FREE THROUGH Recovery

PROGRAM GUIDANCE

Published Date	09/26/2017
Revised Date	10/27/2025 (effective 12/01/2025)

North Dakota Department of Health and Human Services
Behavioral Health Division

North Dakota Department of Corrections and Rehabilitation

Table of Contents

Purpose of This Program Guidance

This document serves as both a process guide and a training manual for Free Through Recovery (FTR) providers, including Care Coordinators and Peer Support Specialists. It is intended to reinforce best practices, and provide a consistent reference for effective program delivery.

Program Background

Established through legislation in Senate Bill 2015 and House Bill 1041 during North Dakota's 65th Legislative Assembly (2017), Free Through Recovery is a community-based behavioral health program jointly administered by the Department of Health & Human Services (HHS) Behavioral Health Division (BHD) and the Department of Corrections and Rehabilitation (DOCR). North Dakota Century Code t54c23.3

Free Through Recovery was created to reduce recidivism and improve behavioral health outcomes by linking effective community supervision and high-quality behavioral health services to justice-involved individuals on DOCR supervised probation and parole, with behavioral health needs and launched on February 1, 2018.

Services are delivered statewide through a diverse network of providers, including traditional, culturally specific, faith-based, and specialized organizations.

BHD enters into agreements with providers who deliver comprehensive care coordination and peer support to individuals at risk of committing violations or new offenses and who present with complex behavioral health concerns.

According to state law, FTR operates under a pay-for-performance model, with payment determined by participant progress in and/or positive maintenance in the four outcome areas: housing, recovery, employment, and criminal justice. Outcomes are reported each period by both the provider and the participant's assigned DOCR probation, parole, or pre-trial services officer. The BHD reconciles these reports, verifies service delivery, and issues payments accordingly.

NDCC 54-23.3: Community behavioral health program – Reports to legislative management and governor

1. The Department of Corrections and Rehabilitation shall establish and implement a community behavioral health program to provide comprehensive community-based services for individuals who have serious behavioral health conditions, as a term and condition of parole under chapter 12-59, and as a sentencing alternative under section 12.1-32-02.
2. In developing the program under this section, the Department of Corrections and Rehabilitation shall collaborate with the Department of Health & Human Services to:
    a. Establish a referral and evaluation process for access to the program,
    b. Establish eligibility criteria that includes consideration of recidivism risk and behavioral health condition severity,
    c. Establish discharge criteria and processes, with a goal of establishing a seamless transition to post program services to decrease recidivism,
    d. Develop program oversight, auditing, and evaluation processes that must include:
        i. Oversight of case management services through the Department of Health & Human Services;
        ii. Outcome and provider reporting metrics; and
        iii. Annual reports to the legislative management and the governor on the status of the program.
    e. Establish a system through which
        i. The Department of Health & Human Services:
            1. Contracts with and pays behavioral health service providers; and
            2. Supervises, supports, and monitors referral caseloads and the provision of services by contract behavioral health service providers.
        ii. Contract behavioral health service providers accept all eligible referrals, provide individualized care delivered through integrated multidisciplinary care teams, and continue services on an ongoing basis until the discharge criteria are met.
        iii. Contract behavioral health service providers receive payments on a per-month-per-referral basis. The payment schedule must be based on pay-for-performance model that includes consideration of identified outcomes and level of services required.
        iv. Contract behavioral health service providers bill third parties for services and direct payment to the general fund.
    f. The Department of Health & Human Services may adopt rules as necessary to implement this program.

Administrative Roles in FTR

The BHD is responsible for:

- Onboarding approved provider agencies.
- Ensuring adherence to behavioral health best practices.
- Issuing provider payments and monitoring contract compliance.
- Reviewing service delivery and participant outcomes.
- Providing training, technical assistance, and fidelity monitoring.
- Collaborating with DOCR on all aspects of program administration.

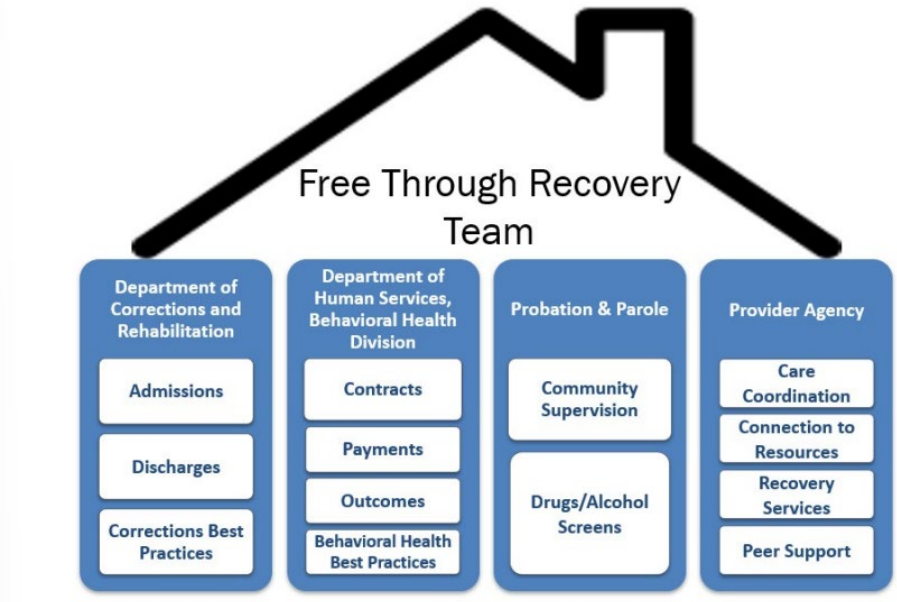
The DOCR is responsible for:

- Managing participant admissions, discharges, and transfers.
- Overseeing correctional program best practices.
- Monitoring provider service delivery.
- Collaborating with BHD on overall program operations and oversight.

Administrative roles in Free Through Recovery (FTR) are carried out by the DOCR FTR Clinical Administrator, BHD Lead Administrator, BHD Administrators, and Parole, Probation, and Pre-trial Services Officers.

The DOCR Clinical Administrator and BHD Lead Administrator work collaboratively to oversee statewide program operations, ensure adherence to corrections and behavioral health best practices, and monitor provider performance. BHD Administrators manage provider oversight, address contract and service concerns, review documentation, complete level changes, and provide training and technical assistance when needed. Parole, Probation, and Pre-trial Services Officers screen participants for eligibility, complete referrals, administer the LSI-R, conduct drug and alcohol screens, and collaborate with providers.

All administrative roles work in coordination to ensure program quality, effective service delivery, and successful participant outcomes.



Program Mission, Goals and Principles

Mission

The mission of Free Through Recovery is to improve healthcare outcomes and reduce recidivism by delivering high-quality community behavioral health services linked with effective community supervision.

Goals

The goals of Free Through Recovery are to connect and assist individuals in navigating appropriate services to address their needs and goals and provide cross-sector partnership by:

1. Improve engagement in quality services:
    a) Participants engage with a Care Coordinator who identifies their needs and helps the participant find creative, effective, and pro-social ways to meet them.
    b) Participants engage with a Peer Support Specialist with lived experience with a serious behavioral health condition

2. Provide access to individualized services that are responsive to each person's specific needs.
    a) Care Coordinators establish relationships with behavioral healthcare providers, housing resources and recovery support services.
    b) Care Coordinators and Peer Supports help with access to recovery services which include access to nourishment assistance programs, supportive housing, educational opportunities, meaningful employment, leisure activities and wellness, family and community social supports, parenting education, spiritual engagement, and any other individualized resources the person needs to help them lead a healthy and fulfilling life.
    c) Communities identify and report service gaps or barriers to meeting the needs of FTR participants that are specific to their location.

Shared Principles and Best Practices

The following principles and practices were developed by integrating the North Dakota Department of Health & Human Services (HHS) core values with the Eight Evidence-Based Correctional Practices identified by Latessa & Lowenkamp (2006). These practices guide the delivery of services within the Department of Corrections and Rehabilitation (DOCR) and inform the foundation of this program.

For additional context, refer to the publication *Evidence Based Correctional Practices* prepared by the Colorado Department of Corrections Office of Research and Statistics (August 2007).

These principles are intended to guide program implementation and service delivery. However, they are not exhaustive—other evidence-based practices and values may also influence the ongoing development and refinement of the program.

Person-Centered

Person-centered care focuses on developing and implementing individualized plans based on each participant's preferences, strengths, and choices. A meaningful life is realized when family, friends, providers, and community members actively listen and honor what matters most to the individual. Participants should have control over their services—including amount, duration, scope, and provider—and be supported in defining their own happiness and desired life.

- **Emphasize Person First with Customized Supports:** The person, not their diagnosis or system involvement, directs the planning process. Their voice, values, and relationships should guide and shape all services received.
- **Focus on Strengths:** Identify and build upon each person's talents, skills, and sources of pride. Engage those who know them well to help realize their goals and lifelong growth.
- **Balance Choice and Risk:** Respect individual autonomy by recognizing what is important to and for the person. Dignity, self-esteem, and growth often come through taking informed risks.
- **Meet the Person Where They Are:** Understand and respect the person's culture, values, and lived experiences, including past trauma. Approach with humility, recognizing that health, well-being, and community are interconnected. Avoid imposing personal beliefs or values.
- **Regularly Review Goals:** Acknowledge that needs and goals change over time. Services and supports must be flexible and updated promptly to remain aligned with the person's evolving vision.
- **Build Equity of Voice:** Empower participants to engage in decision-making. Create inclusive opportunities for underrepresented individuals to be heard and actively involved in their care and advocacy.
- **Equip for Informed Decision-Making:** Clearly explain available options and ensure the person understands potential benefits and consequences. Provide the information needed to make informed, confident choices.
- **Be Kind:** Lead with genuine compassion and care. Kindness builds trust and supports the delivery of high-quality, person-centered services aligned with the individual's needs and aspirations.

These guiding principles serve to **empower individuals**, **honor their voice and dignity**, and ensure care is truly centered around their unique life and goals

Recovery-Oriented

A recovery-oriented approach prioritizes access to a comprehensive continuum of behavioral health care, going beyond traditional clinical treatment. It integrates recovery-based supports such as peer support, recovery coaching, physical healthcare, housing, and employment assistance, recognizing that recovery is multi-dimensional and unique to each individual.

This approach is grounded in hope, empowerment, and personal choice, offering services that affirm the belief that recovery is possible for everyone. Recovery-oriented systems are strengths-based, engaging individuals with mental health and substance use conditions in care that promotes resilience, connection, and long-term recovery.

> *"Systems of health and human services that affirm hope for recovery, exemplify a strengths-based orientation, and offer a wide spectrum of services and supports aimed at engaging people with mental health and substance use conditions into care and promoting their resilience and long-term recovery—from which they and their families may choose."*
> *— SAMHSA*

- **Multiple Pathways:** There is no single path to recovery; individuals find healing in diverse ways.
- **Self-Directed & Empowering:** Recovery is led by the individual and driven by their choices.
- **Personal Transformation:** It begins with recognizing the need for change and the desire for growth.
- **Holistic:** Recovery addresses the whole person—mind, body, spirit, and life circumstances.
- **Culturally Responsive:** It honors cultural background, identity, and values.
- **Health & Wellness Continuum:** Recovery progresses over time and looks different for each person.
- **Hope & Gratitude:** These are essential foundations for resilience and healing.
- **Healing & Self-Redefinition:** Recovery involves redefining oneself beyond the diagnosis or past experiences.
- **Overcoming Stigma:** Recovery includes confronting discrimination and rising above shame and stigma.
- **Peer & Community Support:** Encouragement from peers and allies is essential.
- **Reintegration:** Recovery is about (re)joining and (re)building a meaningful life in the community.
- **Recovery is Real:** Recovery is not only possible, it happens every day.

Source: *Glossary of Recovery Terms*, SAMHSA. Retrieved May 18, 2015 from Guiding Principles and Elements of Recovery-Oriented Systems of Care

Trauma-Informed Care

A trauma-informed approach is grounded in an understanding of the widespread impact of trauma and the need to create safe, supportive environments for both participants and providers. It is a strengths-based framework that prioritizes physical, psychological, and emotional safety, with the goal of fostering trust, empowerment, and healing.

This approach recognizes that trauma is common, affecting not only program participants but also the workforce. By integrating this awareness into all aspects of service delivery, trauma-informed care aims to avoid re-traumatization and support recovery.

Core Elements of a Trauma-Informed Approach

1. **Realize** the widespread impact of trauma.
2. **Recognize** how trauma affects all individuals within the program, including staff.
3. **Respond** by integrating trauma knowledge into policies, procedures, and practices.
4. **Resist re-traumatization** by creating safe, predictable, and respectful environments.

