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North Sound Behavioral Health Organization Clinical Practice Guidelines

Effective 2004
Revisions Effective 2005, 2006, 2008, 2010, 2013, & 2017*

***Note: See APPENDIX I Review/Revision Chronology**

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Statement of Intent:

The intent of the North Sound Behavioral Health Organization's (North Sound BHO) Clinical Practice Guidelines is to provide a foundation to assist the behavioral health system in the delivery of high quality, consistent clinical services.

The Clinical Practice Guidelines are **not** to be construed to limit the individualization of treatment, clinician judgment, or the ability of the clinician to provide treatment in the best interests of the individual. Provision of services may be qualified by limitations of payment sources and funding.

The basis for these guidelines is the Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition (DSM 5); however, the North Sound BHO recognizes that symptoms and clinical presentation do not always meet clear DSM 5 diagnostic criteria and response to clinical intervention is not uniform.

Any clinical intervention requires the clinician to adapt services based on medical necessity for an individual. The Clinical Practice Guidelines are based on evolving scientific research and experience. Consequently, the Clinical Practice Guidelines will be reviewed and updated periodically.

The Clinical Practice Guidelines should be considered *guidelines* only, and the North Sound BHO realizes that adherence to them does not guarantee a successful outcome, nor should the Clinical Practice Guidelines be construed as including all the proper methods of care or excluding other acceptable methods of care aimed at the same results.

Please note that the Clinical Practice Guidelines are qualified by the limitations of payment sources and funding as designated through current contracts, the Washington State Administrative Codes (WACs), the Revised Codes of Washington (RCWs) and Federal requirements.

The North Sound BHO's Clinical Practice Guidelines Workgroup recommended to the North Sound BHO Quality Management Oversight Committee (QMOC) to utilize an internet format as the American Psychiatric Association (APA) and the American Academy of Child & Adolescent Psychiatry (AACAP) websites are self-updating. Therefore, the Clinical Practice Guidelines includes internet addresses to the APA and the AACAP clinical practice guidelines as available for each diagnosis included herein.

Please note that the APA and the AACAP are currently in the process of updating their clinical guidelines some of them have been suspended temporarily.

One of the two non-diagnosis related guidelines, *Individual-Centered Recovery and Resiliency*, can be found in this manual in its entirety. A second non-diagnosis related guideline *Child & Youth Suicidal Behaviors* can also be found on the AACAP website.

Behavioral Health Agencies (BHAs) contracted with the North Sound BHO shall develop and implement policies and procedures that support these guidelines. A BHA Medical Director must approve a BHA's policies and procedures related to these guidelines. When the Clinical Practice Guidelines are not felt to be desirable for an individual, the rationale for not following the Clinical Practice Guidelines will be documented in the individual's clinical record.

All services are provided in accordance with the current North Sound BHO's access to care, continued stay and discharge criteria.

Delineated Clinical Practice Guidelines:

- The approved Clinical Practice Guidelines are listed below.
- The bullet points beneath each diagnosis reflect the core elements associated with the individual guideline.
- Core elements have been identified by the North Sound BHO Medical Director as minimum critical elements that must be present when the North Sound BHO reviews an individual clinical file as reflecting that services are being provided in accordance with North Sound BHO Clinical Practice Guidelines.
- To gain access to the full APA current guidelines for adults, follow these steps:
  a. Copy and paste the web address http://psychiatryonline.org/guidelines.aspx into the address bar on your web browser. This will take you to the APA Practice Guidelines home page.
  b. Search for the diagnosis and review the practice guideline
- To gain access to the full AACAP guidelines for children & youth, follow these steps:
  a. Copy and paste the web address http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry into the address bar on your web browser. This will take you to the AACAP Guideline Summary page.
  b. Click on the "authoring" tab.
  c. Click on "American Academy of Child and Adolescent Psychiatry."
  d. Scroll to the bottom of the page to access the current guidelines.
- As journal guideline watches are periodically published on the AACAP website, between formal updates, an ongoing survey of the watches will be undertaken by the North Sound BHO Medical Director, and elements of these watches will be added to the core elements, where indicated, during a routine, clinical guidelines review/revision by a designated North Sound BHO Quality Specialist, every three years.

