North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
Improving the mental health and well being of individuals and families in our communities
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North Sound Mental Health Administration Clinical Guidelines

10/16/13

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

***Note: See APPENDIX I Guideline Adoption/Review Chronology**

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North Sound Mental Health Administration
Statement of Intent

The intent of the North Sound Mental Health Administration's Clinical Guidelines is to provide a foundation to assist our mental health system in the delivery of high quality, consistent clinical services. They promote the delivery of consistent clinical care on a regional basis.

These clinical 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 client. Provision of treatment may be qualified by limitations of payment sources and funding.

The basis for these guidelines is the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) however we recognize 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 a treatment program based on medical necessity and individualized for each client. Guidelines are based on evolving scientific research and experience. Consequently, these guidelines will be reviewed and updated periodically.

All should be considered guidelines only, and we realize that adherence to them does not guarantee a successful outcome, nor should they 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 these guidelines are qualified by the limitations of payment sources and funding as designated through current contracts, state WAC and RCW standards and Federal requirements.

This revision of the clinical guidelines includes internet web addresses to the **American Psychiatric Association** (APA) and **American Academy of Child & Adolescent Psychiatry** (AACAP) Clinical Practice Guidelines as they are available for each diagnosis included herein. The Clinical Guidelines Workgroup recommended to Quality Management Oversight Committee (QMOC) to utilize this format as the APA and AACAP websites are self-updating. Therefore, this revision of the Clinical Guidelines Manual reflects this decision approved by QMOC and the NSMHA Board of Directors to identify the internet address where the delineated guidelines can be found. Two of the three non-diagnosis related guidelines, *Person-Centered Recovery and Resiliency*, and *Differential Diagnosis for Childhood & Adolescent Behavioral Disturbances* can be found in this manual in their entirety.

All NSMHA providers shall develop and implement policies and procedures that support these guidelines. The provider's Medical Director must approve the provider policies and procedures. **When the guidelines are not felt to be desirable for a particular consumer, the rationale for not following the guidelines will be documented in the consumer's medical record.**

All services are provided in accordance with the current NSMHA Clinical Eligibility and Care Standards Manual which establish access to care, continued stay and discharge criteria.

DELINEATED CLINICAL GUIDELINES

- The approved clinical guidelines are listed below.
- The bullet points beneath each guideline reflect the core elements associated with the individual guideline. Note: *Core elements have been identified by the NSMHA Medical Director as minimum critical elements that must be present when NSMHA Utilization Reviewers score a consumer record as reflecting that services are being provided in accordance with NSMHA clinical guidelines.*
- To gain access to the full American Psychiatric Association 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.
    b. Select APA Guidelines - PsychiatryOnline
    c. Select (single left click on) the desired diagnosis from the list found on the left-center (dark blue on light blue)
    d. Select "Practice Guideline" (center of page, dark blue on light blue)
- To gain access to the full American Academy of Child & Adolescent Psychiatry current guidelines for children & youth, follow these steps:
    a. Copy and paste the web address **http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx** into the address bar on your web browser.
    b. Select Practice Parameters.
    c. Scroll down & select (single left click on) the desired parameter from the "Current Parameters" or "Historic Parameters" list found on the left-center.
- As journal guideline watches are periodically published on the American Academy of Child & Adolescent Psychiatry (Child) website, between formal updates, an ongoing survey of the watches will be undertaken by the NSMHA 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 NSMHA Quality Specialist, occurring during the summer, every three years.

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 consumer has a history of substance abuse, then non-sedative medications should be tried first.

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

- Screen for co morbid substance abuse.
- 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 to family and peers.

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 or depression

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

- The treatment team has established a method to discourage self-injury.
- Use of 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)

- The MH provider must coordinate care with substance abuse provider

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 demonstrate behaviors that are aggressive, psychotic or depressed.* Care should be coordinated with primary care givers and PCP.
- 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 SSRI or Anfranil or documentation that that it was considered for rationale for not prescribing.

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 or not the consumer is agreeing to take prescribed psychiatric medications

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) *Note: Suicide Behaviors guidelines can be found in the bottom right corner of the screen, subsequent to the diagnosis related guidelines.*

- At intake, risk factors & protective factors are identified & noted in the risk assessment section of the Intake Assessment
- The risk assessment section of the Intake Assessment assesses of 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 & Youth Anxiety Disorders

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

- There is some form of cognitive behavioral therapy to address anxiety.
- There is an attempt at medication management. If the consumer has a history of substance abuse, then non-sedative medications should be tried first.