Guiding Principles of Trauma-Informed Care

- **Safety**: Everyone—participants and staff—should feel physically and emotionally safe throughout all levels of the organization.
- **Trustworthiness & Transparency:** Organizational practices and decisions are made openly, fostering trust among staff, participants, and their families.
- **Peer Support & Mutual Self-Help:** Peer relationships are essential for building trust, promoting recovery, and fostering empowerment for participants and staff alike.
- **Collaboration & Mutuality:** Healing occurs in relationships where power is shared. Everyone in the organization, from direct care staff to leadership, plays a role in creating a trauma-informed culture. *One does not have to be a therapist to be therapeutic.*
- **Empowerment, Voice, & Choice:** A trauma-informed approach honors individuals' strengths, builds on their skills, and supports informed choices. Services are tailored to meet unique needs, recognizing the resilience of individuals, families, and communities.
- **Cultural, Historical, & Gender Responsiveness:** The approach actively addresses cultural stereotypes, acknowledges historical trauma, and provides culturally and gender-responsive services. It incorporates traditional healing practices and respects diverse identities and experiences.

Note: Individuals' experiences with trauma are unique, and trauma-informed care must be flexible and responsive to these differences.

Source: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Risk, Need and Responsivity Principles

Assessment Using Actuarial Tools
Participants on community supervision are assessed using the Level of Service Inventory–Revised (LSI-R), an evidence-based tool that identifies criminogenic risk, need, and behavioral health functional status. This assessment informs care coordination and guides appropriate service referrals, supporting individualized planning and successful program discharge.

Training Requirements
All Care Coordinators and Peer Support Specialists receive training on the LSI-R and are expected to understand its ten core domains:

1. Criminal History
2. Employment
3. Financial
4. Family/Marital
5. Accommodations
6. Leisure/Recreation
7. Companions
8. Alcohol/Drug
9. Emotional/Personal
10. Attitude/Orientation

Target Interventions: Needs

Interventions and care plan goals must directly address the individual need areas identified through the Level of Service Inventory–Revised (LSI-R) assessment. These identified needs guide the development of individualized, goal-oriented care plans.

The delivery of interventions and the integration of those needs into care plans will be continuously monitored through:

- Direct observation of service delivery
- Ongoing data collection to assess progress and ensure alignment with assessed needs

This approach ensures that services remain responsive, effective, and tailored to the participant's risk and need profile.

Responsivity Principle

Interventions and care plan goals must consider and address factors that may affect a participant's ability to fully engage in Free Through Recovery (FTR). These factors, referred to as Social Determinants of Health, can significantly influence participation and outcomes.

Examples include:

- Food insecurity
- Utility needs
- Limited financial resources
- Lack of transportation
- Exposure to violence
- Socio-demographic barriers
- Mental health challenges
- Trauma history
- Limited or no community support

By identifying and addressing these factors, care coordinators and peer support specialists can remove barriers to engagement and tailor services to each participant's unique circumstances, supporting more effective and meaningful participation in the program.

Enhance Motivation

An evidence-based practice proven effective with justice-involved individuals is Motivational Interviewing (MI), a collaborative, person-centered approach that enhances motivation to change.

Care Coordinators and Peer Support Specialists are expected to use MI techniques to help participants explore and resolve ambivalence about change and to support their use of community resources and supports.

Providers must consistently apply effective engagement strategies, including motivational interviewing, to increase the likelihood that participants will:

- Actively engage
- Progress through their care plans
- Successfully transition from the program

Providers must also demonstrate an understanding of the Stages of Change model, using this framework to tailor interventions and support participants appropriately throughout their recovery journey.

Data Driven

Program data will be regularly shared with stakeholders to support their engagement and alignment with program goals. This includes providing timely and relevant feedback to inform decision-making, service delivery and continuous quality improvement.

Transparency in sharing data ensures that all partners are informed and able to adjust practices to better meet participant needs and enhance program outcomes.

Individual Eligibility

To be eligible for Free Through Recovery (FTR), an individual must meet **all** the following criteria:

- **Age:**
  - 18 years or older

- **Residency:**
  - Resides in North Dakota

- **Involved in the criminal justice system in one of the following ways:**
  - The person has been charged with a crime and ordered to pre-trial supervision by the district court,
  - The person was sentenced to a term of supervised probation without a preceding term of incarceration in a DOCR facility, OR
  - The person is incarcerated in a DOCR facility and is transitioning to parole status or serving a term of DOCR supervised probation to follow incarceration.

- **Criminogenic Risk:**
  - A Levels of Service Inventory Revised (LSI-R) score of 34 or higher.
    - *Note: While the primary FTR population will have a score of 34+, exceptions may be considered by the DOCR FTR Clinical Administrator based on additional risk factors.*

- **Behavioral Health Need:**
  - Presence of a serious behavioral health condition
    - A DSM-5 diagnostic profile* that includes one or more of the following:
      - Anxiety Disorder
      - Major Depressive Disorder
      - Bipolar Disorders
      - Borderline Personality Disorder
      - Obsessive Compulsive Disorder and Related Disorders
      - Posttraumatic Stress Disorder
      - Dissociative Disorders
      - Schizophrenia and Related Disorders
      - Substance Use Disorders

    - **AND** functional impairment in one of the following domains as identified in the LSI-R:
      - Housing
      - Education or Employment
      - Social Support, to include friendships and family and intimate partner relationships
      - Financial stability
      - Leisure/Recreation
      - Ability to actively engage in community supervision

**Participants do not need to be diagnosed with both a serious mental illness and a substance use disorder to be eligible. Individuals who have not been formally diagnosed may be considered based on signs of functional impairment related to a behavioral health condition.*

Referral Process

To participate in Free Through Recovery (FTR), individuals must be referred by authorized DOCR personnel. Referrals to FTR may only be submitted by authorized DOCR personnel, including:

- Parole, Probation, and Pre-trial Services staff
- DOCR facility case managers
- Transitional facility case managers

FTR is a voluntary program. Eligible individuals are given the opportunity to choose the provider they wish to work with. Providers are not guaranteed a specific number of referrals.

Referrals are submitted via the FTR referral form located in the DOCR documentation system Docstars and are reviewed by the DOCR FTR Clinical Administrator to determine final eligibility.

- The provider is notified of approved referrals by the Docstars automated messaging system, and a corresponding task is generated within the system.
- The provider administrator is responsible for reviewing information in the FTR referral and assigning a Care Coordinator within one business day.
- The assigned Care Coordinator reviews the referral and staffs the participant with the referring party prior to the intake meeting.

Transitioning from a DOCR facility or reentry facility

If an individual is eligible, a DOCR facility case manager or a transitional facility case manager may submit a FTR referral form prior to discharge from a DOCR facility or reentry center. The timing of the referral is based on the individual's needs.

It is the Care Coordinator's responsibility to collaborate with the participant's prison and/or reentry case manager to prepare for the participant's transition to the community. Outcome areas should be addressed and a care plan developed and updated once the person has transitioned to the community.

- For approved referrals in DOCR custody, the DOCR FTR Clinical Administrator will provide the case manager's contact information to the provider administrator/s.
    - Provider administrators are responsible for ensuring the assigned Care Coordinator contacts the case manager within three days (3) to begin FTR services.

The BHD and DOCR jointly oversee the administration of Free Through Recovery and may update the referral process or prioritize referrals as needed to support program goals.

Providing Agencies

North Dakota's behavioral health system is strengthened by a diverse network of providers who honor participant choice and support multiple pathways to recovery. Agencies may serve as program providers by entering into a formal agreement with the North Dakota Department of Health and Human Services, Behavioral Health Division (BHD) and signing a Memorandum of Understanding (MOU) with the North Dakota Department of Corrections and Rehabilitation (DOCR). These agreements authorize agencies to deliver care coordination, peer support, and access to recovery support services as part of the program.

Provider Expectations and Requirements

To maintain the integrity and effectiveness of the Free Through Recovery (FTR) program all providers must meet the following expectations.

- Adhere to all terms outlined in the Program Provider Agreement.
- Notify BHD and the DOCR Clinical Administrator within one business day when a Care Coordinator or Peer Support Specialist leaves the program. Include the departure date, reason, and transition plan for impacted participants.
- Assign Care Coordinators within one business day of receiving an approved referral. Assignments must align with the participant's region.
- Match participants with Care Coordinators and Peer Support Specialists based on needs, demographics, personality, and lived experience.
- Ensure timely, accurate documentation of all services by Care Coordinators and Peer Support Specialists in accordance with program standards.
- Provide back-up Care Coordination and Peer Support coverage during any staff absence.
- Submit monthly outcome data for each participant by the 20th of each month.
- Serve individuals with complex needs, including those with mental illness, substance use disorders, and brain injuries, and criminal justice involvement.
- Present Care Coordination and Peer Support as equally essential. All participants must be offered Peer Support and may opt out; if they do, the reason must be documented in detail and services should be re-offered as needs evolve.
- Ensure separate individuals provide Care Coordination and Peer Support to the same participant.
- Uphold clear role distinctions between Care Coordinators and Peer Support Specialists, ensuring all staff are trained accordingly.
- Acknowledge that referrals may be paused by the Behavioral Health Division/DOCR or the provider at any time.
- Establish a designated email for referral communication and monitor automated Docstars notifications.
- Notify the DOCR FTR Clinical Administrator if provider is at capacity.
- Identify and maintain a participant capacity limit. Request to increase capacity will be reviewed by BHD and DOCR.
- Understand the Behavioral Health Division reserves the right to refuse to allow an individual to serve in the role of care coordinator or peer support for participants.
- Have the capacity for timely, accurate needs assessments.
- Build empathetic, respectful relationships with participants.

- Identify and develop creative resolution of gaps in community-based supports.

Becoming a Provider Agency

Organizations interested in becoming a Free Through Recovery provider agency must complete the Free Through Recovery Program Provider Application sfn00811.pdf and submit all required documents, in their entirety, in one of the three following ways:

1. Email: freethroughrecovery@nd.gov
2. Mail: 600 E. Boulevard Ave. – Dept. 325
   Bismarck, ND 58505-0250
3. Fax: 701-328-8979

Reporting Provider Concerns

To report **concerns** regarding another FTR provider's services, **email** freethroughrecovery@nd.gov and include **"Attn: Lead Administrator"** in the subject line.

Care Coordination

Care coordination ensures that participants receive comprehensive, coordinated services tailored to their needs. Care Coordinators connect individuals to resources, unify care teams, and reduce service gaps, improving continuity, follow-up, and outcomes. Every participant in the program must be matched with a Care Coordinator. The primary function of care coordination is to connect and organize services across systems—ensuring participants receive the right care, at the right time, from the right provider, the "glue" that binds together multiple service systems (clinical, housing, justice, employment, and recovery supports).

Qualifications

- **Background Check**: Must be completed through DOCR before care coordination training, DocStars access, or service delivery.
- **Education/Experience**: Degree in a related field **or** at least 1 year of human services experience.

How to become a Care Coordinator in Free Through Recovery

1. Be hired by an approved Free Through Recovery (FTR) provider.
2. Complete a DOCR Background check before care coordination training, DocStars access, or service delivery.
3. Complete Behavioral Health Division approved onboarding.
4. Complete Behavioral Health Division in-person Care Coordinator Training.

Service Expectations

- **Assess:** Assess the participant's strengths, preferences and needs, addressing social determinants of health and monthly outcome areas.
- **Person-Centered Care**: Develop and update collaborative care plans within ten (10) business days of referral; review monthly, or as needed.
- **Collaborative Staffing**: Regularly coordinate with POs and peer support specialists; document all staffing.
- **Referrals & Follow-Up**: Initiate connections to community services early, follow up to ensure effectiveness, and avoid dependency on staff as the sole support.
- **Crisis & Safety Planning**: Provide 24-hour crisis resources and individualized safety plans.
- **Ethics & Boundaries**: Follow the Care Coordinator Code of Ethics; maintain professional boundaries and scope of expertise.
- **Training & Technical Assistance:** Participate in required meetings, training, and technical assistance.

Documentation Standards

- Enter all contact, attempted contact, staffing, and updates in DocStars within five (5) business days.
- Monitor and update care plans monthly, or more often, if needed.
- Submit outcomes by the 20th of each month.
- All documentation must be submitted by the 20th of each month.

Coordination with Peer Support

- The same individual may not serve as both the Care Coordinator and Peer Support Specialist for a participant.
- If a participant declines peer support, Care Coordinator must fulfill all engagement requirements and document why they declined peer support services in detail.

Service Delivery Requirements

- Care Coordinator should reside in the same North Dakota region as the participant unless otherwise approved by a BHD admin.

