, prescription, and monitoring of psychotropic medications are all the responsibility of the psychiatrist affiliated with each young person. Part of that responsibility involves discussing the need for medication, its effects, and its side effects with each patient. However, as part of the mental health team, the case manager needs to have a general understanding of the purposes of medication and its effects so that he/she can support the medical aspects of the treatment plan. This responsibility may involve discussing uncomfortable side effects with the youth, requesting an unscheduled appointment with the physician, or helping the young person to get prescriptions filled.

Case managers must remember that young people have the right to treatment and the right to refuse treatment, including medication. Except under very special circumstances, young people, like other citizens, have the right to do things, which in the view of others are not good for them. Each case manager should discuss problems with medication “compliance” with the treatment team.

Personal Money Management: Often a crucial area of case management is helping the young person budget his or her financial resources. Living independently means new financial responsibilities that require self-discipline and delaying long-term purchases.

Some young people will require a Protective Payee to manage their money. The case manager may be assigned this responsibility. Here are some additional guidelines if this is the situation:

- Know your agency policies and procedures about a Protective Payee.
- Know the rules and regulations from Social Security about a Protective Payee.
- Continuously review the need for Protective Payee. Remember that a basic value of case management is to help young people to be independent and gain more control over their own affairs. Encourage them to manage their own money as soon as possible.
- Make sure to plan for holidays and vacations of staff. Young people should be able to receive their payments in spite of staff absences or agency closings.

Transportation: Often one of the duties of a case manager will be to transport young people. Some points to keep in mind are:

- If you are *not* able to drive agency vehicles, you may want to check with your own personal insurance company about coverage. You may also want to check with your own personal insurance company about coverage as a driver using an agency vehicle.
- Know and follow your agency policies about transporting young people. Discuss these policies with your supervisor.
- Do not transport young people alone whom you believe are unstable or unpredictable.
- Remember that a basic value of case management is to help young people to be independent and gain more control over their own affairs. Encourage them to explore other means of transportation.

Hygiene and Grooming: Adequate hygiene and grooming are problems for many young people. Case managers must carefully assess the possible origins and remedies for these problems before advising or directing young people to “clean up” or “get a haircut.” Advice like this will most often result in hurt feelings and will fail to change behavior. Intervention by the case manager should be preceded by a thoughtful assessment of the possible reasons for poor hygiene and grooming, and ways to help with these problems. What are some of the reasons behind these problems?

The most obvious answer to this is a lack of money. Young people living on meager public entitlements prioritize their spending to include many other needs before hygiene. Often they purchase second-hand clothes or accept donations of used clothes to conserve their fixed incomes. Second, they attend to other more pressing concerns, including their symptoms. Third, laundromats may not be easily accessible and they are always expensive. Fourth, they may not have anything or anybody to clean up for. They may see no reason to improve hygiene and grooming. Finally, poor grooming and hygiene often reflects loss of self-esteem, which commonly accompanies mental illness.

Medical and Dental Care: Adequate, timely medical and dental care is often a problem for young people. Again, common reasons are poverty and no medical coverage. Young people attempting to qualify for entitlements will find certain illnesses and disabilities “covered” and other beyond their means. The care manager needs to know or find out what medical and dental care can be obtained for the individual young person and from where. Sometimes low-cost or no-cost services can be obtained for young people from local professional or service organizations, or from colleges or universities in your area. People who qualify for Supplemental Security Income (SSI) also qualify for Medicaid coverage.

Basic Approaches to Vocational Rehabilitation of Youth:

There are two basic approaches to helping young people engage in working. Each one attempts to effectively deal with the individual's experience of mental illness. The first approach may be termed adjustment of disability.

An example of this approach is the sheltered workshop, which adjusts the tasks, length of work time, and compensation to an individual's presumed capacity for the demands of work. Basically, this involves few requirements for disabled workers and according to certain guidelines, less pay. Some individuals find this kind of situation quite satisfactory. These environments are necessarily very tolerant of the symptoms and idiosyncrasies of individuals. However, some young people complain that these environments are depressingly filled with people who have intellectual or developmental disabilities.