Child & Youth ADHD

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

- Patient 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 & Youth Bipolar Disorder

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.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 or depression

Child & Youth Conduct Disorder

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

- Patient 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 treatment providers are not allowing or supporting efforts for the client to avoid consequences (legal or other consequences) for violating the rights of others.

Child & Youth Co-occurring Disorders

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

- The MH provider must coordinate care with substance abuse provider

Child & Youth Dissociative Disorder

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

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

Child & Youth Eating Disorders

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.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.

Child & Youth Major Depressive Disorder

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.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

Child & Youth Obsessive Compulsive Disorder

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

- There is some form of cognitive behavioral therapy to address intrusive thoughts and compulsive behaviors.
- Trial of medication has been attempted with SSRI or Anfranil or documentation that that it was considered for rationale for not prescribing.

Child & Youth Psychotic Disorders

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx)

- 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, misperception, suggestion from caregivers or cultural issues such as religion or other family beliefs.

Child & Youth Trauma Disorders

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.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.

Child & Youth Suicidal Behaviors

(http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx) *Note: Suicide Behaviors guidelines can be found in the bottom right corner of the screen, subsequent to the diagnosis related guidelines.*

- At intake, risk factors & protective factors are identified & noted in the risk assessment section of the Intake Assessment
- The risk assessment section of the Intake Assessment assesses of 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

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

Person-Centered Recovery and Resiliency

I. Introduction

The Department of Health and Human Services (DHHS) and the Substance Abuse and Mental Health Administration (SAMHSA) cite **recovery as the "single most important goal for the mental health service delivery system".** As such, ten fundamental components to recovery have been identified: Self-Direction, Individualized and Person-Centered Care, Empowerment, Holistic, Non-Linear, Strengths-Based, Peer Support, Respect, Responsibility, and Hope (SAMHSA, 2004). With this guidance in mind, the North Sound Mental Health Administration (NSMHA) supports and encourages **Person-Centered Recovery Planning;** a process that serves as a working and dynamic roadmap to help **individuals achieve personally meaningful goals** and that **assists agencies in quality and risk management practices.**

Since 2007, NSMHA has also supported trainings in Wellness Recovery Action Plans (WRAP) to assist individuals and agencies increase their own and their communities' wellness. WRAP's primary goal is to teach participants recovery, self-management skills, and strategies for dealing with psychiatric symptoms (Mary Ellen Copeland, 2009). Similar in name and in focus, NSMHA also robustly supports the implementation of the Wraparound model when delivering service and

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

On May 20, 2010, Washington State Department of Social and Health Services (DSHS) has adopted new and revised Washington Administrative Codes (WACs) 388-865-0420; 0425; and 0430 related to Intake Evaluation, Individual Service Plan and Clinical Record (Department of Social and Health Services, Health and Recovery, 2010). These revisions allow mental health providers more flexibility in meeting the needs of individuals while still meeting the statutory requirements for collecting client history data and focusing on the individual's unique needs and recovery plan. It should be noted, that WACs are administrative rules and regulations by which agencies operate to execute the Laws enacted by the Legislature. With this guideline, we endeavor to coordinate the application of WAC and other legislated or contracted requirements with current and nationally accepted and best practices in the field of mental health recovery and resiliency.

II. Person-Centered Treatment & Recovery 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 consumer-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 Plan** is developed **in partnership with the individual receiving mental health services** and/or their caregivers and family. A recovery plan 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 recovery plan further serves as a primary step in the **engagement phase** of treatment and promotes **person-centered treatment**. Recovery plans should demonstrate **shared decision-making** and **consumer-defined outcomes**. Recovery planning and person-centered treatment "promote **client choice, empowerment, resilience, and self-reliance**" (Adams & Grieder, 2005).

A clearly articulated recovery plan provides the following benefits to the individual and the treatment team:

1. A **roadmap for the individual and the treatment team**, providing direction and allowing the team and individual or family to evaluate the individual's progress toward his/her treatment goals and the effectiveness of interventions;
2. Demonstrates individual or family goals towards recovery;
3. Documents both **individual and provider responsibilities** towards recovery;
4. Provides data from which the organization 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 provider will be more successful during **regulatory compliance** surveys, as it demonstrates the professional competence of the individual

clinicians who collaborate to develop the plans, and shows the treatment team's adherence to provider organization policies and procedures and regulatory standards on which those policies and procedures are generally based;
7. Protects the provider organization and clinicians against litigation (**Risk Management**).