NEW! Code of Ethics for Care Coordinators

All Care Coordinators must read, acknowledge, and adhere to the Care Coordinator Code of Ethics. A signed acknowledgment form must be retained in the Care Coordinator's personnel file by the provider agency.

Care Coordinators are expected to uphold ethical standards in all professional and potential personal interactions with participants. Lack of awareness or misunderstanding of the Code does not excuse misconduct.

Care Coordinators must:

- Practice within the scope of their expertise and training,
- Recognize the limits of their capabilities,
- Collaborate with other professionals to best serve participants,
- Maintain objective, ethical relationships at all times.

Violations may result in disqualification from providing care coordination services within the program.

Peer Support Specialists

A Peer Support Specialist is an individual with lived experience of recovery from a mental health condition, substance use disorder, brain injury, or a combination thereof. Using both personal experience and formal training, they provide behavioral health services and supports to individuals facing similar challenges. Peer support offers a level of acceptance, understanding, and validation not always found in other professional relationships.

Qualifications

To become a **Certified Peer Support Specialist** in North Dakota, individuals must:

- Have at least one year of healthy living and/or recovery and
- Reside or work in North Dakota and
- Identify as being in recovery from a mental health disorder, brain injury, substance use disorder, or combination thereof and
- Possess a high school diploma, GED, or equivalent literacy skills and
- Successfully complete an approved Peer Support Training Program.

For more information on North Dakota Peer Support Certification, visit www.hhs.nd.gov/behavioral-health/peer-support/certification.

How to become a Peer Support Specialist in Free Through Recovery

1. Be hired by a Free Through Recovery (FTR) provider.
    - If any individual is on correctional supervision by federal, state, or tribal authorities and is seeking employment as a Free Through Recovery provider, they must seek written approval from their supervising officer, and there will be an additional review by the FTR Administrative team.
2. Meet the state certification requirements, and become certified within ninety (90) days of becoming a service provider
3. Complete onboarding requirements.

Service Expectations

- **Engagement:** Meet with the participant as described in level guidance.
- **Advocate:** Advocate and promote self-advocacy
- **Person-Centered Care:** Understand a participant's goals on their care plans and help support the participants in reaching their goals.
- **Navigation and Connection:** Utilize lived experience to assist with navigation and connection to services and resources, avoid dependency on staff as the sole support.
- **Communicate:** Collaborate and communicate with the participants care team.
- **Documentation:** Document meetings, service provided, and work done with or on behalf of the individual through case notes.
- **Ethics & Boundaries**: Follow the Peer Support Code of Ethics; maintain professional boundaries and scope of expertise.
- **Training & Technical Assistance:** Participate in required meetings, training, and technical assistance.

NEW! Documentation Standards

- Enter all contact, attempted contact, staffing, and updates in DocStars within five (5) business days. If the peer support does not have access to DocStars they will work with the Care Coordinator to update documentation.

Coordination with Care Coordinator

- The same individual may not serve as both the Care Coordinator and Peer Support Specialist for a participant.
- If a participant declines peer support, Care Coordinator must fulfill all engagement requirements and document the refusal in detail

Service Delivery Requirements

- Peer Support should reside in the same North Dakota region as the participant unless otherwise approved by a BHD admin.

NEW! Code of Ethics for Peer Support Specialists

All Peer Support Specialists must read, acknowledge, and adhere to the Peer Support Code of Ethics. A signed acknowledgement form must be retained in the Peer Support's personnel file by the provider agency.

Peer Supports are expected to uphold ethical standards in all professional and potential personal interactions with participants. Lack of awareness or misunderstanding of the Code does not excuse misconduct.

Peer Support Specialists must:

- Practice within the scope of their expertise and training,
- Recognize the limits of their capabilities,
- Collaborate with other professionals to best serve participants,
- Maintain objective, ethical relationships at all times.

Violations may result in disqualification from providing peer support services within the program.

Recovery Support Services

Recovery is a personal, non-linear process that may include clinical treatment, medication, faith-based approaches, peer and family support, self-care, and other strategies. It involves ongoing growth and improvement in health, well-being, and quality of life.

Four Dimensions of Recovery

1. **Health:** Managing symptoms and making informed choices that support physical and emotional well-being.
2. **Home:** Maintaining a safe, stable place to live.
3. **Purpose:** Engaging in meaningful activities (work, school, volunteering, caregiving, creative pursuits) and having the resources to participate in society.
4. **Community:** Building supportive relationships and networks that provide hope and connection.

Recovery Support Services

These services help individuals and families:

- Access and navigate care systems.
- Remove barriers to engagement.
- Stay connected to recovery resources.
- Lead fulfilling lives in their chosen communities.

Examples of recovery support services include *food assistance, supportive housing, education, employment, leisure and wellness activities, parenting support, spiritual engagement, and other individualized needs.*

Considerations

- Recognize recovery looks different for each person.
- Involve supportive family and friends when possible.
- Facilitate participant choice and problem-solve provider concerns.
- Encourage community connection through support groups, volunteer opportunities, and healthy activities.
- Identify and reinforce strengths regularly.
- Build rapport by listening actively, meeting in safe and comfortable locations, and showing genuine interest in the person beyond their diagnosis.
- Use appropriate self-disclosure to foster trust.
- Explore goals beyond treatment (educational, recreational, relational, spiritual, financial).

North Dakota Resources

FirstLink
24/7 support, referrals, and crisis intervention. Call 211 or 988.
myfirstlink.org

GamblerND
Resources, treatment and recovery support for problem gambling.
www.gamblernd.com

ND Brain Injury Network
Support for individuals and families affected by brain injury.
www.ndbin.org

ND Mental Health Program Directory
Statewide mental health service locator.
www.hhs.nd.gov/behavioral-health/directory

ND Medicaid 1915i Services
Home and community-based behavioral health supports.
www.hhs.nd.gov/1915i

Recovery Housing Assistance Program (RHAP)
Up to 12 weeks of living expenses for eligible individuals in recovery housing.
www.hhs.nd.gov/behavioral-health/recovery-housing/providers

State-Operated Behavioral Health Clinics
Regional services for counseling, treatment, and other supports.
www.hhs.nd.gov/HSC

SUD Voucher Program
Increases access to substance use disorder treatment.
www.hhs.nd.gov/behavioral-health/sudvoucher

Free Through Recovery Care Team

The Care Team includes the participant, Care Coordinator, Peer Support Specialist, Parole or Probation Officer, family or loved ones, and other professionals such as counselors, social workers, housing coordinators, or healthcare providers. For participants in custody or reentry facilities, the team may also include a DOCR case manager until transition to the community. If unsure whether a case manager is assigned, contact the FTR DOCR Clinical Administrator.

Care Team Collaboration Guidance

- Clearly define each member's role and responsibilities.
- Meet regularly to review goals, track progress, address barriers, share resources, and coordinate efforts.
- Best practice: Hold structured monthly staffings to avoid duplication and ensure appropriate care, with urgent meetings convened as needed based on participant needs.

Documentation

The Care Coordinator documents care team activities in the participant's care plan and DocStars chronos.

The responsibilities of a **Care Coordinator** and **Peer Support Specialist** are different, but the roles complement each other and are equally valuable in the delivery of person-centered recovery support.

Care Coordinator	Peer Support Specialist
Perform initial and ongoing assessments	Meet with the individual regularly
Identify the individual's inter-disciplinary team	Advocate and promote self-advocacy
Develop and maintain Plan of Care	Implement Care Plan • *The Peer Support Specialist is **accountable** for the implementation of the Plan of Care*
Provide referrals and facilitate connections	Assist with navigation to services and resources
Monitor service delivery and progress toward desired outcomes • *Care Coordinator is **responsible** for the implementation of the Plan of Care*	Document and share the individual's progress
Care Coordinator & Peer Support Specialist	
Communicate and collaborate with the individual's interdisciplinary care team	
Document meetings, service provided, and work done with and on behalf of the individual through case notes	

Collaboration with Parole and Probation

Care Coordinators and Peer Support Specialists will maintain regular collaboration with the participant's assigned parole, probation, or pre-trial services officer, or when applicable, the DOCR or transitional facility case manager.

Collaboration occurs:

- At referral
- When unable to reach a participant
- When concerns arise
- As needed for staffing, level changes, and discharge.

Staffing Requirements

When a participant stops meeting with the Care Coordinator and/or Peer Support Specialist despite repeated contact attempts, the provider must staff with the Parole Officer (PO) to develop engagement strategies.

- **After 30 days of not meeting with participant**: Care Coordinator must staff with the PO to discuss engagement strategies.
- **After 60 days of not meeting with participant**: Care Coordinator must staff with the PO regarding discharge.
    - Refer *Discharge Guidance* on page 60.

Participant Concerns

- If a participant reports issues such as recurring substance use, new charges, or probation violations, staff should encourage self-reporting to the PO.
- Document all reported concerns in DocStars. POs have access to this information; participants should be aware of this open communication.

Safety-Related Reporting

- Any reported or observed activity that poses a risk to an individual must be reported to the PO immediately.
- If the PO cannot be reached, contact the PO office main line. Office numbers: DOCR Parole and Probation Contact Information.

Docstars Access and Requirement

Docstars is a secure, web-based client management system used by the Department of Corrections and Rehabilitation (DOCR), Parole and Probation, and approved community-based providers. Access to Docstars is strictly regulated and granted only to individuals who meet requirements.

Access Process

Individuals must:

1. Must be hired by a Free Through Recovery (FTR) Provider as a Care Coordinator.
2. Must complete a FTR approved on-boarding.
3. Must pass a DOCR-conducted background check prior to viewing or receiving access to DocStars.
    - The DOCR Clinical Administrator (CA) coordinates this process and provides:
        - Criminal Record Check Form
        - Conduct waiver and confidentiality form
        - DocStars Confidentiality Agreement
4. Prior to gaining access, all users must review and sign the DocStars Confidentiality Agreement.
5. The FTR provider administrator and the Care Coordinator will be notified of the background check results.
    - The DOCR FTR Clinical Administrator will notify the Care Coordinator via email after completion of the background check, including:
        - Confirmation of approval, and
        - Instructions on how to log in and access DocStars.

Important Compliance Information

Unauthorized use of the Docstars system or its data may result in criminal prosecution and/or termination of the Provider Agreement.

Submitting false documentation to receive payment for services is illegal and constitutes a violation of Sections 7 and 8 of the DOCR Agreement.

Strict adherence to these protocols is essential to maintain access and uphold the integrity of the Docstars system.

Docstars Confidentiality Agreement

By signing the **Docstars Confidentiality Agreement**, users acknowledge and agree to the following:

Access and Login Credentials

- I will keep my username and password confidential and will not share them with others.
- My password must:
    - Be at least 15 characters long
    - Include at least 1 uppercase letter, 1 lowercase letter, 1 number, and 1 special character
- I will only log in from secure, private locations and use Docstars solely for purposes related to the Free Through Recovery (FTR) Program.
- I will not allow others to access the electronic devices I use to log into Docstars.

Use and Disclosure of Information

- I will not disseminate Docstars information for unauthorized purposes without explicit permission from the DOCR FTR Clinical Administrator.
- I will promptly notify the FTR Clinical Administrator if I receive any external requests for data or records.
- I understand my Docstars access is subject to periodic review, and my activity may be monitored, logged, and reviewed.

Confidential Information

I understand I will have access to confidential electronic records of individuals under DOCR supervision, including:

- Treatment information
- Medical and psychological records
- Criminal history
- Personally identifiable information

I understand:

- This information is confidential, and I agree to maintain its confidentiality.
- I will not disclose or redisclose this information unless required or authorized by state or federal law.
- Even if I believe disclosure or redisclosure of the information is required or authorized, I will inform the DOCR FTR Clinical Administrator of the request. If I become aware of any unauthorized disclosure of information, I will immediately report it to the DOCR FTR Clinical Administrator.

Scope of Use

- I am responsible for understanding and complying with all applicable laws and DOCR policies regarding information disclosure.
- I will only access data relevant to my role as an FTR Care Coordinator. Browsing unrelated information is prohibited.
- Upon separation from the organization, I will not retain or disclose any confidential information obtained through Docstars.

Violations of this agreement may result in revocation of access, disciplinary action, or legal consequences

Care Coordinators are required to review, sign and agree to information outlined in the Waiver and Confidentiality and Docstars Confidentiality forms including but not limited to:

- Agreeing to not divulge any information, including identifying information that is confidential under state or federal law.
- Acknowledging that North Dakota Century Code §12.1-13-01 provides: A person is guilty of a Class C Felony if, in knowing violation of a statutory duty imposed on him as a public servant, he discloses any confidential information which he has acquired as a public servant. “Confidential information” means information made available to the government under a governmental assurance of confidence as provided by statue. If I have any knowledge of any adult in custody

or under supervision being involved in drugs, criminal activity or alcohol, I will immediately notify a member of the security staff at the adult in custody's facility or the adult under supervision's supervising officer.