The second approach to helping mentally ill individuals involves adjustment to the job. This simply means that the requirements of the anticipated job determine the behavior of the employee. This is a normal work situation. It requires a certain level of cooperation with peers and supervisors, appropriate dress and grooming, punctuality, regular attendance and job specific skills. The strength of this approach is that it is a real job and real success; even partial success can give a tremendous boost to the young person's self-image. Perhaps the greatest remedy for low self-esteem that accompanies mental illness is the opportunity for the young person to escape endless "patienthood." Doing a job and being a worker means being "normal" in spite of mental illness. Getting into competitive employment is a great success and should be "celebrated" with a young person like other victories of case management.

Assistance with Employment Problems: In Utah, you may contact your nearest office of the Utah State Office of Rehabilitation (USOR). Depending upon the counselor's judgment of the young person's likelihood of regular employment, they can help, particularly with work assessment and training.

Chapter VII: Crisis and Safety Planning

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

THE BEST PREDICTOR OF FUTURE BEHAVIOR IS PAST BEHAVIOR

Predict, Prevent, and Plan

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

Effective Crisis Planning

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

Safety Plans for Children

- **Safety plans are not the same as crisis plans. All plans have a crisis plan, but safety plans exist when a safety risk to child, family, or community is present.**
- **When to develop a safety plan.** A safety plan should be developed when solid evidence of past unsafe behaviors toward self or others by the child exists.
- **Safety plans should be developed** when community concerns over safety are threatening the chances that a child may remain in their community.
- **“Better safe than sorry”.** If a family member or a professional has a sense that safety is an issue, then a safety plan should be developed.
- **Who develops safety plans?** Ideally, the child and family team working with a service coordinator or another professional with experience writing safety plans develop the safety plan. It is sometimes awkward to include persons who have been responsible for committing high-risk behaviors in the planning session; however, it is critical to attempt to have plan ownership by the child in question.

Developing a Safety Plan

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

Problem Behaviors That May Precipitate a Crisis

Popular culture and the media have portrayed people with a mental illness as violent and unpredictable. These false images of people with a mentally illness perpetuate the stigma and deepen the feelings of isolation and low self-worth already carried by many clients.

The fact is that SED children/young adults who are taking their medication are no more dangerous than the general population. People who have been or are being treated for mental illness are usually anxious, timid, and passive. They are far more likely to be the

victims of violence than to be the perpetrator. Most clients are quiet, responsible citizens who share the predominant values of their home communities. People with mental illness who are not taking their medication can be more dangerous than the general population. Factors such as substance abuse, medication noncompliance, and low insight into the illness operate together to increase violence risk. However, individuals with serious mental illnesses probably are responsible for no more than five percent of violent episodes in the United States.

Sometimes some clients do act against property, other people, or more commonly, themselves. This may involve willful law breaking or impulsive reactions to stressful situations or their own thoughts and feelings. It is impossible for anyone, including mental health professionals, to reliably predict how someone else is going to behave. There are guidelines that can help you respond helpfully and safely to these types of situations. The following sections describe some different categories of problematic behaviors along with suggestions for ways to respond.

Illegal Behaviors

Behaviors that are illegal for one citizen are also against the law for every other citizen. It is not the case manager's job to protect clients from the consequences of their own behavior. The motive behind criminal acts, whether sane or not, is a matter for legal authorities to determine. All case managers and clients should understand that the police should be notified when the law is broken.

Substance Abuse

Clients will sometimes choose to use alcohol and/or street drugs for a variety of reasons. Adult clients are free to use alcohol in accordance with applicable laws in their communities. However, they should be informed of the dangers usually associated with both drug and alcohol use, along with the possibility of dangerous interactions that these substances may have with psychiatric medications. Clients will sometimes stop taking their prescribed medication and prefer to "self-medicate" with alcohol or street drugs to relieve their symptoms, preferring these substances to their prescribed medication and the accompanying side effects. The case manager can provide the client with accurate information upon which to make decisions.

Threatening, Violent, or Homicidal Behavior

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

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

If the danger does not diminish, then physically remove yourself and others from the situation and contact the police. The law requires that you inform anyone that has been threatened by another that his or her safety is jeopardized, and Utah state law also specifically requires all mental health personnel to report known or suspected situations of child or adult abuse to the appropriate authorities. 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 the case manager, to physically restrain people who are out of control.

Suicidal Thoughts and Behaviors

Suicidal thoughts and behaviors are fairly common with clients 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 him/herself (or others) or take his/her own life during a psychotic episode.

All suicide threats must be taken seriously. It is essential that you consult with your supervisor and remains in close contact with your supervisor throughout the danger period.