As noted above, the core elements of each guideline are listed below the diagnosis. These core elements are expected to be present when the North Sound BHO reviews an individual clinical file to demonstrate that services are being provided in accordance with North Sound BHO Clinical Practice Guidelines. If the clinical decision is made not to incorporate a core element into an individual's treatment, this decision and the rationale for it should be documented in the individual's chart.

Adult Anxiety Disorders http://psychiatryonline.org/guidelines.aspx

- There is some form of Cognitive Behavioral Therapy to address anxiety
- There is an attempt at medication management. If the individual has a history of substance abuse, then non-sedative medications should be tried first
- Medication was considered

Adult ADHD http://psychiatryonline.org/guidelines.aspx

- Screen for co-occurring substance disorders
- Alternatives to stimulants are tried first such as Strattera, Wellbutrin, and Effexor
- If stimulants are used, then there are efforts to monitor for substance abuse and diversion of medication

Adult Bipolar Disorder http://psychiatryonline.org/guidelines.aspx

- A mood stabilizer was used or there is documentation that it was considered with the rationale for not prescribing
- There is documentation of psycho-education regarding strategies to prevent episodes on mania and/or depression

Adult Borderline Personality http://psychiatryonline.org/guidelines.aspx

- The service team has established a method to discourage self-injury
- Use of Dialectical Behavioral Therapy (DBT) informed therapy or documentation that it was considered with rationale for not providing DBT informed therapy

Adult Co-occurring Disorders http://psychiatryonline.org/guidelines.aspx

- If treated by separate providers (i.e. one for mental health disorders and one for substance use orders) then the two providers must coordinate care

Adult Dissociative Disorder http://psychiatryonline.org/guidelines.aspx

- There is a form of psychotherapy which is focused on integration of personality

Adult Eating Disorders http://psychiatryonline.org/guidelines.aspx

- There is some form of Cognitive Behavioral Therapy to address distorted body image
- There is coordination with a medical provider who is monitoring weight and nutrition
- Failure of intensive outpatient treatment is required before considering higher levels of care

Adult Major Depressive Disorder http://psychiatryonline.org/guidelines.aspx

- An antidepressant medication is being used or there is documentation that it was considered with the rationale for not prescribing
- Some form of psychotherapy is being used or there is documentation that it was considered with a rationale for why it is not being offered

Adult Neurocognitive Disorder (Dementia) http://psychiatryonline.org/guidelines.aspx

- This group demonstrates behaviors that are aggressive, psychotic or depressed
- Care should be coordinated with primary care givers and primary medical provider

- Efforts should be made to establish a baseline of behaviors, exploring any environmental triggers and medications should be reviewed

Adult Obsessive Compulsive Disorder http://psychiatryonline.org/guidelines.aspx

- There is some form of cognitive behavioral therapy to address intrusive thoughts and compulsive behaviors
- Trial of medication has been attempted with SSRIs or Anfranil

Adult Schizophrenia http://psychiatryonline.org/guidelines.aspx

- An anti-psychotic medication is being used or there is documentation that it was considered with the rationale for not prescribing
- The clinician/case manager is monitoring whether the individual is agreeing to take prescribed psychiatric medications

Adult Substance Use Disorders (For *all Substance Use Disorders)* http://psychiatryonline.org/guidelines.aspx:

- Detoxification, if medically indicated, has been implemented or considered
- There is an attempt to screen for co-occurring mental health issues and co-morbid medical issues
- There is a method for monitoring of potential ongoing substance use
- The individual is receiving relapse prevention training
- Peer support is being used or considered
- Pharmacological intervention has been implemented, or considered, to reduce future substance use
- Psychosocial issues such as homelessness are being addressed