To comply with all state and federal laws and regulations pertaining to use, disclosure, maintenance, retention, and safeguarding of confidential information regarding participants, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 CFR Part 160 and Part 164, and the federal privacy law for Substance Use Disorder patient records, 42 USC § 290dd-2, and its implementing regulations, 42 CFR Part 2, and other confidentiality laws and regulations that may apply.

Authorization to Disclose Information:

- Providers are responsible for obtaining any necessary authorization forms required for care coordination and data reporting.
- Providers must develop and use disclosure forms that fully comply with the requirements outlined in the provider agreement.

**Disclaimer- Providers are required to use and follow the most updated version of all DOCR forms.*

NEW! Confidentiality

Confidentiality is the foundation of ethical behavioral health practice. All providers, including Care Coordinators and Peer Support Specialists, must protect participant information and ensure compliance with federal and state confidentiality laws.

1. **Respect for Privacy**
   - Information shared by participants is private and must not be disclosed unless required or permitted by law.
   - Confidentiality applies to verbal conversations, written notes, electronic records, and all other formats.

2. **Legal and Ethical Compliance**
   - Providers must:
     - Comply with all state and federal laws and regulations pertaining to use, disclosure, maintenance, retention, and safeguarding of confidential information regarding participants, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 CFR Part 160 and Part 164.
     - Comply with Federal privacy law for Substance Use Disorder patient records, 42 USC § 290dd-2, and its implementing regulations, 42 CFR Part 2, and other confidentiality laws and regulations that may apply.
     - Assume responsibility for obtaining any Authorization to Disclose Information forms that may be necessary to meet coordination requirements and data reporting per this Agreement

3. **Minimum Necessary Standard**
   - Only the minimum amount of participant information necessary to accomplish the intended purpose may be shared.

Provider Responsibilities

- **Confidentiality Agreements**: All staff must sign and comply with agency confidentiality policies and applicable codes of ethics.
- **Documentation Practices**:
  - Use secure systems (e.g., DocStars) for records.
  - Avoid unnecessary details that could disclose sensitive information to unauthorized readers.
- **Secure Communication**:
  - Do not use personal email, text messaging, or social media to share participant information.
  - Follow agency-approved methods for electronic communication.
- **Environmental Awareness**:
  - Conduct discussions in private spaces.
  - Avoid talking about participants in public settings or with individuals not involved in their care.

Breach of Confidentiality

- A breach occurs when participant information is shared inappropriately or without authorization.
- All breaches must be reported immediately according to agency policy and state/federal requirements.
- Corrective action, retraining, or disciplinary measures may result from breaches.

Key Takeaways for Providers

- **Confidentiality is ongoing,** it does not end when a participant leaves the program.
- **When in doubt, don't disclose,** always consult agency policy or a supervisor before releasing information.
- **Trust is central,** protecting confidentiality builds participant trust and supports recovery.

NEW! Dual Relationships and Conflict of Interest

To ensure professional boundaries, protect the integrity of services, and safeguard the well-being of participants, all behavioral health providers must be alert to and avoid dual relationships and conflicts of interest in the provision of care.

Definitions

- **Dual Relationship**: A situation where a provider has more than one type of relationship with a participant (e.g., personal, financial, social, or business in addition to the professional relationship).
- **Conflict of Interest**: A situation where a provider's personal, financial, or professional interests may interfere with their ability to act in the best interest of a participant.

Core Principles

1. **Professional Boundaries**
   - Providers must always maintain clear and professional relationships with participants.
   - Boundaries are essential to ensure that services remain focused on the participant's recovery and wellness.

2. **Avoiding Exploitation**
   - Providers must not use their professional position to gain personal, financial, or other benefits from participants.

3. **Transparency**
   - Any potential dual relationship or conflict of interest must be disclosed immediately to a supervisor.
   - Decisions should always be guided by the best interest of the participant.

Examples of Dual Relationships (Not Allowed)

- Entering into personal friendships or romantic relationships with current participants.
- Providing behavioral health services to close friends, family members, or individuals with whom the provider has/had a significant personal relationship.
- Engaging in business, financial, or service exchanges with participants inside or outside of the treatment relationship (e.g., lending/borrowing money, buying/selling goods or services).

Conflict of Interest Situations

- Favoritism or bias in service delivery due to personal connections.
- Accepting personal gifts, favors, or services from participants that could influence professional judgment.
- Referring participants to services or vendors from which the provider benefits financially.
- While not always inherently unethical, dual relationships require careful consideration to avoid conflicts of interest and to protect prior participants from harm and/or exploitation.

> *Example: While hiring a past participant may be appropriate, depending on the circumstances, it would be unethical to terminate services to hire an individual.*

Provider Responsibilities

- **Maintain Boundaries**: Ensure relationships remain professional and recovery focused.
- **Consult and Report**: If a situation arises that could be perceived as a dual relationship or conflict of interest, seek immediate guidance from a supervisor or agency administrator.
- **Decline Gifts or Favors**: Providers should politely decline offers of gifts, money, or services from participants.
- **Avoid Over-Familiarity**: Keep communications and interactions professional and focused on the participant's goals and service plan.

Agency Expectations

- **Training:** Provide regular training and supervision on boundaries, dual relationships, and conflicts of interest.
- **Policies:** Follow agency's internal policies and procedures for dual relationships and conflicts of interest.
- **Supervision:** Support staff in identifying, preventing, and managing potential conflicts.

Key Takeaways

- **Keep relationships professional.** Personal, social, or financial entanglements with participants are not appropriate.
- **Protect trust and recovery.** Boundaries ensure participants feel safe and respected.
- **Disclose and consult.** When in doubt, report potential conflicts to a supervisor.

NEW! Crisis Intervention

Behavioral health providers play a critical role in recognizing, responding to, and supporting individuals experiencing a behavioral health crisis. This guidance outlines expectations and best practices to ensure a safe, person-centered, and effective crisis response.

Definition of Crisis

A crisis is any situation in which an individual perceives an event or experience as intolerable, overwhelming, or threatening, and their usual coping skills are not effective.

- Suicidal thoughts or behaviors
- Self-harm or risk of harm to others
- Severe emotional distress (e.g., panic, trauma response)
- Acute symptoms of a mental health or substance use disorder
    - Symptoms may include but are not limited to isolating, physical change in appearance, neglecting self-care, dilated or constricted pupils, confusing thoughts or verbalizations, extreme mood changes, irritability, lethargy, impaired judgment or decision making.
- Situations of abuse, neglect, or unsafe living conditions

Other examples of a crisis could include feeling overwhelmed with applying for jobs, cravings to use, CPS involvement, law enforcement involvement, receiving an eviction notice, not having enough food, etc.

Provider Responsibilities in a Crisis

Step 1: Immediate Assessment

- Evaluate the participant's safety and risk level.
- Use agency-approved screening tools when available.

Step 2: Response Actions

- If the participant is at imminent risk of harm, call 911 or appropriate emergency responders.
- If not imminent but urgent, connect the participant with local crisis response resources through the 988 call line.
- Utilize de-escalation techniques to help the participant regain a sense of control.
- Utilize a formal safety plan to assist the participant in utilizing resources and coping skills.

Step 3: Communication

- Notify supervisors or agency leadership of crisis events per agency protocol.
- Document the incident factually and promptly in the participant record, noting actions taken and resources involved.

Step 4: Follow-Up

- Ensure continuity of care after a crisis.
- Revisit the participant's care plan to add or strengthen crisis prevention strategies.
- Offer debriefing and emotional support to participants and staff impacted by the crisis.

Core Principles of Crisis Intervention

1. **Safety First**
    - Prioritize the immediate physical and emotional safety of the participant, provider, and others.
    - Assess risk of harm to self or others promptly.

2. **Calm and Supportive Presence**
    - Approach the participant with empathy, patience, and respect.
    - Use a calm tone and non-threatening body language.

3. **Least Restrictive Approach**
    - Intervene in the least restrictive manner possible while maintaining safety.
    - Support participant autonomy and choice whenever feasible.

4. **Collaboration and Connection**
    - Partner with the participant to identify immediate needs and potential coping strategies.
    - Engage natural supports, when appropriate, with participant consent.

Crisis Prevention and Planning

Work with participants proactively to develop individualized Crisis Prevention and Safety Plans, which may include:

- Identifying early warning signs of crisis.
- Outlining coping strategies and grounding techniques.
- Listing supportive contacts (family, friends, sponsors, peers).
- Providing crisis hotline numbers (e.g., 988 Suicide & Crisis Lifeline).
- Naming preferred hospitals or providers if emergency care is needed.

A **Crisis Safety Plan template** can be found here: predprod-behavioralhealth.x-shops.com/988/crisis-life-plan

Agency Expectations

- **Policies**: Follow policies and procedures for crisis intervention, suicide prevention, and de-escalation techniques.
- **Resources**: Providers must be familiar with local and state crisis response systems and how to access them.
- **Collaboration**: Providers are expected to coordinate with law enforcement, emergency medical services, mobile crisis teams, and community partners when appropriate.

NEW! Suicide Prevention and Intervention

Suicide is a critical public health issue that impacts individuals, families, and communities. Providers play a vital role in recognizing risk, offering support, and connecting individuals to lifesaving resources.

Understanding Suicide Risk

- **Complex Causes:** Suicide is rarely caused by a single event. Risk arises from multiple factors at the individual, relationship, community, and societal levels.
- **Warning Signs:** Changes in mood, withdrawal, hopelessness, or direct statements about wanting to die should always be taken seriously.
- **Risk and Protective Factors:** Prevention efforts should focus on reducing risks (such as access to lethal means, untreated mental illness, or isolation) while increasing protective factors (such as connection, coping skills, and access to care).

Provider Responsibilities

Care Coordinators and Peer Support Specialists may be the first point of contact when a participant is struggling. Your role includes:

- Recognizing warning signs and risk factors.
- Asking directly about suicide when concerns are present.
- Establishing immediate safety and connecting individuals to resources.
- Supporting participants with compassion while maintaining self-care and professional boundaries.
- Following your agency's internal policies and procedures for suicide prevention and crisis intervention.

Five Key Steps for Suicide Prevention

1. **Ask Directly:** "Are you thinking about suicide?"
    - Using clear, direct language shows care and reduces stigma. Asking does **not** increase risk.
    - **Ask: Are you thinking about suicide?**

2. **Keep Them Safe:** Determine if the participant has access to lethal means and address safety.
    - For more information, visit: Lethal Means Safety in North Dakota | Health and Human Services North Dakota. **Keep Them Safe: Establish immediate safety.**

3. **Be There:** Stay with the person in crisis or remain connected by phone until other supports are in place. **Be There: Be there or speak with them on the phone.**

4. **Help Them Connect:** Link participants to crisis services, supports, and ongoing care. **Help Them Connect: Connect them with resources.**
    - www.hhs.nd.gov/behavioral-health/directory

5. **Follow Up:** Check in after the initial crisis to show continued support and encourage engagement in services. **Follow Up: Follow up to see how they're doing.**

Training and Tools

- **Columbia-Suicide Severity Rating Scale (C-SSRS):** Care Coordinators and Peer Support Specialists are encouraged to attend training on use of the C-SSRS suicide screening tool, provided by FirstLink.
    - Example Demonstrations:
      Low Risk: *FirstLink C-SSRS Demonstration*
      Moderate Risk: *FirstLink C-SSRS Demonstration*
      High Risk: *FirstLink C-SSRS Demonstration*

- **988 Suicide & Crisis Lifeline:** Promote awareness of the 988 Lifeline, which provides free, confidential support 24/7 through call, text, or chat. Lifeline also connects individuals to local resources. 988lifeline.org

Provider Self-Care

Supporting individuals experiencing suicidal thoughts can bring up strong emotions. Providers are encouraged to:

- Practice self-care strategies regularly.
- Seek supervision or peer consultation when needed.
- Utilize your agency's support systems and employee resources.
- If needed, call 988 for support.

By recognizing warning signs, addressing risk factors, using direct and compassionate communication, and promoting resources like 988, Care Coordinators and Peer Support Specialists play a vital role in suicide prevention.

NEW! Assertive Engagement and Active Efforts

Assertive Engagement

Assertive engagement is a purposeful and proactive approach to connecting people with services.

- Meeting locations should be chosen by the participant, whether at home, work, or another community setting, to ensure comfort and accessibility.
- Interactions are person-centered and tailored to the unique needs, circumstances, and preferences of each individual.