Safety is the number one priority during these times. Case managers should ensure that clients are aware of the availability of 24-hour crisis services in their area and know how to access these services when needed. This information should be reviewed with the client, and with the client’s treatment provider, on a regular basis.

Taking Care of the Caregiver

Working with people can be stressful. Working with persons who are poor and who suffer from mental illness can be even more stressful. It is important to take care of yourself – physically, emotionally, and socially. You may have opportunities to attend time management and stress management workshops. They will go into more detail about coping with the challenges of your job. But here is a list of suggestions that may be useful.

Time Management

- Make a daily plan of tasks.
- Prioritize the list. Identify those tasks that have to be done today (As) from those which should be done, but could be done tomorrow (Bs) and those which are not that important (Cs).
- 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, not a ball and chain. You will find that you often have to adapt and revise.
- Let the clients know when you will have time to provide transportation, go shopping, etc. 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 clients the way you want to be treated.
- Make a “grass-catcher” list. This is an ongoing list of things to be done, but do not have a specific deadline. When you are making your daily “to do” list, consult this “grass-catcher” list.
- Always ask “what is the best use of my time right now?”
- Do not always do other people’s “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
Moderate withdrawal from social contact

Stage III – Burnout

Skin rashes
Generalized physical weakness
Strong feelings of depression
Increased alcohol intake
High blood pressure
Ulcers
Migraines
Severe withdrawal
Loss of appetite for food
Loss of sexual appetite
Excessive irritability
Emotional outbursts
Rigid thinking

Stage IV – Burnout

Asthma
Coronary artery disease
Cancer
Severe depression
Lowered self-esteem
Inability to function on 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.
- Cultivate pleasurable activities and hobbies that will offer you balance and peace.

- Develop a positive, nurturing support system.
- Exercise regularly.

Chapter VIII: Administrative Models of Case Management

In Utah, Community Mental Health Centers (CMHCs) are operating from one of the two primary models of case management delivery systems, or a combination of both models, to fit the needs of the child and family (both in quantity and intensity of services), based on location or other factors individual to the organization. The CMHC will have a plan to develop a model of case management delivery that meets the indicators of effective practice.

- **Decentralized Case management** units with case managers who act as a member of the child's core service team in partnership with the family, mental health therapist, and others.

Indicators of effective practice in the decentralized model:

- a. The case manager monitors all services the child is receiving,
 - b. The case manager provides focus to the coordinating function,
 - c. Supervisors assure the priority and time allotment for the case management service,
 - d. The case manager is capable of providing skills development and behavior management if necessary,
 - e. Services are primarily community based,
 - f. Supervisors have developed an internal process to effectively manage the additional layer of communication between the case manager and psychotherapist and medication provider for the child and family,
 - g. Supervisors monitor to assure that acuity and stabilization govern discharge from services, not length of time.
- **Centralized Case Management** utilizing the Primary Service Coordinator (PSC) who is the child's psychotherapist and case manager.

Indicators of effective practice in the centralized model consist of:

- a. The child and family are relieved of an additional layer of communication,
- b. The PSC links and monitors child and family to internal and external services,
- c. Supervisors assure the PSC has a reduced caseload to adequately provide this function for children who are SED and involved in multiple services,
- d. The child and family receive the appropriate level of case management that reflects their needs based on their acuity,
- e. Supervisors see that acuity and stabilization govern the array of services and discharge from services,
- f. Providers are available to broker behavior management and skills development to children and families.

Supervision and Training Guidelines for Children's Case Managers

Supervision of case management staff begins with the critical decision of hiring competent staff. The CMHC assures the case manager meets provider qualifications and

requires them to function within the accepted scope of service. The CMHC demonstrates its commitment to a successful case manager by providing regular training needs assessments and provision of in-service training to meet these needs. Supervision of case managers is done weekly for probationary staff and at least monthly for staff that has achieved permanent status. Supervision meetings occur regularly and are documented. Supervisory meetings occur in the natural service sites for observation of and role modeling for case managers.

Supervisory Criteria to Determine Case Acuity and Weighting

Recommended caseloads and service plans are based on the child's acuity derived from a regularly scheduled review process that includes a functional evaluation. Each CM Supervisor utilizes a case acuity and weighting process to assist case managers in determining the level of service intensity required, and to determine caseload distribution.