Core Principles

In the book, Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery, Neal Adams and Diane Grieder suggest that general health literature points to **five core principles of person-centered recovery planning**:

1. Understanding needs from a broad bio-psychosocial perspective rather than a deficit or symptom driven perspective;
2. The ability to see the "consumer-as-person" and not diminished or dehumanized in any way by his/her help-seeking;
3. The sharing of power and responsibility in decision making;
4. The recognition of a therapeutic alliance and partnership between the provider and the individual;
5. The ability to view the provider-as-person and not cast him/her into a position of power or undue authority.

Key Components

Per WAC 388-865-0425, "The community mental health agency must develop a consumer-driven, strength-based individual service plan (ISP) that meets the individual's unique mental health needs. The individual service plan must be developed in collaboration with the individual, or the individual's parent or other legal representative if applicable." In addition to the 10 elements required in WAC, NSMHA recommends integration of the 10 Fundamental Components of Recovery as found in the National Consensus Statement on Mental Health with the Recovery Plan (aka ISP). We believe these fundamentals greatly assist the philosophical and practice shift from a standard ISP or "treatment plan" development to a more Person-Centered Recovery Plan. These 10 Fundamental Components of Recovery are (SAMHSA, 2004):

1. **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his/her own life goals and designs a unique path towards those goals.
2. **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies, as well as, his/her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as, an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his/her own destiny and influences the organizational and societal structures in his/her life.

4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Non-Linear:** Recovery is not a step-by step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.
8. **Respect:** Community, systems, and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

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):

1. Beliefs, values, traditions and practices of a culture;
2. Culturally-defined, health-related needs of individuals, families and communities;

3. Culturally-based belief systems of the etiology of illness and disease and those related to health and healing; and
4. Attitudes toward seeking help from health care providers.

Person-Centered Recovery plans should reflect an understanding of each individual's unique cultural identity. The following elements are presented as a guide for agencies 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 treatment?
3. Is the plan written at a reading level understandable the individual?
4. Is the plan age appropriate to the individual seeking treatment?
5. Does the plan reflect any & all recommendations provided by the consultant in the special population consultation?

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, NSMHA recommends additional specific training and clinical focus in **System of Care philosophy** including **resiliency and recovery** for all staff who work predominantly with children, youth, and families.

System of Care Defined

(Technical Assistance Partnership for Child and Family Mental Health, 2010)

The system of care model is an organizational philosophy and framework that involves collaboration across agencies, families and youth for the purpose of improving services and 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 the system of care:

1. Should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. Should be community-based, with the locus of services, as well as, management and decision-making responsibility resting at the community level.
3. Should be culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

System of Care Values

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

System of Care Guiding Principles

The following represent the **10 Foundational Principles of the System of Care** philosophy:

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potential of each child and guided by an ISP.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult services system as they reach maturity.
9. The rights of children with emotional disturbances should be protected and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services should be sensitive and responsive to cultural differences and special needs.

Family Driven Defined

Family-driven means families have a primary decision-making role in the care of their own children, as well as, the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

1. Choosing supports, services, and providers;
2. Setting goals;
3. Designing and implementing programs;
4. Monitoring outcomes;
5. Partnering in funding decisions; and

6. Determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

Guiding Principles of Family-Driven Care

1. Families and youth are given accurate, understandable and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
2. Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes with providers.
3. Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.
4. Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information and strengthen the family voice.
5. Families and family-run organizations provide direction for decisions that impact funding for services, treatments and supports.
6. Providers take the initiative to change practice from provider-driven to family-driven.
7. Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth and families.
8. Community attitude change efforts focus on removing barriers and discrimination created by stigma.
9. Communities embrace, value, and celebrate the diverse cultures of their children, youth and families.
10. Everyone who connects with children, youth and families continually advances their own cultural and linguistic responsiveness as the population served changes.