Key Principles of Assertive Engagement

- Prioritize meeting participants in their chosen environment.
- Build rapport and trust before introducing motivational approaches.
- Address immediate, tangible needs (e.g., food, ID, medical care) to establish credibility and encourage continued engagement.
- Provide direct assistance in accessing resources. not just referrals. Examples include:
    - Accompanying the participant to sign up for a class.
    - Helping complete a job application.
    - Joining a meeting with family to plan support.
    - Taking the participant to view available housing.

Assertive Engagement is *Not*

- Offering generic resources without tailoring them to the participant's situation.
- Telling participants what to do without providing adequate, hands-on support.
- Sending only text "check-ins" such as "Hi! Do you need anything this week?" without other forms of engagement
- Waiting for the participant to initiate contact.
- Relying solely on verbal updates and documenting them as service delivery.

Active Efforts

Active efforts are continuous, intentional actions to assess needs, identify goals, track progress, and connect participants with supports that help them succeed. They apply across all levels of care and require ongoing follow-through.

Core Actions in Active Efforts

- **Diligent outreach:** Make persistent/diligent attempts to locate and engage with participants, including community visits when contact is difficult.
- **Prompt follow-up:** Address missed appointments immediately with a renewed engagement plan.
- **Service delivery at the point of contact:** Provide meaningful assistance during meetings, ensuring there is a reason for participants to stay engaged.
- **Participant-first approach:** Place their needs, priorities, and preferences at the center of decision-making.
- **Hands-on navigation:** Help them overcome barriers by directly facilitating access to services and natural supports.

Minimal Efforts (Not Acceptable)

Minimal efforts involve doing only the bare minimum to fulfill program requirements without advancing meaningful progress for the participant.

Indicators of Minimal Effort

- Simply filling out required forms without addressing barriers.
- Being reactive rather than proactive.
- Relying on quick “check-ins” or participant-reported updates with no follow-up action.
- Failing to pursue engagement when a participant is out of contact.

Minimal efforts fail to meet the expectations of behavioral health support services and are not acceptable.

It is the responsibility of the Care Coordinator and Peer Support Specialist to:

- Take the lead in initiating engagement.
- Develop creative, effective strategies for connection.

Active Efforts	Minimal Efforts
Assisting the participant in contacting the service provider to get connected, with regular follow-up.	Providing a phone number or providing a generic list without tailoring to participant need, no follow-up.
Calling participant to introduce program and role.	Initial contact is text message with no previous attempts at calling.
Using various types of outreach methods.	Sending text messages only.
Collaborating with other care team members, including other community providers.	Not connecting with or collaborating with other care team members or community providers.
Proactively scheduling the next meeting to meet the needs of participant.	Not scheduling the next meeting at the end of their current meeting.
Scheduling meetings based on participant's needs.	Scheduling meetings based on payment rate.
Actively working to engage participant and work on goals and action steps during each meeting to work towards program completion.	Completing "check ins"
Anticipate challenges and implement prevention and early intervention strategies.	Only respond when a crisis occurs.
Relationship-centered approach that promotes recovery, self-determination, and trust.	Transactional interactions focused on tasks.

NEW! Intake

Intake is the starting point for building rapport, identifying needs, and planning for both service delivery and eventual program completion. Assessment begins here and continues throughout the participant's time in Free Through Recovery (FTR).

Timelines & Preparation

- The provider must reach out and offer a face-to-face intake meeting with each participant within three (3) business days of receiving the referral.
- The Care Coordinator is expected to conduct a face-to-face intake meeting within five (5) business days of receiving a referral.
- Before the meeting:
    - Reach out to assigned PO or case manager.
    - Review LSI-R need areas and supervision end date.
    - Review Case history, diagnoses, and referral reason.
    - Review Supervision plan (if available).

The intake meeting should:

1. **Clarify Roles**
    - Explain the roles of the Care Coordinator and Peer Support Specialist (in plain language).
    - Provide Peer Support contact info if not present; best practice is to have them attend.
2. **Identify Needs & Barriers**
    - Explore Social Determinants of Health (SDOH):
        - Food insecurity
        - Housing instability
        - Financial strain
        - Transportation needs
        - Exposure to violence
        - Socio-demographic factors (e.g., language, education, immigration status)
    - Assess behavioral health needs and natural support networks.
3. **Explore Strengths & Goals**
    - Discuss what is important to the participant, existing strengths, and skills that can support goal achievement.
    - Identify key people to include in the care team; obtain necessary releases.
4. **Address Health Coverage**
    - Confirm insurance status and coverage details.

Begin Discharge Planning at Intake

- Participants may explain what successful completion of program would look like for them.
- Begin planning with the end goal in mind.
- Begin planning with their supervision end date in mind.

Intake Documentation Requirements (Docstars)

Record as a face-to-face chrono including:

- Meeting location, length, and date.
- Role clarification and Peer Support discussion.
- Intake paperwork and releases completed.
- Strengths and needs identified (including LSI-R and Social Determinants of Health).
- Information supporting the four outcome areas
    - Housing
    - Employment/Financial
    - Recovery
    - Criminal Justice Involvement
- Care Plan discussion and agreed next steps.
- Follow-up expectations for both coordinator and participant.
- Date and time of next meeting.

Reference Materials

Example Intake Form and step-by-step intake instructions are available in the **Care Coordinator Manual** in the **Resources tab of Docstars.**

Documentation Guidance

This section outlines expectations, timelines, and types of documentation for Free Through Recovery (FTR) in Docstars. Documentation is essential for communication within the care team, ensuring service quality, and determining provider payment.

Purpose of Chronological Notes (Chronos)
Chronos are the designated place in Docstars where all:

- Contacts,
- Attempted contacts,
- Work completed on behalf of a participant, and
- Care team staffings must be documented.

Why Chronos Matter:

- Communicate participant progress, frequency of contact, barriers, and goals with the care team.
- Allow the FTR Administrator to verify services and determine payment.
- Serve as a legal and official record.

Documentation Expectations

- **Timeliness:** Document any contact, attempted contact, or participant-related work. Complete documentation within 5 business days. All documentation must be submitted by the 20th of each month.
  Examples: care team staffings, scheduling appointments, coordinating services, researching resources.
- **Accuracy:** Documentation must reflect actual events.
- **Language:** Use person-first, objective, clear, descriptive, relevant, and concise language. Avoid opinions, slang, and assumptions.
  Example: "The participant presented today with slurred speech and droopy eyelids."
- **Meetings or outreach:** Notes must demonstrate that meetings occurred or attempts to meet, fulfilling level requirements, or payment may be denied. *(See Levels Guidance for details.)*
- **It is the responsibility of the individual Docstars user to confirm their documentation is saved each time it is completed.**

Chrono (Case Note) Standards

Case notes must be:

- **Objective** – Factual, unbiased.
- **Accurate** – Truthful and precise.
- **Clear** – Avoid jargon, acronyms, or ambiguous terms.
- **Descriptive** – Provide enough detail to understand what occurred.
- **Relevant** – Relate directly to outcomes, Care Plan goals, and barriers.
- **Concise** – Summarize without writing a full transcript.

Chronos (Case Notes) Should Include:

- Information supporting the **four outcome areas**:
  - Housing; Employment/Finance; Recovery; Criminal Justice Involvement
- Other possible topics: Care Plan updates, level changes, discharge planning, transfers, gap funding, parenting, barriers, successes, referrals, and upcoming appointments.
- Details such as:
  - Length & location of meeting
  - New risks, challenges, or barriers & plans to address them
  - Supports provided, referrals made, resources connected
  - Collaboration with other providers, agencies, or PO
  - Updates to Care Plan and/or review goals
  - Plan for next meeting (best practice: schedule before ending the meeting)
  - What the participant will work on before the next meeting
  - Summarize meeting

*Resource: Chrono guidance in resource tab in DocStars.

Types of Chronos

Attempted Contact	• Tried to contact the participant but received no response. • Weekly active engagement attempts may use varied methods (phone, text, email, letter, outreach).
Collateral Contact	• Contact made with an organization/person on behalf of the participant. Example: calling Job Service about openings, contacting a thrift store about furniture. • Maintain confidentiality—no participant info shared without a signed ROI.
Face-to-Face	• Planned in-person meeting covering Care Plan areas and active service efforts.
No Show	• Participant did not attend a scheduled meeting without prior notice.
Offender Communication	• Communication via phone, email, mail, or text.
Treatment Staff	• Contact with participant's provider at a treatment facility (release of information required).
Care Coordination Team	• Includes contact with the PO, DOCR case manager, FTR Clinical Administrator, FTR Administrator, or case staffing.

Multiple Types

- If multiple types of communication happen, select all that apply in Docstars.
  - Example: During Face-to-Face meeting with a participant, you called the PO (Face to Face + Care Coordination Team)
  - Example: Called an organization and participant to update them (Collateral Contact + Offender Communication)

Editing Chronos:

- Can be edited within 24 hours of submission via the "Edit" button.
- After 24 hours, contact the DOCR FTR Clinical Administrator for corrections.

Care Plan

A Care Plan is a person-centered roadmap that outlines strengths, needs, and goals. It supports participants in identifying and working toward their personal objectives while enabling the Care Coordinator, Peer Support Specialist, and other team members to monitor progress and address changing needs.

The Care Plan is a living document, reviewed at least monthly, and serves as a critical tool for guiding participants toward program completion and building long-term connections to community and natural supports. The Care Coordinator is responsible to monitor and update care plans monthly, or more often, if needed.

Keys to Successful Care Planning

- Approach all interactions without judgment.
- Communicate expectations clearly.
- Identify motivators important to the participant.
- Align with the Parole/Probation Officer's supervision plan and supervision end date.
- Review and update monthly to remain relevant.

Common mistakes to avoid:

- Attempting to motivate through fear or unrealistic threats.
- Using false accountability or consequences.
- Relying on motivators that are not meaningful to the participant.

Motivational Interviewing is recommended for uncovering personal reasons for change. Additional resources are available at motivationalinterviewing.org.

Components of the FTR Care Plan

Care Plan Section	Expectation
Strengths/ Needs	Summarize strengths and needs identified during intake; update as circumstances change.
Objectives (long-term goals)	Written in the participant's own words, connecting identified needs to what matters most to them. a.) **Risk/ Needs Section-** Identify the most relevant LSI-R domain from the 10 available: Criminal History, Education/Employment, Financial, Family/Marital, Accommodations, Leisure/Recreation, Companions, Alcohol/Drug, Emotional/Personal, Attitudes/Orientation. b.) **Status Options-** – Complete, In Progress, Declined, Incomplete, Terminated, or Pending. i. Complete: participant has achieved the objective ii. In progress-participant is working on this objective iii. Declined: objective was identified as a need area and the participant declines to continue to work towards Incomplete: participant did not meet the objective and is not able to continue to address (discharge, transfer, etc.) iv. Terminated: This will generally occur when the care coordinator terminates the objective due to higher level of care, objective is no longer appropriate. v. Pending: objective is relevant, however is not actively being addressed and will be addressed in the future
Date Created	The date the participant identified and developed the goal to include the month, date, and year. This date should not change once it is created.
Action Steps (short-term goals)	Specific, measurable, and time-limited steps toward each objective. Track the start date and update status upon completion or change.
Date Started	This is the date the participant agrees to start working on their goal.
Date Ended	This is the date the participant completes the goal or action step.
Notes	Record monthly reviews, even if there are no updates, including the review date and any relevant information.

Care Plan Expectations and Timelines

- **Initiation** – Care Coordinator will develop the plan within ten (10) days of receiving the referral, including completion of the Needs and Strengths section in DocStars.
- **Collaboration** – Care Coordinator will work with the participant, Peer Support Specialist, supervising PO, and any other individuals the participant chooses to involve.
- **Approach** – Care Coordinator and Peer Support Specialist will use person-centered practices and motivational interviewing to create both short- and long-term goals.
- **LSI-R Integration** – Care plan will address at least two LSI-R need areas. Targeting 4–6 domains has been shown to reduce recidivism by up to 31% (Latessa & Lowenkamp, 2006).
- **Goal Structure**:
    - **Long-Term Goals (Objectives)** – Foster hope, empower the participant, and remain focused on recovery.
    - **Short-Term Goals (Action Steps)** – Address immediate priorities, serve as stepping-stones, and focus on what is important *to* and *for* the participant.
- **Participant Voice** – Objectives should reflect the participant's perspective, with direct quotes included when appropriate.

Ongoing Review and Updates

The Care Plan, including all objectives and action steps, should be reviewed by the Care Coordinator at least monthly, or as needed.

- Add new objectives and steps as needed.
- Update completed goals.
- Discontinue objectives no longer relevant to the participant's progress.