- Supervisors use the case weighting to determine appropriate caseloads and required level of service intensity.
- Case weighting to match the client's level of functioning within that life domain for the previous 30 days is done monthly between case manager and supervisor.
- Case weighting is totaled per client to determine which level of case management services they need.
- The evaluation of a client's acuity should be done at least monthly to determine which level of case management is needed.
- A point differential is allowed for urban/rural caseload based on urban access to public transportation and availability of services. For rural areas, higher points are required for a full caseload due to the frequent necessity to act as a provider of services rather than a broker along with the lack of public transportation.

Guidelines for Levels of Case Management Intensity

Children's case management is a special service in the array of mental health services provided to children with SED and their families. It is a special service because it increases the acceptability and effectiveness of other services provided to the child and family. Providing the level of intensity of case management needed by the family only increases the likelihood of other therapeutic efforts working. Graduating the levels of intensity increases the likelihood of these efforts having a lasting effect with children and families.

Supervision for Sticky Situations

There are situations that a case manager must be aware of and the CMHC has a written policy and procedure in place that case managers and supervisors are knowledgeable about for handling these difficult situations. Supervisors and case managers meet face-to-face to assure the case manager has adequate knowledge, skills, ability, and support to handle these and other "sticky situations."

- Suspected child abuse and neglect
- Threats and assaultive behaviors
- Suicidal thoughts and behaviors
- Refusal of medications and/or psychotherapy

- Alcohol and/or substance abuse
- Illegal behaviors
- Interagency conflicts with service plan and/or providers
- Dual roles of case manager
- Allegations of professional misconduct

Health Insurance Portability and Accountability Act (HIPAA)

The “Privacy Rule,” is a Federal regulation under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that protects certain health information. The Privacy Rule was issued to protect the privacy of health information that identifies individuals who are living or deceased. The Rule balances an individual’s interest in keeping his or her health information confidential with other social benefits, including health care research. The Privacy Rule (also known as *Standards for Privacy of Individually Identifiable Health Information*) is in Title 45 of the Code of Federal Regulations, Part 160 and Subparts A and E of Part 164. The full text of the Privacy Rule can be found at the HIPAA Privacy website of the Office for Civil Rights (OCR): <http://www.hhs.gov/ocr/hipaa>.

Key Points:

- The Privacy Rule establishes minimum Federal standards for protecting the privacy of individually identifiable health information. The Rule confers certain rights on individuals, including rights to access and amend their health information and to obtain a record of when and why their protected health information (PHI) has been shared with others for certain purposes.
- The Privacy Rule establishes conditions under which covered entities can provide researchers access to and use of PHI when necessary to conduct research. The Rule is not intended to impede research.
- Compliance with the Privacy Rule was required on and after April 14, 2003, for most covered entities. (Small health plans had an extra year to comply.)

De-Identifying Data

The HIPAA Privacy Rule provides two routes by which a Covered Entity may properly de-identify a data set:

Safe Harbor Method

All eighteen identifiers (listed below) concerning the individual and the individual’s employer, relatives and household members must be removed by the Covered Entity before releasing the data to the investigator. There must be no possibility that the information remaining in the de-identified data set could be used alone or in combination with information from other sources to identify an individual within the data set.

Identification codes may be retained in a de-identified data set only if they meet all of

the following conditions:

- Codes must not be derived from any other identifiers
- Codes must not be translatable such that an individual can be identified
- Codes must not be used by the Covered Entity for any other purpose
- The Covered Entity must not disclose its key (method of re-identifying the data)
- Codes may not be derived from the Social Security Number or medical records number

The Eighteen Identifiers That Must Be Removed To De-Identify Data Are:

1. Names
2. Geographic subdivisions, addresses, and Zip codes:
All geographical subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geo codes. However, the initial three digits of a zip code may remain on the information if, according to current publicly-available data from the Bureau of the Census, the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people, and the initial three digits for all such geographic units containing 20,000 or fewer people is changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including:
Birth date, dates of admission and discharge from a medical facility, and date of death; for persons age 90 and older, all elements of dates (including year) that would indicate such age must be removed, except that such ages and elements may be aggregated into a single category of “age 90 or older.”
4. Telephone numbers
5. Fax numbers
6. Electronic mail addresses
7. Social security numbers
8. Medical record numbers and prescription numbers
9. Health plan beneficiary numbers
10. Account numbers

11. Certificate/license numbers
12. Vehicle identifiers, serial numbers, and license plate numbers
13. Device identifiers and serial numbers
14. Universal Resource Locators (URL) for websites
15. Internet Protocol (IP) address numbers
16. Biometric identifiers, including fingerprints and voice prints
17. Full face or comparable photographic images
18. Any other unique number, characteristic, or code that could be used to identify the individual

Statistical Method

A Covered Entity may obtain certification from a statistician familiar with accepted de-identification methods that there is a “very small” risk that recipients of the data would be able to identify individuals using the information alone or in combination with information from other sources.