Adult Trauma Disorders http://psychiatryonline.org/guidelines.aspx

- The focus of therapy (group or individual) is on resolving the trauma, through use of Cognitive Behavioral techniques such as uncovering, exposure, and desensitization or there is documentation that it was considered with a rationale for why it is not being offered

Adult Suicidal Behaviors http://psychiatryonline.org/guidelines.aspx

- Risk factors and protective factors are identified and noted in the initial/intake assessment
- The initial/intake assessment rates risk (provides a clinical opinion), based on the risk and protective factors, and assigns a level of risk
- The Recovery/Resilience Plan reflects a treatment strategy consistent with the level of risk presented
- Progress notes reflect that risk assessment is ongoing

Child & Adolescent Anxiety Disorders http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- There is some form of Cognitive Behavioral Therapy to address anxiety
- There is an attempt at medication management. If the individual has a history of substance abuse, then non-sedative medications should be tried first
- Medication was considered or there is documentation that it was considered with the rationale for not prescribing

Child & Adolescent ADHD http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- Individual management training has occurred with the primary caregivers or there is documentation that it was considered with a rationale why it is not being offered.
- There are documented efforts at school accommodations or there is documentation that it was considered with a rationale why it is not being offered

- A psycho-stimulant has been tried or there is documentation that it was considered with a rationale for not prescribing

Child & Adolescent Bipolar Disorder http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- A mood stabilizer was used or there is documentation that it was considered with the rationale for not prescribing
- There is documentation of psycho-education regarding strategies to prevent episodes on mania or depression with both the individual and the primary caregivers, if applicable

Child & Adolescent Conduct Disorder http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- Individual management training has occurred with the primary caregivers or there is documentation that it was considered with a rationale why it is not being offered
- The service providers are not allowing or supporting efforts for the individual to avoid consequences (legal or other) for violating the rights of others

Child & Adolescent Co-occurring Disorders http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- If treated by separate providers (i.e. one for mental health and one for substance use) then the two providers must coordinate care

Child & Adolescent Dissociative Disorder http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- There is a form of psychotherapy which is focused on integration of personality

Child & Adolescent Eating Disorders http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- There is some form of Cognitive Behavioral Therapy (CBT) to address distorted body image
- There is coordination with a medical provider who is monitoring weight and nutrition
- Failure of intensive outpatient treatment is required before considering higher levels of care

Child & Adolescent Major Depressive Disorder http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- An antidepressant medication is being used or there is documentation that it was considered with the rationale for not prescribing
- Some form of psychotherapy is being used or there is documentation that it was considered with a rationale for why it is not being offered

Child & Adolescent Obsessive Compulsive Disorder
http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- There is some form of Cognitive Behavioral Therapy (CBT) to address intrusive thoughts and compulsive behaviors
- Trial of medication has been attempted or documentation that that it was considered and for rationale for not prescribing

Child & Adolescent Psychotic Disorders http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- An anti-psychotic medication is being used or there is documentation that it was considered with rationale for not prescribing

- There has been an exhaustive effort to rule out organic causes of the psychosis such as medical disorders, metabolic disorders, infection, brain injury & drug intoxication or withdrawal
- If the child is 13 or younger, then there is documentation of consideration if psychotic symptoms related to malingering, attention seeking, misperceptions, and/or suggestions from caregivers or cultural issues such as religion or other family beliefs.

Child & Adolescent Substance Use Disorders http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- Detoxification, if medically indicated has been, has been implemented or considered
- There is an attempt to screen for co-occurring mental health issues and co-morbid medical conditions
- There is a method for monitoring of potential ongoing substance use
- The individual is receiving relapse prevention training
- Peer support is being used or considered
- Pharmacological intervention has been implemented, or considered, to reduce future substance use
- Psychosocial issues such as homelessness are being addressed.