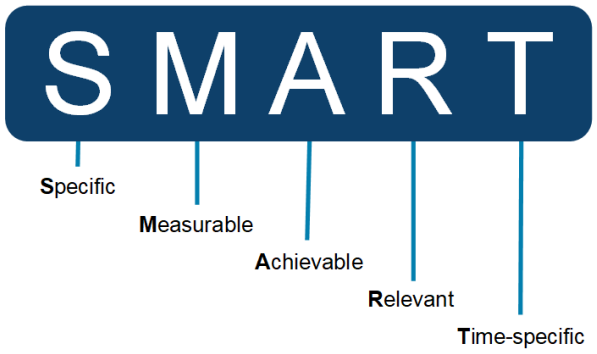
When an objective is achieved, the Care Coordinator is responsible for guiding the participant in either updating the goal or developing a new one, ensuring the plan remains relevant, motivating, and aligned with the participant's recovery journey.

NEW! SMART Goals

In **Free Through Recovery (FTR)**, the action steps should follow the **SMART** framework.

SMART Framework

- **Specific** – Clearly defined
- **Measurable** – Include objective measures of success; define the evidence that will show progress
- **Attainable** – Realistic and achievable with the resources available, while still being challenging
- **Relevant** – Aligned with the participant's short- and long-term goals and important to them personally
- **Time-Specific** – Include a realistic and ambitious end date with progress milestones



Ongoing Review:

Evaluating progress on objectives and action steps is essential to determine whether goals need to be adjusted, added, or removed. Reviews should also highlight participant successes and reinforce motivation.

Goals must be reviewed at least monthly with the participant to ensure they remain relevant, achievable, and aligned with their recovery journey.

Example: Bob's Goals and Action Steps

For Bob's first goal, he wants to address his lack of stable employment. This would directly correlate to the outcome area of Employment/Financial. We know from identifying his strengths, that he enjoys cooking and spending time with his dog, he is caring and wants stability in his life. He has a desire to feel accomplished.

Goal #1: *"I want to find stable employment that I enjoy."* - In Progress

Action Steps:

1. Complete Indeed job search for work involving cooking or with animals by 1/10/2026- Complete, 1/6/2026
2. Develop a list of potential jobs based on job search by 1/25/2026- In Progress, 1/15/2026
3. Apply to top 5 jobs by 2/10/2026- In Progress, 2/5/2026

Considerations:

Bob enjoys cooking, spending time with his dog, and wants stability in life. He struggles with motivation due to mental health challenges and uses alcohol to cope. Addressing these barriers will support his employment success.

For his second goal, Bob wants to address his mental health needs. This would directly correlate to the outcome area of Recovery/Social Supports.

Goal #2: *"I want to feel motivated to work on my depression without drinking*." -In Progress

Action Steps:

1. I will identify a therapist and schedule an intake appointment by 1/15/2026 – Complete, 1/1/2026
2. I will attend all individual therapy appointments as scheduled, through March 2026. - In Progress, 01/12/2026
3. I will complete an annual physical exam by 2/28/2026 to include discussion of medications for depression - In Progress, 01/12/2026

For his third goal, Bob wants to address his lack of positive support. This would be directly correlated to the outcome area of Recovery/Social Supports. We know from identifying his strengths that he wants to have social relationships, and he has a history of spending time with people who use substances which is a large factor in his substance use.

Goal #3: *"I really want to hang out with people that will not tempt me to use so I can stay out of jail."* – In Progress

Action Steps:

1. I will identify and join a local support group I am interested in by 2/28/2026 - In Progress, 2/1/2026
2. I will take my dog to the dog park two times a week through 2/28/2026. - In Progress, 2/1/2026
3. I will explore social activities in the community – InProgress 2/22/2026

Outcomes

Outcomes measure and evaluate participant progress toward, or maintenance in, four core areas: **Housing, Employment/Finances, Recovery, and Criminal Justice Involvement**. Outcomes determine payment.

Outcomes are person-centered, considering each participant's choices, circumstances, and characteristics. What is progress for one participant may not be for another.

Example:

- If a participant moves from an unstable, unsafe living situation into supportive shelter housing, the Housing outcome for that period would likely be "Yes."
- If a participant moves from stable supportive housing into a shelter due to eviction, the Housing outcome for that period would likely be "No."

Program Outcome Categories

Housing	Employment/ Finances	Recovery	Criminal Justice Involvement
Is the participant living in a safe and recovery-supportive residence?	Is the participant making progress toward or maintaining employment and/or financial stability?	Is the participant demonstrating efforts to reduce harmful substance use or improve mental health functioning?	Is the participant avoiding law enforcement engagement resulting in arrest, criminal charge, or probation violation resulting in initiation of revocation? Is the participant is reporting to their probation/ parole officer as required by their supervision?
○ Includes independent housing, living with family/friends, halfway houses, or other safe housing arrangements. ○ Progress or maintenance varies by individual needs.	○ May include job seeking, current employment, meeting basic needs through income, or participating in work alternatives such as school, training, or internships.	○ May include abstinence from non-prescribed substances, harm reduction strategies, participation in treatment or therapy, and connection to prosocial, supportive relationships.	○ Includes compliance with supervision requirements and no new arrests or serious law enforcement interactions.

Outcomes Submission Requirements

- **Reporting Period:** The 21st of each month through the 20th of the following month.
  Example: October reporting covers 9/21/25–10/20/25; documentation is submitted between October 15–20. *The deadline for submitting documentation is October 20.*
- **Due Date:** Outcomes for each participant can be submitted by the 20th of each month, regardless of weekends or holidays. *The deadline for submitting outcomes is the 20th of each month.*
- **Responsible Parties:** Outcomes are entered by both Care Coordinators and Parole/Probation/Pre-Trial Services Officers at the end of each reporting period.
- **Non-Compliance:** Failure to submit by the 20th of each month results in ineligibility for payment.
- **Monthly Notification:** Care Coordinators will receive a task notification in Docstars on the 15th of the month when outcomes can be submitted for each participant.

Example of internal agency workflow: Agencies may set their own internal deadlines, for example, requiring all Outcomes to be submitted by the 18th, followed by supervisor review prior to the 20th.

Documentation Standards

- Outcomes must be objective, fact-based, and free from opinions, bias, assumptions, or slang.
- Comments are required for each outcome and must explain the evidence supporting a "Yes" or "No" determination.
  Example: Housing – "Has own apartment that is safe and supportive."
- Review any comments or feedback from FTR Administrators.

Levels and Payment Guidance

Service levels are designed to deliver **person-centered care** by adjusting the frequency of services to align with each participant's goals and needs. Level movement supports participant progress, strengthens community connections, and promotes successful program completion.

All participants enter the program in level 3.

Level 3

The Care Coordinator and Peer Support Specialist should focus on building rapport, developing and implementing a care plan, assessing needs and progress, making referrals to community-based services and resources, navigating services and supports and providing cross-sector partnership and collaboration with care team members.

Meeting Standards

At **Level 3**, the participant must be **given the opportunity** to meet face to face with their Care Coordinator and/or Peer Support Specialist at least weekly (calendar week) **and** meet face to face with their Care Coordinator at least one time per reporting period to:

- Work on identified care plan goals
- Build and maintain rapport
- Assess outcome areas
- Make referrals and assist with navigating community resources
- Collaborate with other providers involved in the participant's care (care team)

Level 3	During reporting period:
Performance Pay (*DocStars=Outcome)*	There is chrono documentation indicating the participant **was given the opportunity** to meet face to face with their Care Coordinator and/or Peer Support Specialist **at least weekly (calendar week) and** meet face-to-face with their Care Coordinator at least one time during the reporting period. **Participant has 3 or more positive outcomes.**
Base Pay (*DocStars=Engagement)*	There is chrono documentation indicating the participant was **given the opportunity** to meet face to face with their Care Coordinator and/or Peer Support Specialist **at least weekly (calendar week) and** meet face to face with their Care Coordinator at least one time during the reporting period. **Participant has 2 or less positive outcomes.**
Diligence	There is chrono documentation indicating the participant was given the opportunity to meet face-to-face with their Care Coordinator and/or Peer Support Specialist **at least weekly (calendar week);** however, the Care Coordinator did not meet face to face **with the participant** at least one time during the reporting period. **Outcomes were unable to be assessed by the Care Coordinator.**
Ineligible	**Provider did not fulfill meeting standards**, there is no chrono documentation indicating that the participant was given the opportunity to meet face to face with their Care Coordinator and/or Peer Support Specialist at least weekly (calendar week), or the Provider did not submit outcomes.

Level 2

The Care Coordinator and Peer Support specialist should continue working to connect the participant to long-term community-based services.

Meeting Standards

At **Level 2,** the participant must meet face to face with their Care Coordinator at least one time per reporting period to:

- Work on identified care plan goals
- Build and maintain rapport
- Assess outcome areas
- Make referrals and assist with navigating community resources
- Collaborate with other providers involved in the participant's care (care team)
- The Peer Support Specialist may continue to meet and engage with the participant throughout the reporting period, however the in person, face-to-face meeting must include the Care Coordinator.

Level 2	During reporting period:
Performance Pay (*DocStars=Outcome)*	There is chrono documentation indicating that the Care Coordinator met face-to-face with the participant at least one time during the reporting period. **Participant has 3 or more positive outcomes.**
Base Pay (*DocStars=Engagement)*	There is chrono documentation indicating that the Care Coordinator met face-to-face with the participant at least once during the reporting period. **Participant has 2 or less positive outcomes.** *If outcomes indicate that a higher level may be beneficial, a higher level of care should be discussed with the participant and staffed with the care team.*
Diligence	There is chrono documentation indicating the Care Coordinator did not meet face-to-face with the participant at least one time per month. Documentation must indicate a minimum of two attempts to meet diligence criteria. **Outcomes were unable to be assessed by the Care Coordinator.**
Ineligible	**Provider did not fulfill meeting standards.** Documentation indicates one or less attempts were made to contact the participant, and the Care Coordinator did not meet with the participant face to face during the reporting period. Or the Provider did not submit outcomes.

Level 1

The Care Coordinator and/or Peer Support Specialist must be accessible to the participant in order to quickly respond to changes in the participant's needs and care plan. The participant is independently maintaining services and supports.

Meeting Standards

At **Level 1,** the participant must meet with their Care Coordinator at least once during the reporting period. This meeting is not required to be face to face and can be web-based video or phone call. Text messaging, emailing or any form of direct messaging does not meet this requirement.

During the meeting the Care Coordinator should:

- Monitor continued progress or completion of identified care plan goals.
- Build and maintain rapport.
- Assess outcome areas, if outcomes indicate that a higher level may be beneficial, a higher level of care should be discussed with the participant and staffed with the care team.
- Assist with information on referrals to community resources, as needed.
- Collaborate with other providers involved in the participant's care (care team).

Level 1	During reporting period:
Performance Pay (*DocStars=Outcome)*	There is chrono documentation indicating that the Care Coordinator met with the participant at least once during the reporting period. **Participant has 3 or more positive outcomes.**
Base Pay *(DocStars=Engagement)*	There is chrono documentation indicating that the Care Coordinator met with the participant at least once during the reporting period. **Participant has 2 or less positive outcomes.**
Diligence	Not Applicable. There is no diligence pay for level 1
Ineligible	**Provider did not fulfill meeting standards.** Documentation indicates the Care Coordinator did not meet with the participant during the reporting period. Or the Provider did not submit outcomes.

Levels FAQ

Web-Based or Phone Services (Level 2 and Level 3 only)

- All web based or phone meetings intended to replace the face-to-face meeting requirement for payment must be pre-approved by a FTR Administrator.
- FTR Administrators retain discretion to approve or disapprove web-based or phone services in place of face-to-face meetings that were not pre-approved due to unusual circumstances.

Missed Meetings

- If a scheduled meeting is missed, due to a participant's circumstances, the reason must be documented in the chrono. If a participant misses a meeting or declines to meet, this must be documented in Chronos.
- After sixty (60) days without documentation supporting a reason for continuing services, including justification after staffing with the PO, the provider may be ineligible for payment.

Coverage Responsibilities:

- If a Care Coordinator has a planned/unplanned absence, the provider must have a coverage plan to meet the face-to-face meeting requirement.

Incidental Contact with Program Participant

- Incidental contact does not meet the face-to-face meeting requirement Incidental contact is defined as contact with the participant that was not intended for a care coordination or peer support meeting in FTR, such as running into the client grocery shopping.

Level Changes

- A provider may request to increase or decrease a participant’s level throughout the reporting period to align with the participant’s goals. The provider will be reimbursed at the highest level that the participant was in anytime during the reporting period, as long as documentation supports the level of care.

Level Changes

Adjusting a participant's service level ensures they receive person-centered support that matches their progress, needs, and circumstances. Level changes may be **increases** or **decreases** depending on participant outcomes, care plan goals, and barriers.