If you have questions about de-identified data in research, please contact:
Vinita Witanachchi, J.D., USF DRC Research Privacy Officer, HIPAA Program
Coordinator
Telephone: (813) 974-5478 or e-mail: vwitanachchi@research.usf.edu

Chapter IX: Evaluation Tools

Case Management Services Assessment Form

NEED AREAS		ONE	TWO	THREE	FOUR	FIVE	FIRST ACUITY	30-DAY ACUITY	60-DAY ACUITY	90-DAY ACUITY	CLOSING ACUITY
Safety		No history apparent danger to/from self/others	No apparent danger to/from self/others; crises are few and effectively managed with minimal intervention	Remote history or mild risk of danger to/from self/others; crises are decreasing	Recent history of danger or moderate risk of danger to/from self/others; -- Crises are frequent -- Problem solving skills are poor	Severe risk of danger to/from self/others; clear pattern of crises: -- Frequent use -- Underutilization of crisis services					
Housing & Living Environment		Stable and standard living conditions exist; no monitoring needed	Stable and standard living conditions exist; minimal monitoring needed	Stable and standard living conditions are recent; temporary monitoring need	-- Eviction notice or other landlord warnings received -- Substandard conditions present likely dangers	-- Eviction in process -- Substandard conditions present imminent danger					
School Attendance and Performance		Attendance & performance at optimal level	Attendance & performance adequate; resource services appropriate	Attendance & performance adequate; resource services appropriate, but must be monitored	Attendance & performance periodically poor or resource services are not adequate	Attendance & performance consistently poor or resource services are inappropriate, withheld or not arranged					
Substance Abuse		No history or no apparent evidence	No apparent evidence within past month	Occasional impairment or disruption	Minor, but constant impairment or disruption	Impairment or disruption within 2 or more life domains					
Physical & Medical		Needs are met	Needs recently met	Needs met but require monitoring	Needs met but require coordination and linking	Physical & medical needs unmet					
Multi-Agency Collaboration		Agencies involved function collaboratively	Agencies involved coordinate well, occasional monitoring	Agencies coordinate, but must be monitored	Communication & coordination is poor, requiring advocacy	Agencies involved are unclear or are simply making situation worse					
Financial Resources		Adequate and managed without assistance	Adequate & managed with minimal monitoring	Newly increased & managed, but requires monitoring	Standard entitlements are in place, but are still inadequate	Resources, entitlements & benefits are not arranged or application is in process					
Treatment Participation		Active participation in treatment without assistance	Active participation in treatment with minimal assistance	Participates in treatment with ongoing assistance	Somewhat resistant; participation minimal	Resists treatment; participation minimal or non-existent					
Structure & Supervision		Structure & supervision satisfactory and meets client's needs	Structure & supervision adequate requiring minimal monitoring	Structure & supervision newly arranged and must be monitored for adequacy/compliance	Structure & supervision arranged, but compliance is poor or sporadic	Structure & supervision is not adequate for client's needs or compliance is minimal					
F A M I L Y	Relations & Support	Active family participation & support; relating in a constructive manner	Active family participation & support; relating in a constructive manner with minimal prompting	Family participation & support; relating in a constructive manner with prompting	One or more family member's participation & support is minimal or tenuous; relates in a constructive manner < 75% of the time	One or more family member's participation is destructive to treatment process; relates in a constructive manner < 50% of the time					
	Vocational Training & Employment	Family enrolled and attending vocational training or suitably employed	Family member enrolled and attending vocational training or suitable employment; minimal monitoring needed	Family member recently enrolled in and attending vocational training or suitable employment; monitoring needed	Enrolled in vocational training, but does not attend regularly or is temporarily unemployed	Family member appropriate & eligible for vocational training but is not currently enrolled or is persistently unemployed.					
	Community & Social Support Network	Appropriate use of stable and supportive network	Appropriate use of stable and supportive network with minimal monitoring	Network newly expanded, but must be monitored to avoid isolation.	History of isolation or sole dependence upon agencies for support	Severe isolation or sole dependence upon agencies for social support					
TOTALS											
AVERAGE											
DATE											
Global Acuity at Opening of Episode [± by 12]			Global Acuity at Closing of Episode			Change in Goal Acuity					
Goal #1:				Opening Acuity	Date	Closing Acuity		Date			
Goal #2:				Opening Acuity	Date	Closing Acuity		Date			
Goal #3:				Opening Acuity	Date	Closing Acuity		Date			
				OPENING AVERAGE				CLOSING AVERAGE			