Child & Adolescent Suicidal Behaviors(http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- Risk factors & protective factors are identified & noted in the initial/ initial assessment
- The initial/initial assessment assesses risk (provides a clinical opinion), based on the risk & protective factors, and assigns a level of risk
- The RRP reflects a treatment strategy consistent with the level of risk presented
- Progress notes reflect that risk assessment is ongoing

Child & Adolescent Trauma Disorders http://www.guidelinecentral.com/summary-authoring-organization/american-academy-child-and-adolescent-psychiatry

- The focus of therapy (group or individual) is on resolving the trauma, through use of Cognitive Behavioral techniques such as uncovering, exposure, and desensitization or there is documentation that it was considered with a rationale for why it is not being offered.

Note: The non-diagnosis related guidelines are reflected in their entirety, below.

Individual-Centered Recovery and Resiliency

I. Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines **recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential"** (SAMHSA, 2011). Through its Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery: Health, Home, Purpose, and Community. SAMHSA has also delineated ten guiding principles of recovery: Hope, Individual-Driven, Many Pathways, Holistic, Peer Support, Relational, Culture, Addresses Trauma, Strengths/Responsibility, and Respect.

With these dimensions and principles as guidance, the North Sound BHO supports and encourages **Individual-Centered Recovery/Resiliency Planning;** a process that serves as a working and dynamic roadmap to help **individuals achieve personally meaningful goals** and that **assists BHAs in quality and risk management practices.**

Since 2007, North Sound BHO has also supported trainings in Wellness Recovery Action Plans (WRAP) to assist individuals and BHAs increase individual and community wellness. WRAPs' primary goal is to teach individuals recovery, self-management skills, and strategies for dealing with psychiatric symptoms (Mary Ellen Copeland, 2009).

The North Sound BHO also supports the implementation of the Wraparound model when delivering service and supports to children and families. The Wraparound model is fundamentally rooted in the System of Care philosophy and provides coordination, planning and service delivery that is family-driven/youth-guided and culturally competent.

On June 15, 2016, the State of Washington's Department of Social and Health Services (DSHS) adopted new and revised Washington Administrative Codes (WACs) 388-877-0610; 0620; 0630; and 0640 and WAC 388-877A, and WAC 388-877B related to Initial Assessment, Individual Service Plan, and Clinical Record.

These WAC revisions allow BHAs more flexibility in meeting the needs of individuals while still meeting the statutory requirements for collecting history data and focusing on the individual's unique needs.

With the Clinical Practice Guidelines, the North Sound BHO endeavors to coordinate the application of WACs and other legislated or contracted requirements with current and nationally accepted and best practices in the field of behavioral health recovery and resiliency.

II. Individual-Centered Services & Recovery/Resiliency Planning

Historically, a "treatment plan" is a professionally-driven document that is often considered a time-consuming exercise conducted in a manner to meet requirements of external auditors or mandates.

Traditionally, the individual is referred to as the "consumer" who may be requested to provide "input" into the "treatment plan". However, the document itself may not be written in individual-friendly language. Individuals often report that they know they have a treatment plan, but are unaware of the content and therefore are unaware of both their responsibilities and the professionals' responsibilities to the plan.

In contrast, a **Recovery/Resiliency Plan (RRP)** is developed **in partnership with individuals receiving behavioral health services** and/or their caregivers and family. A RRP is **not viewed solely as a compliance tool**; rather as an integral and essential part of the overall clinical documentation and service delivery process.

The RRP further serves as a primary step in the **engagement phase** of services and promotes **individual-centered services**. RRPs should demonstrate **shared decision-making** and **individual-defined outcomes**. Recovery/resiliency planning and individual-centered treatment "promote **individual choice, empowerment, resilience, and self-reliance**" (Adams & Grieder, 2005).

A clearly articulated RRP provides the following benefits to the individual and the services team:

1. A **roadmap for the individual and the services team**, providing direction and allowing the team and individual or family to evaluate the individual's progress toward his/her goals and the effectiveness of interventions;
2. Demonstrates individual or family goals towards recovery;

3. Documents both **individual and BHA responsibilities** towards recovery;
4. Provides data from which the BHA and North Sound BHO can monitor and evaluate the quality of services provided (**Quality Improvement**);
5. Functions as a "clinical invoice," justifying admission and length of stay, and substantiating the diagnoses (**Utilization Review**);
6. Increases the probability that the BHA will be more successful during **regulatory compliance** surveys, as it demonstrates the professional competence of the individual clinicians who collaborate to develop the RRPs, and shows the service team's adherence to BHA and the North Sound BHO policies and procedures and regulatory standards on which those policies and procedures are generally based;
7. Protects the BHA and clinicians against litigation (**Risk Management**).