Decreasing Levels

A decrease in level should be considered when:

- The participant has demonstrated several months of positive outcomes.
- There has been progress on care plan goals.
- The participant's needs have naturally declined.

When decreasing a level:

1. **Discuss with the participant** – The conversation should be natural, positive, and focus on their progress and success.
2. **Consult with the participant's PO** – Document the discussion in DocStars.
3. **Send an email notification** of the level change to the provider's assigned FTR Administrator.

   Example conversation (Level 3 to Level 2):

   "I've noticed you've continued to make progress on all your goals and have been doing really well for the past several months. I'm really impressed with the progress you have made. I'd like to begin meeting with you once a month rather than weekly. What do you think?"

Increasing Levels

An increase in level should be considered when:

- The participant's needs have increased while on Level 1 or Level 2.
- Barriers to stability have emerged (e.g., loss of housing, difficulty managing medications).

When increasing a level:

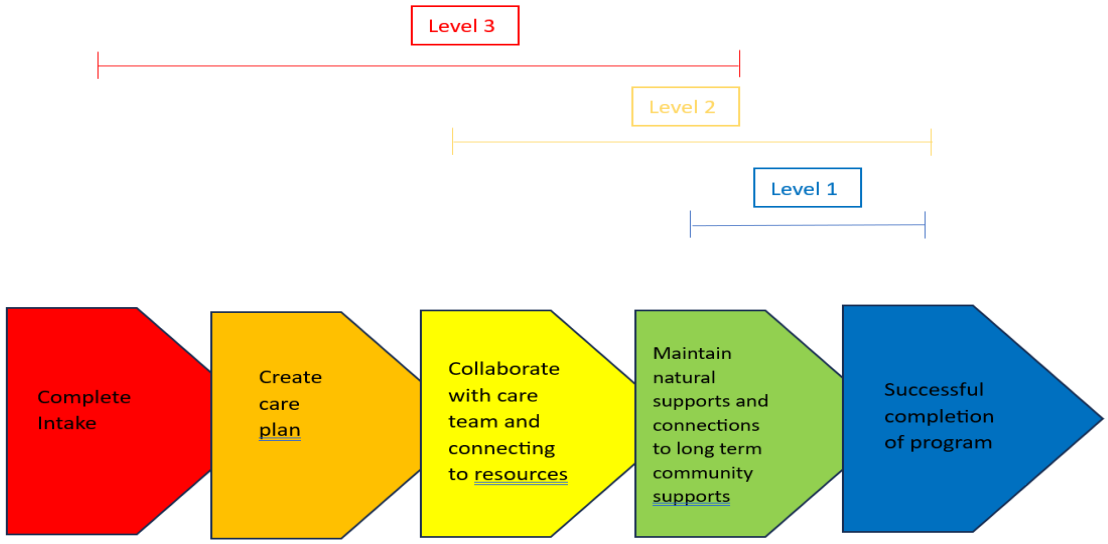
1. **Discuss with the participant** – The conversation should be supportive, strengths-based, and focused on working together to address barriers.
2. **Update the care plan** – Ensure it reflects new goals and barriers.
3. **Send an email notification** of the level change to the provider's assigned FTR Administrator.

   Example conversation:

   "You have been working so hard these past couple of months and recently hit some bumps in the road. You recently lost your housing, and it has been challenging for you to take medications consistently. It's normal to experience setbacks during recovery, and I'm confident we can work together to get things back on track. I'd like to begin meeting with you again on a weekly basis."

Procedural Notes for All Level Changes

- **Care Plan Review:** Before requesting any level change, review the care plan with the participant to ensure it reflects the change in level of care and includes any new goals or barriers.
- **If PO is unavailable**: Do not delay a level change. Review with the DOCR FTR Clinical Administrator and proceed by emailing the request to the FTR Administrator.
- **Special Circumstances**: If a participant is unable to meet in person according to their current level (e.g., incarceration, hospitalization, treatment), consider decreasing their level of care.



Payment

The Free Through Recovery reporting period runs from the 21st of each month through the 20th of the following month. Care Coordinators must submit outcome reporting for each participant by no later than the 20th of each month.

Starting on the first business day following the 20th of the month, the FTR Administrator will:

- Review chrono documentation (case notes) to confirm meeting standards were fulfilled, based on their assigned level.
- Reconcile outcomes submitted by the provider and the Probation or Parole Officer, including any comments.
- Determine payment, justifications for payment decisions are added as comments.

Payments are made using a **pay-for-performance model**, with each Level assigned a specific payment tier. Below is the payment structure and explanation.

Provider Reimbursement Rates Per Level

Level of Service	Level 3	Level 2	Level 1
Ineligible	$0	$0	$0
Diligence	$214	$161	NA
Base Pay	$428	$214	$107
Performance Pay	$514	$300	$193

Provider Transfer

The Care Coordinator or supervising officers shall inform DOCR FTR Clinical Administrator that the participant is requesting transfer to a different provider. This may be due to the participant requesting a new provider, or the participant has relocated within the state and needs a new provider.

Generally, a participant may request transfer after ninety (90) days of working with the participant's selected provider.

- The DOCR FTR CA may approve transfers prior to the ninety (90)-day period if the participant moves to another area of the state or there is a reasonable need for transfer.

A release of information for the new provider must be signed by the participant. The DOCR FTR CA or designee reassigns the participant in Docstars and notifies both the previous and new provider that the transfer is complete.

Transfer Process

1. PO obtains a new Authorization to Disclose Information for the new provider.
2. PO submits the transfer request to the DOCR Clinical Administrator.
3. DOCR Clinical Administrator reviews and completes the transfer.
4. Current Care Coordinator continues providing services until the transfer is complete and the participant is officially off their caseload.
5. Provider cannot discharge or transfer a participant so the participant can be hired by the provider.

Provider Responsibilities Before Transfer

- Update all chronos before the transfer is finalized.
- Complete transfer outcomes (by provider administrator).
- Understand that once transferred, the previous provider loses access to the participant in DocStars.
- Send FTR Administrator gap funding history for participant.

New Provider Responsibilities After Transfer

- The new provider will outreach the participant within three (3) business days
- The new provider will request the gap funding history from the FTR Administrator before using any gap funding. See gap funding guidance for more information.
- The new provider will update the current care plan in Docstars within ten (10) days.

Gap Funding

- Gap funding history must transfer through the FTR Administrator.
- The new provider must email the FTR Administrator to request gap funding history before using any gap funds.
- See the Gap Funding Guidance for full details.

Discharge Guidance

When to Talk About Discharge

- Discharge planning starts at intake.
- Participants should communicate what successful completion looks like for them.
- Discuss discharge during Care Plan creation and monthly goal reviews.

    Example question to ask early: "What does success look like for you, and how will we know when you're ready to complete the program?"

Loss of Engagement

When a participant stops meeting with the Care Coordinator and/or Peer Support Specialist for **60 days,** despite repeated contact attempts, the provider must staff with the **PO regarding discharge**. If the PO is unavailable to discuss discharge, the Care Coordinator must staff with the DOCR FTR Clinical Administrator.

Program Length

- There is no set time limit for individuals to participate in the program. An individual's participation in the program depends on each individual's needs.
- Providers must assess monthly whether the program is still appropriate for the participant and include information in chronos.

When to Discharge Successfully

Consider discharge if:

- The participant has had several months of positive outcomes.
- All Care Plan goals are met or supports are in place to continue progress.
- Needs have naturally declined through level decrease.
- The participant has built recovery supports and natural/community connections.
- The participant has met supervision requirements and has supports in place to continue progress.
- The participant has other services in place to meet needs.

Always consider participant choice when considering discharge.

Example conversation: "You've made great progress on your goals for several months. Let's talk about completing the program and what that timeline looks like."

Provider Responsibilities in Discharge

- Know and track supervision end dates to guide planning.
- Help connect participants to non-justice and recovery support community resources before supervision ends.
- Discuss discharge planning with:
    - Participant
    - Probation/Parole/ Pre-trial Officer (PO)
    - Care team
- Document discharge planning discussions in chronos.
- Make sure participant is aware of resources and services in the community, if they need them in the future.
- If participant is no longer on supervision, staff with the DOCR FTR Clinical Administrator (include the participant if possible).
- Discharge should not be delayed if the PO is unavailable, the provider may reach out to the DOCR FTR Clinical Administrator.
- All participants are engaged in this program voluntarily; therefore, a participant may choose to opt out of services at any time.
- Provider cannot discharge or transfer a participant so they can be hired by the provider.

Requesting a Discharge

Care Coordinator or provider administrator submits request in Docstars, that must include:

- Discharge date, last date of service (including staffings, collateral contacts, etc.)
- Type of Discharge
- Final Outcomes
- Social Determinants of Health

Types of Discharge

1. **Completion / Transfer to Long-Term Supports**: Participant discharges from FTR due to having community/ natural supports in place, achieving and/or continued progress towards goals, completion of or maintenance of supervision requirements, demonstrating a crime free lifestyle, and stability in outcome areas. Participant may have areas they are continuing to work on and have demonstrated the ability to continue to make progress in these areas with supports and resources in place.
2. **Declined Services / Stopped Participating**: Participant changed mind, requests to be discharged or is no longer in communication with care coordinator/peer support and does not meet completion of program definition.
3. **Moved Out of Service Area**: Participant has moved out of state, supervision status is Interstate Compact-Out. At the time of the move participant does not meet completion of program description.
4. **Absconded**: Participant has absconded from supervision and status has been determined by PO.
5. **Re-incarceration**: Participant jailed/prison for over 60 days.
6. **Transfer to Higher Level of Care**: Participant's needs are met by a service outside of FTR at a higher level of care. For example, ND State Hospital, Human Service Center (State-Operated Behavioral Health Clinic), 1915i, inpatient treatment, long term residential treatment.
7. **Adverse Program Termination**: Participant is removed from FTR for reasons such as inappropriate or dangerous behaviors, etc.

Final Outcomes

Final Outcomes are submitted by the Care Coordinator based on the status at time of discharge when there is sufficient information available. Information can be obtained through a staffing with the PO when the participant is not in communication with the care coordinator or peers support specialist.

1. **Stable Housing:** Yes/ No**:** Participant's housing situation is secure, safe and reliable
2. **Stable Employment:** Yes/ No**:** Participant is employed in a position that is expected to last for the foreseeable future or financial needs are met by a stable source: SSI, SSDI.
3. **Stable Recovery:** Yes/ No**:** Participant manages setbacks, seeks out support when needed and has demonstrated significant growth.
4. **Law Enforcement Contact:** Yes/ No**:** Participant has not shown behavior that has resulted in contact with law enforcement.

Social Determinants of Health

Social Determinants of Health are answered by the Care Coordinator at the time a discharge when there is sufficient information available. Information can be obtained through a staffing with the PO.

1. **Health: Yes/No:** Does the participant make informed, healthy choices that support their physical and emotional wellbeing (physical activity, attends medical appointments, takes medications as prescribed)?
2. **Community: Yes/No**: Does the person have relationships and social networks that provide support, friendship, love and hope?
3. **Purpose: Yes/No:** Does the person engage in meaningful, gainful activities (employment, school, volunteering, family, hobbies, etc)?
4. Does the person have medical insurance?

**A Free Through Recovery discharge guide is available in the Resources Tab in Docstars*

Gap Funding

What is Gap Funding?

Gap Funding is designed to help participants overcome financial barriers that prevent them from meeting their outcomes and goals, after all other resources and funding options have been exhausted in the community.

What is the Purpose of Gap Funding?

- To fill a "gap" when all community resources/funding have been exhausted.
- Gap Funding is **not** a monthly or ongoing financial assistance program.

Provider Expectations

- Each provider must follow their own internal process that aligns with this guidance.
- Internal processes may include steps specific to the agency. Consult your provider's administration for details.
- Record-keeping requirement: All Gap Funding documentation must be kept for four years. This includes:
    - Gap Funding Exception Request form
    - Itemized receipts
    - FTR Participant Category Tracker
    - Monthly Reimbursement Form
- The most up-to-date Gap Funding forms can be found here: Free Through Recovery

Gap Funding Categories List

The Gap Funding Categories List is a list of approved categories and items that a participant may utilize gap funding for without pre-approval.

Purchases requiring prior approval that are made before approval will be denied for reimbursement.