_____ / ____ / ____ Parent/Guardian's Signature	Date	_____ / ____ / ____ Client's Signature	Date
_____ / ____ / ____ Case Manager's Signature/Title	Date	_____ / ____ / ____ Treatment Coordinator's Signature/Title	Date

UTAH SCALE FOR CHILDREN/ADOLESCENTS WITH SERIOUS EMOTIONAL DISORDERS (SED)

SED DEFINITION

Serious Emotional Disturbances (SED) is the inclusive term for children and adolescents whose emotional and mental disturbances severely limits their development and welfare over *a significant period* of time and requires a comprehensive coordinated system of care to meet their needs.

SED DETERMINATION

Children/adolescents must be **under** 18 years of age, or under 22 years of age if disabled and receiving special education services or under the jurisdiction of the Court. **All** three (3) of the following criteria must be met in order to be defined as SED. The severity of the child's/adolescent's disorder may place or potentially place him/her at significant risk for out of school, home, or community placement. **Indicate the appropriate response to each of the areas below.**

_____	_____	DIAGNOSIS: Child/adolescent must have a recent (within 1 year) DSM IV diagnosis. Children diagnosed with a designated V-Code must also have a non-V-Code, Axis I diagnosis to meet this criterion.
Yes	No	

_____	_____	DISABILITY: Child's/adolescent's degree of impairment consistently prevents appropriate functioning in at least two of the following life domains for ages 3 and older: a) Age appropriate self-care b) Family life c) Education d) Community living e) Personal hygiene f) Leisure time management g) Peer relationships
Yes	No	

For infants and toddlers, 0-2 years of age, only one area of significant delay in age appropriate development is required.

_____	_____	DURATION: The disorder must have been present for at least one year is anticipated to persist for a year or longer is of such a <i>significantly high severity</i> that the impairment of appropriate functioning and the residual effect is anticipated to negatively persist for a year or longer.
Yes	No	

_____	_____	SED DEFINITION: The child/adolescent meets all three of the criteria above.
Yes	No	

ORIGINAL DATE	____/____/____.	REVIEW DATE	____/____/____.	____/____/____.
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Review Date: Must be reviewed at least annually, or sooner if there is a significant change in the diagnosis or disability.

Name of Client _____ **ID#** _____

Signature of Therapist _____ **Date** _____

Revised: 06/30/99
Approved: 10/15/99

FAMILY CASE MANAGEMENT LEVEL OF CASE ACUITY AND WEIGHTING

- Case weighting is totaled per child and their family. The evaluation of a client's acuity will be done at least monthly to determine which level of case management is needed.
- Recommended caseloads and individual service plans are based on the child and their family's acuity derived through a regularly scheduled review process that includes a functional evaluation.

Assessment guidelines for determining eligibility for case management.

Priority Three: Children who: 1) have been determined to have a serious emotional disorder, 2) who have an open chart with the CMHC, 3) who have been treatment at Utah State Hospital, a residential treatment center and/or two or more psychiatric inpatient hospitalizations, and 4) there is no other agency that is statutorily responsible for case management for this child.

Priority Two: Children who: 1) have been determined to have a serious emotional disorder, 2) who have an open chart with the CMHC and 3) who are at an increased risk of being placed at any psychiatric inpatient hospital or residential treatment center.

Priority One: Children who 1) have been determined to have a serious emotional disorder, and 2) that would benefit from having a coordinated, comprehensive system of care, behavioral management and/or skills development.