Key Components

The North Sound BHO recommends integration of the SAMHSA's 10 Guiding Principles of Recovery (SAMHSA, 2011). The North Sound BHO believes that these guiding principles greatly assist the philosophical and practice shift from a standard ISP or "treatment plan" development to a more Individual-Centered RRP.

The 10 Guiding Principles of Recovery are (SAMHSA, 2011):

1. Recovery emerges from **Hope**: The belief that recovery is real provides the essential and motivating message of a better future-that individuals can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies and others. Hope is the catalyst of the recovery process.

2. Recovery is **Person-Driven**: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In doing so, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

3. Recovery occurs via **Many Pathways**: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds-including trauma experience-that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

4. Recovery is **Holistic**: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment,

transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

5. Recovery is **Supported by Peers** and Allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

6. Recovery is supported through **Relationship** and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the individual's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unwilling life roles behind and engage in new roles (e.g. partner, caregiver, friend, student, and employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

7. Recovery is **Culturally**-based and influenced: Culture and cultural background in all of its diverse representations-including values, traditions, and beliefs-are keys in determining an individual's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

8. Recovery is supported by **Addressing Trauma**: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

9. Recovery is individual, family, and community **Strengths and Responsibility**: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires and aspirations.

10. Recovery is based on **Respect**: Community, systems, and societal acceptance and appreciation for individuals affected by mental health and substance use problems-including protecting their rights and eliminating discrimination-are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

III. Cultural Competence

The National Center on Cultural Competence suggests that delivery of services and support in a culturally competent manner facilitates better individual outcomes and increases satisfaction with the services received. Critical factors in the provision of culturally competent care include the understanding of (Georgetown University, 2010):

Beliefs, values, traditions and practices of a culture;
Culturally-defined, health-related needs of individuals, families and communities;
Culturally-based belief systems of the etiology of illness and disease and those related to health and healing; and
Attitudes toward seeking help from health care providers.

Individual-Centered Recovery/Resiliency plans should reflect an understanding of an individual's unique cultural identity. The following elements are presented as a guide for BHAs to self-assess culturally competent plans:

1. Is culture reflected including and beyond race and ethnicity?

For example:

   a. Language
   b. Gender
   c. Sexual orientation
   d. Socioeconomic status
   e. Family roles
   f. Housing status
   g. Regional differences

2. Is the plan written in language understandable by the individual seeking services?
3. Is the plan age and developmentally appropriate to the individual seeking services?
4. Does the plan reflect all recommendations provided by consulting specialists?

IV. Special Considerations for Children, Youth, and Families:

The information presented in sections I-III above is applicable when providing services and supports to individuals of any age. However, North Sound BHO recommends additional specific training and clinical focus in **System of Care philosophy** including **recovery and resiliency** for all BHA staff who work predominantly with children, adolescents, and families.

System of Care Defined:

(Technical Assistance Partnership for Child and Family Mental Health, 2016)

A "system of care" is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families.

The core values of the System of Care philosophy specify that Systems of Care are:

1. Family driven and child and adolescent guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

System of Care Core Values:

- Family Driven
- Youth Guided
- Culturally and Linguistically Competent
- Individualized and Community-Based
- Evidence-Based

System of Care Guiding Principles:

The following represent the foundational principles of the System of Care philosophy that Systems of Care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems

at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.

Family Driven Defined:

The System ofCcare should be **family driven**, with the needs of the child and family dictating the types and mix of services provided. Family driven means that families have a primary decision-making role in the care of their children, as well as in the policies and procedures governing care for all children in their communities, states, tribes, territories, and nations. This includes:

- Choosing supports, services, and providers
- Setting goals
- Designing and implementing programs
- Monitoring outcomes
- Determining the effectiveness of all efforts to promote the behavioral health of children and youth.