Housing (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Rental application fees • Security deposit • Emergency overnight sheltering • Rent assistance • Required Documentation: • Copy of application, lease, or itemized bill/proof of cost including the participant's name. • Itemized receipts for hotel stays showing all charges. **NOTES**: • Housing-related background checks must be submitted to the Gap Funding Committee for review.
Transportation (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Gas *(receipt from pump purchase required — no gas card reimbursement)* • Bike and bike lock • Bus fare/replacement bus pass • Uber, Lyft, or taxi (excluding tips or donations) • Driver's license, state or tribal ID fees **NOTES**: • Transportation expenses for Care Coordinators or Peer Support Specialists are not included. • Uber Eats gift cards will not be approved. • Registration and reinstatement fees are not included; submit to the Gap Committee for review.
Employment (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Work-related attire (boots, shoes, uniforms, black pants, or clothing required by employer) • Tools or supplies necessary to gain or sustain employment **NOTES**: • Employment-related background checks must be submitted to the Gap Committee for review.
Education (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Application fees

Basic Needs (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Toilet paper • Toothpaste, toothbrush • Shampoo, conditioner, soap • Deodorant • Feminine hygiene products • Razor, shaving cream • Band-aids/first aid supplies • Socks, underwear • Laundry supplies: detergent • Bedding: sheets, pillow, blanket, mattress, air mattress, cot • Bath towels: body towels, hand towels • Cleaning supplies: cloth rag, sponge, disinfectant, broom/dustpan • Winter/cold weather clothing: jacket, hat, mittens/gloves, boots • Over-the-counter pain relievers: Tylenol, Advil, Ibuprofen, etc. • Prenatal vitamins • Fees for ordering a birth certificate
Communication (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Cell phone *(participant use only)* • Cell phone minutes/cards *(including while participant is incarcerated to contact CC or PSS)*
Clinical Services (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • One clinical assessment per year when other funding opportunities are exhausted • May not be used to fulfill criminal sanctions/court orders **NOTES**: • Does not include medical exams/visits, eye exams, or dental exams.
Family (Requests are limited to $100 per 12-month period)	**ELIGIBLE**: • Car seat • Diapers • Wet wipes • Bottles • Crib/child's bed • Child's clothes and/or shoes • Child's birth certificate or social security card • Bus fare for minor child

**A participant's 12-month period starts when they are referred to the program, this resets after 12 months and a new 12-month period starts. It is the responsibility of the provider to track and verify a participant's use of gap funding.

Gap Funding Process

Step 1: Determine the Need

1. Identify if a financial obstacle is preventing the participant from reaching their goals.
2. The Care Coordinator/Peer Support Specialist must:
    - Explore all other funding options and community resources.
    - Assist the participant in accessing community referrals.
    - Determine if the participant can cover part of the cost.
    - Use gap funding only after all other options are exhausted.
3. If the expense is recurring, work with the participant to create a future payment plan.

Step 2: Determine the Type

1. **Requests Not Requiring Prior Approval**
    - Expense is on the Gap Funding Category list and
    - Total cost is less than $100 and
    - Participant has remaining funds in the category.
      *(Limit: $100 per category per participant per 12-month period.**)*

2. **Requests Requiring Prior Approval**
    - Not on the Gap Funding Category list, or
    - On the list but cost exceeds $100, or
    - Participant has no remaining funds in that category.

    Process for Requesting Approval
    - Email the following to freethroughrecovery@nd.gov Attn: Gap Funding Committee:
        - Gap Funding Exception Request form
        - Updated participant budget including all income, expenses, and total remaining balance
        - Denial letters from community resources, if available.
        - Proof of cost of the item
        - Future payment plan (if recurring)
    - If all the information listed above is not submitted in its entirety, the request will be denied. Provider may re-submit when all documentation is obtained.
    - Allow at least one week for a decision or request for more information.
    - If approved, make the purchase according to the provider's policies.
        - Itemized receipt should include only gap funding items.

Step 3: Reimbursement

1. Submit the following to the assigned FTR Administrator by the 15th of each month:
    - Monthly Reimbursement Form (MRF).
    - Corresponding itemized receipts in the same order as listed on the MRF.
        - Itemized receipt should include only gap funding items.
    - Participant Category Trackers.
      (Receipts must include vendor, date, and total amount. Itemized receipts should contain only gap-funded items.)

2. Reimbursement may be denied or adjusted if:
    - Items are not on the Gap Funding Category list.
    - Purchase exceeded available participant funds.
    - Gap Funding Exception Request was denied, or purchase was made before the request was submitted to the committee for review.
    - Incomplete reimbursement submitted (e.g., missing receipts or other required information).
    - Late reimbursement submissions or resubmissions.

3. **Deadlines**: All reimbursements must be submitted by the 15th of the month following the purchase.
   Example: Purchases made in July must be submitted by August 15th; purchases made in August must be submitted by September 15th, and so on.
    - If required documentation isn't provided in the initial submission (e.g., non-itemized hotel receipt or missing receipt), that month's reimbursement will be adjusted accordingly, and the provider will be notified.
        - Providers may resubmit the reimbursement request with all required documentation (MRF, receipts, and participant category tracker) by the 15th of the following month.
            - A re-submission that does not include all required documentation (MRF, itemized receipt, participant category tracker) will be denied, there is no additional opportunity for resubmission.
    - Late reimbursement requests and late resubmissions requests will be denied.

   Example: A provider submits a reimbursement request for a July hotel stay by August 15th. The reimbursement request is missing an itemized hotel receipt. The provider will be notified by the FTR Administrator, and they have an opportunity to resubmit a reimbursement request by no later than September 15. This resubmission of the reimbursement request MUST include all required documentation (MRF, Itemized Receipt, and Participant Category Tracker). If any of this documentation is missing after the re-submission, the provider will not have an opportunity to resubmit again.

Receipt or Proof of Purchase Requirements

All receipts/proof of purchase must include:

- Date of purchase, and
- Amount, and
- Vendor name, and
- Itemization, and
- Participant name or SID number.

If item descriptions are missing (e.g., Walmart receipts), write a brief description of each item directly on the receipt, along with the participant's name or SID.

Recurring bills (e.g., electric, cell phone, etc.):

- Include the statement/invoice showing participant's name and address.
- Provide payment confirmation.

Hotel stays:

- Include the hotel folio or itemized receipt showing all charges for each day.
    - Hotel confirmations are not receipts and will be denied.

Gap Funding and Participant Transfers

- When a participant transfers to a new provider, their gap funding history must be sent to the assigned FTR Administrator to share with the new provider.
- The new provider is responsible for reviewing the funding history before using gap funding.
- The new provider must enter this history into a new Participant Category Tracker.
- Note: The 12-month funding period is based on the participant's referral date (does not reset upon transfer). The referral date is in DocStars.

Gap Funding Audit Process

The Behavioral Health Division (BHD) conducts periodic audits of gap funding requests and reimbursements. This process ensures compliance with funding guidelines and prepares providers for possible audits.

Audit Steps:

1. **Notification:** Providers will be notified by a BHD FTR Administrator if selected for an audit.
2. **Review:** The BHD will:
    a. Compare the Monthly Reimbursement Form (MRF) with all Gap Funding Request Forms and receipts.
    b. Confirm that:
        i. All expenses are on the Gap Funding Categories list OR have received prior approval.
        ii. All purchases have corresponding receipts.
3. **Pass/Fail Criteria:**
    a. **Pass:** All expenses are approved and properly documented.
    b. **Fail:** Any unapproved item on a receipt causes the entire receipt to be rejected.
        i. Rejected receipts must be reimbursed to BHD within 30 days.

Consequences for Failing an Audit:

- Gap funding services suspended until discrepancies are corrected.
- Possible indefinite suspension of gap funding.
- Evidence of abuse or fraud may result in ending the provider agreement.

Gap Funding FAQs

Can it be used for someone else in the participant's household?

- **No.** Gap Funding is only for the participant.

Can it help with moving into a home?

- **Yes,** for application fees or deposits.
- **No** for moving truck or mover expenses.

Can it pay court-ordered fines or fees?

- **No.**

How long does a request take?

- The Gap Committee meets weekly.
- Missing documentation or incomplete request forms delay decisions.
- All requests must include:
    - Updated budget (all income, expenses and remaining balance).
    - Care Plan with active/completed goals.
    - Plan for covering recurring expenses in the future.

Does every FTR participant automatically get gap funding?

- **No.** Participants must meet criteria and exhaust other resources first. Free Through Recovery is not meant to be a financial assistance type program that provides ongoing/monthly assistance.

If housing assistance ends, can gap funding pay rent?

- **Possibly** — must show how financial/housing goals were addressed before assistance ended and outline a forward plan.

Can gap funding pay overdue bills or monthly bills the participant can't afford?

- **Recurring bills** (cell phone, electric, storage, PO box) require Gap Committee review.

Can it pay for eye exams, glasses, or dental expenses?

- **Not in approved categories** — must be submitted to the committee for review.

Can it pay for prescription medications?

- **Not in approved categories** — must be submitted to the committee for review

What is a budget and why is it important?

- A budget is required when submitting an exception request and it serves as a valuable tool for managing income and expenses, ensuring that bills are covered. A budget is essential for planning purchases and making informed financial decisions. Supporting a participant with financial planning is the responsibility of the Care Coordinator and Peer Support and should be addressed proactively by the care team rather than waiting until a financial crisis occurs.

Glossary of Terms and Abbreviations

Behavioral Health Division (BHD)
The North Dakota Department of Health and Human Services' Behavioral Health Division provides leadership for the planning, development, and oversight of the state's behavioral health system.

Best Practice
A method or practice that has shown to be most effective.

Care Coordinator (CC)
Provides a source of connection and support for FTR participants as well as assisting participants with achieving motivation for long-and short- term goals while creatively problem-solving barriers. Serves as part of the care team.

Chronos
Or chronological notes, are notes entered in Docstars to record all interaction (actual & attempted) and other "work" done on behalf of a participant.

DOCR FTR Clinical Administrator (DOCR FTR CA)
Administers the program in collaboration with the FTR Lead Administrator. Is an employee of the DOCR. Approves referrals, transfers and discharges. This position serves as part of the care team on an as needed basis if a PO is unavailable or the participant is off supervision. Provides training and guidance on Corrections Best Practices.

Docstars
Abbreviation for "Department Of Corrections Subject Tracking And Reporting System"

Database used for care plans, documentation, outcomes, participant identifying information, referral information, etc.

Evidence Based Practices
Any practice that relies on scientific evidence for guidance and decision making.

Free Through Recovery (FTR)
Free Through Recovery is a North Dakota community based behavioral health program designed to increase recovery support services to individuals involved with the criminal justice system who have behavioral health concerns.

FTR Administrator
Employee of the Behavioral Health Division (BHD) and serves the FTR program by delivering technical assistance, training, regional leadership/collaboration, and reconciliation of monthly outcomes and payment sheets for providers. Each agency is assigned an FTR Administrator.

FTR Lead Administrator
Oversees the FTR program statewide including providing training and technical assistance and is the FTR Administrators' supervisor. This position assists with provider reviews and collaborates with the DOCR FTR Clinical Administrator to administer the program.

Gap Funding
Available funding for participants to utilize with the assistance of their Care Coordinator or Peer Support Specialist to help fill gaps where other community resources are unavailable.

North Dakota Department of Corrections and Rehabilitation (DOCR)
Responsible for the direction and general administrative supervision, guidance, and planning of adult and juvenile correctional facilities and programs in North Dakota. Probation/Parole Officers, as well as the FTR Clinical Administrator, are extensions of the DOCR.

Outcomes
Identify participant results in the areas of housing, employment, recovery supports, and criminal justice involvement.

Payment Sheets
A monthly report sent by FTR Administrators to providers detailing how they are reimbursed for services for the reporting period.

Peer Support Specialist (PSS)
An individual who uses their lived experience and skills learned through formal training to deliver services to promote mind-body recovery and resiliency, as well as serves as part of the care team.

Probation/Parole Officer/Pre-Trial Officer (PO)
The supervision officer overseeing the participant's involvement in the criminal justice system. The PO makes the FTR referrals and gets Releases of Information (ROI) signed for the FTR participant and serves as part of the care team.

Provider
The organization or agency that enters into an agreement with BHD and signs an MOU with DOCR to access Docstars to provide services to FTR participants.

Provider Agreement (PA)
The agreement and clarification of responsibilities between BHD and the provider.

Reconciling
The process of vetting participant's outcomes and determining payment to the provider.

Release of Information (ROI)
Also known as an authorization to disclose information form, is a form required to be signed by an individual before entering FTR. This release allows BHD, DOCR, and the chosen provider to talk freely about the participant's services.

Reporting Period
Starts on the 21st of the month and ends on the 20th of the following month. Example, 11/21/2025 to 12/20/2025.

Staffing
Refers to care team members discussing participant services or situations. It is an essential part of the program, providing an opportunity for collaboration among the entire care team to best support participant needs.

Weekly Services/Meetings
Based on a calendar week.