Functional Evaluation

Family's Name:

Date of Review:

	Level 1 2 Points	Level 2 3 Points	Level 3 5 Points	Points
Family:	Parents/guardians are collaborators with the case manager in their child's service plan and they are hopeful for their child's recovery and/or their personal problems are significantly improved.	Parents/guardians are using new skills to manage crises and/or have a plan to address areas that have negatively affected the child in the past.	Parents or guardians find the child's disability to be disturbing and cannot manage the child in the home, and/or parents/guardians are experiencing significant psychosocial problems that significantly impeded their parenting.	
Safety:	Past history of violence, abuse and/or neglect is not currently impeding child or family's functioning and members have begun to feel safe and secure with each other. Neighborhood is relatively safe for children and family.	Past incidence of domestic violence physical or sexual abuse or neglect that has the significant potential for reoccurring. The child is beginning to learn anger or depression management and has not been violent in the past 30 days. Neighborhood and family have taken steps to improve safety concerns.	Recent incidence of domestic violence, physical or sexual abuse and/or child are deprived of basic needs. The child has initiated violence towards self or others. Neighborhood situations threaten family integrity.	
Living Environment:	Stable housing situation and/or the child has become stable after returning home.	Family's housing is inadequate but not threatened and/or child has returned home from alternative out of home care in the past 30 days.	Family is homeless or the family has been/will be evicted with no alternatives or the child is in state custody, a residential treatment, or inpatient hospitalization.	
Medical/ Substance Abuse	Mild disability, no illness. Child is beginning steps in recovery and accessing self-help or drug treatment.	Disability continues, illness has been treated unsuccessfully or intermittent use of substances.	Disability or illness that impedes mobility or access to services or uses substance daily or almost daily.	

	Level 1	2 Points	Level 2	3 Points	Level 3	5 Points	Points
Educational:	Child is attending school regularly and an IEP or 504 plan is place and working for the child.		Child has re-entered school and is having more than spotty attendance; IEP or 504 just initiate and no evidence of it working; or recent referral.		Not attending school at all or expelled.		
Emotional/Behavioral:	Child is participating in treatment with family support. Child is stabilized and is increasing behaviorally appropriate over 60% of the time. Family is beginning to identify child's strengths.		Child is beginning to take medication and/or participating in therapy, skill development and/or experiencing some successes; destructive behaviors have significantly decreased.		Child is demonstrating destructive behaviors to self or other and is resistant to getting help for themselves and/or the help is not adequate.		
Cultural/Social	Child and family is beginning to be comfortable living bicultural and are establishing a social support network, child is learning from mentor and is beginning to have or is re-establishing positive friendships.		Child and family are effluent in both English and first language; have re-established some customs that were important to them, beginning to reach out to others, and/or child has a mentor and beginning to relate to him/her.		Child and family primary language is other than English and isolated from a natural support system and/or child are very isolated or gang involved.		
Legal:	Child and/or family may be on the edge of law involvement or has successfully completed court requirements. Successfully completed court requirements, successfully completed juvenile court requirements.		Child and/or family member has received community service hours and is at risk of further law involvement.		Child is on probation or State Supervision.		
Case Point Total: Between 16 and 40 points.							
Total Case Points are divided by 10. This will give an estimate or recommendation of the number of hours to work with the family per week.							
Level of Case Management Service Intensity Required: 1, 2 or 3							

CHILDREN CASE MANAGEMENT LEVELS OF SERVICE INTENSITY

- A case acuity and weighting process is utilized to assist case managers in determining the level of service intensity required and to determine caseload distribution.
- The evaluation of a client's acuity will be done at least monthly to determine which level of case management is needed.
- Providing the level of intensity of case management needed by the family only increases the likelihood of other therapeutic efforts successes.
- Graduating the levels of intensity increases the likelihood of these efforts having a lasting effect with child and their families.
- Case management is perhaps the most essential unifying factor in service delivery.