Guiding Principles of Family-Driven Care:

- Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility of outcomes
- Families and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their families
- All children, youth, and families have a biological, adoptive, foster or surrogate family voice advocating on their behalf and may appoint them as substitute decision makers at any time
- Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information and strengthen the family voice.
- Families and family-run organizations provide direction for decisions that impact funding for services, treatments and supports and advocate for families and children to have choices.
- Providers take the initiative to change policy and practice from provider-driven to family-driven.
- Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, adolescent and families and where family and adolescent run organizations are funded and sustained.
- Community attitude change efforts focus on removing barriers and discrimination created by stigma.
- Communities and private agencies embrace, value, and celebrate the diverse cultures of their children, adolescents and families and work to eliminate behavioral health disparities.
- Everyone who connects with children, adolescents and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of the diverse populations are appropriately addressed.

Characteristics of Family-Driven Care

- Family and youth experiences, their visions and goals, their perceptions of strengths and needs and their guidance about what will make them comfortable steer decision-making about all aspects of service and system design, operation and evaluation.
- Family-run organizations receive resources and funds to support and sustain the infrastructure that is essential to insure an independent family voice in their communities, states, tribes, territories and the nation.
- Meetings and service provision happen in culturally and linguistically competent environments where family and youth voices are heard and valued, everyone is respected and trusted and it is safe for everyone to speak honestly.
- Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, responsibility and control with them.
- Families and youth have access to useful, usable, and understandable information and data, as well as, sound professional expertise so they have good information to make decisions.
- Funding mechanisms allow families and youth to have choices.
- All children, youth and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

Youth-Guided Defined

The systems of care philosophy places high priority on the youth-guided core value. Youth are viewed as true experts and primary individual services. SAMHSA proposes that the youth-focused movement is defined in three phases: Youth Guided, Youth Directed and Youth Driven. Further, within each phase there are indicators for individual, community and policy.

References:

1. DSHS Washington State Access to Care Standards: For Behavioral Health Organizations, October, 1, 2016
2. 2016 Washington Administrative Codes (WAC) 388-877, 388-877A, and 388-877B
3. Yikshak Shnaps, Princeton, N.J. American board of Psychiatry and Neurology, web publication

4. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Washington, D.C. American Psychiatric Association, 2013

Works Cited:

1. Friesen, B. (2007). Recovery and Resilience in Children's Mental Health: Views from the Field. Psychiatric Rehabilitation Journal , 38-48.
2. Georgetown University. (2010, May). Foundations of Cultural & Linguistic Competence. Retrieved May 2010, from National Center for Cultural Competence: http://nccc.georgetown.edu/foundations/need.html
3. Mary Ellen Copeland, P. (2009). Personal Mental Health Recovery Values and Ethics. Retrieved April 2010, from Mental Health Recovery and WRAP: http://www.mentalhealthrecovery.com/
4. [1]Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
5. http://www.tapartnership.org/

Other Resources:

1. Addiction Technology Transfer Center Network:
   http://attcnetwork.org/home/
2. American Society of Addiction Medicine:
   http://www.asam.org/
3. Implementing Person Centered Care, Practices and Planning:
   http://www.personcenteredtreatmentplanning.com/
4. National Alliance on Mental Illness:
   http://www.nami.org/
5. National Institute on Drug Abuse:
   https://www.drugabuse.gov/
6. National Wraparound Initiative:
   http://www.nwi.pdx.edu/
   http://wrapinfo.org/
7. National Center for Cultural Competence:
   http://www.clcpa.info/
8. Substance Abuse and Mental Health Administration (SAMHSA)
   http://www.samhsa.gov/
9. https://www.pathwaysrtc.pdx.edu/focalpoint

APPENDIX I: Review/Revision Chronology

YEAR	GUIDELINES REVIEWED/REVISED
2004	
2005	
2006	
2008	
2010	
2013	
2017	