	Level I Less than 19	Level II Between 20-29	Level III More than 30
Description	Stabilizing CM is delivered to child and family who are achieving some success in home, school and the community; using new skills and progressing. Assures ongoing workability of service plan and makes adjustments accordingly.	CM coordinates the initially developed comprehensive system of care and monitors its effectiveness and making any necessary adjustments. Child/Child and family strengths are more easily identified and accessed by the CM; ongoing crisis support is available.	Intensive CM with frequent contact and linkages to a comprehensive system of care. Behavior management and skills development. Crisis coverage available 24/7.
Mode:	One face-to-face contact with child and family per month and one or more phone contacts to support changes. One contact per month with each provider to support services being delivered in manner, which meets the goal recovery for the child and family. One face-to-face contact with school personnel. Crisis and relapse prevention planning in place.	One face-to-face contact with both child and family per week in the home; one or more phone contact per week to other providers to accrue coordination of care. At least two visits to the school or child care site and/or job site per month. Crisis intervention as unique learning opportunities.	Face-to-face assessment of needs, behavioral coaching and/or monitoring service effectiveness two or more times per week, with at least one or more contact in the home. Two to three contacts with other providers per week to assure comprehensive plan being followed through. Skills development and behavioral management are part of the in-home contact.
Expected Outcome	The child and family are experiencing success in several life domains. Crisis have significantly diminished and handled when they do occur. The family has developed more natural supports and reflects engaging each other's companionship.	The child will return to steady school attendance with an appropriate IEP or 504 in place. The family will feel supported through adequate services and the child is safe and stable in their home.	The child is able to be transitioning to a home environment or be stabilized in their home. Injurious behaviors to self or others are being replaced with new skills. The child and family have gained access to all needed services and the service plan is addressing their needs.
Movement	Acuity is reviewed monthly with UR or superior. Child and family will be eligible for discharge after adequate stabilization and provided reentry to CM services if situation worsens.	Acuity is reviewed monthly with UR or supervisor. Child may move from one level to another as acuity lessens or increases.	Acuity is reviewed twice monthly with supervisor. Child may move from one level to another as needed.

Medicaid's Provider Qualifications: TCM

Qualified Targeted Case Managers Include: Licensed mental health professional, including licensed physicians, licensed psychologists, licensed certified or clinical social workers, licensed social services workers, licensed registered nurses, licensed marriage and family therapists, or licensed professionals counselors;

-OR-

licensed practical nurses or non-licensed individuals who have met the State Division of Substance Abuse and Mental Health's training standards for case managers, and who are supervised by one of the licensed mental health professionals listed above.

Medicaid's Approved Scope of Services

1. **Targeted Case Management (TCM):** TCM includes Short-term and Team Case Management (CM). CM is a service that assists eligible clients in the target group to gain access to needed medical, social, educational, housing and other services. The overall goal of CM is to help Medicaid recipients access needed services and to ensure that services are coordinated between all agencies and providers involved. The purpose of gaining access to services and service coordination is to assist clients to reach their goals and/or assist clients in the recovery process with improved community integration and gain the abilities to self-manage to the greatest degree possible.
2. **Skills Development Services (SDS):** SDS may be provided by a certified Case Manager or Mental Health staff under the supervision of a licensed provider including: SSWs, LCSWs, and RNs. SDS are rehabilitative services designed to: a) assist individuals to develop competence in basic living skills such as food planning, shopping, food preparation, money management, mobility, grooming, personal hygiene, maintenance of the living environment, and appropriate compliance with the medication regimen, b) teach individuals to develop awareness of community resources, and teach individuals to develop social skills including communication and socialization skills and techniques. Symptom management and/or skills development services may also include supportive counseling directed toward eliminating psychosocial barriers that impeded the individual's ability to function successfully in the community services must be authorized and provided in accordance with the Utah Mental Health Practice Act.
3. **Behavioral Management:** Behavior management is face-to-face intervention with an individual or group of individuals experiencing a specific behavioral problem using a psycho-educational approach, after diagnosis by a mental health therapist, and in accordance with a Service Plan developed, directed and supervised by a mental health therapist and may include stress management, relaxation techniques, assertiveness training, conflict resolution, and behavior modification. Groups should not exceed ten individuals unless a co-leader is present.

May be provided by licensed mental health therapist; an individual not currently licensed but enrolled in a program leading to qualifying for licensure, or engaged in completion of clinical training after completion of the education, working under the supervision of a licensed mental health therapist; licensed registered nurse; licensed social services worker working under the supervision of a licensed mental health therapist; student enrolled in a program leading to licensure as a certified social worker working under the supervision of a licensed mental health therapist or a licensed clinical social worker; student enrolled in a program leading to licensure as a registered nurse, working under the supervision of a licensed registered nurse; or a student enrolled in a program leading to licensure as a social service worker, working under the supervision of a licensed mental health therapist. (Utah's Medicaid Plan)