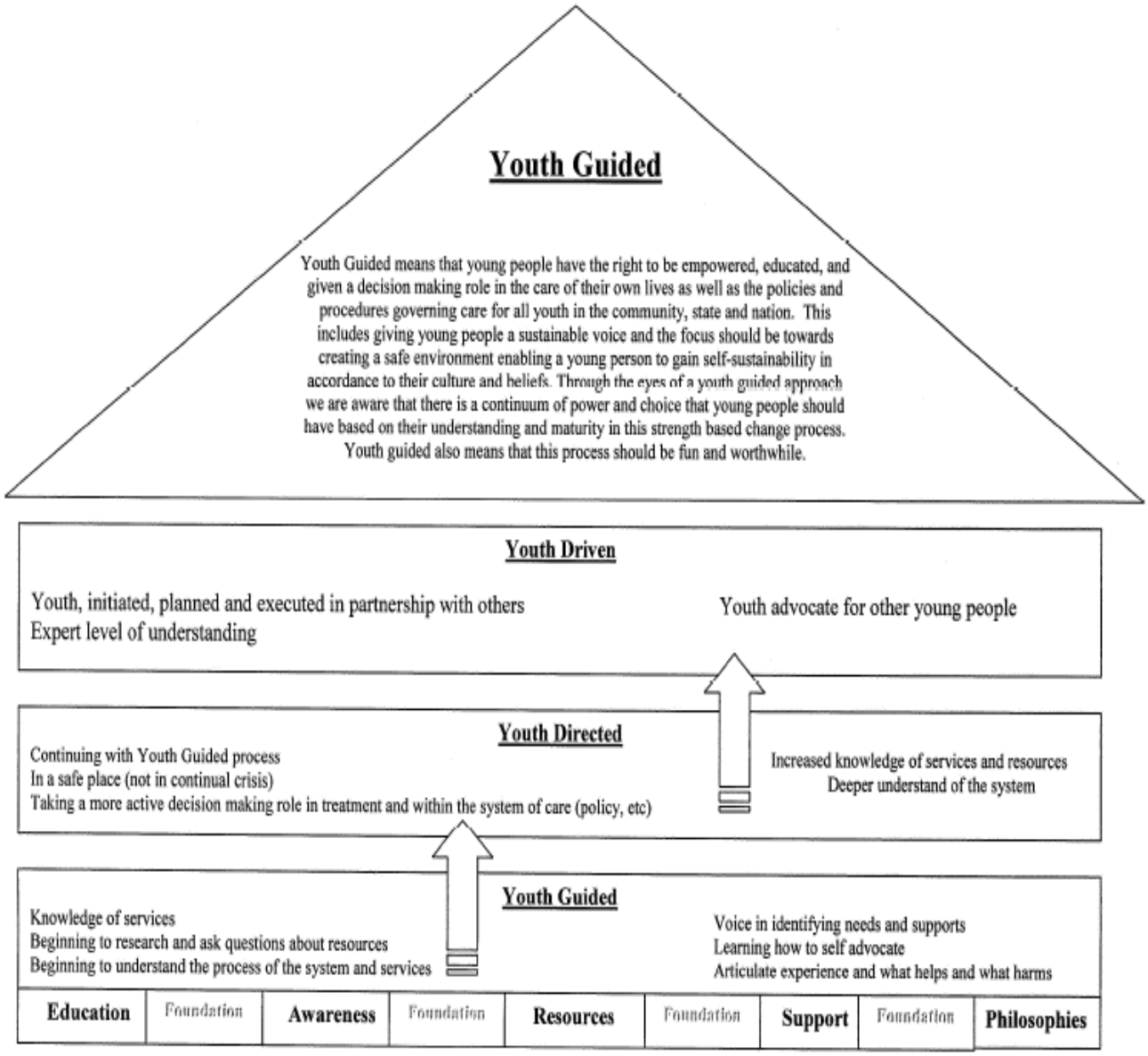
Characteristics of Family-Driven Care

1. 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.
2. 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.
3. 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.
4. Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, responsibility and control with them.
5. 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.
6. Funding mechanisms allow families and youth to have choices.
7. 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 consumer 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. SAMHSA offers the Youth-Guided Pyramid below. For information on Youth Directed and Youth Driven, we refer to the entire document.



Resiliency and Recovery

Much research has been conducted to explore and identify the meaning of both resiliency and recovery in children's mental health. Through the leadership of Portland State University Research and Training Center (RTC) on Family Support and Children's Mental Health – RTC (http://www.rtc.pdx.edu/). Barbara Friesen and Janet Walker of the RTC and Dr. Charlie Huffine, King County RSN Medical Director for Child & Adolescent Programs, have been specifically credited with promoting the transformation of children's mental health care by increasing knowledge of supports, services and policies that:

- Build on family strengths;
- Are community-based, family-driven, and youth-guided;
- Promote cultural competence; and
- Are based on evidence of effectiveness.

In her 2007 article, *Recovery and Resilience in Children's Mental Health: Views from the Field*, Barbara Friesen states that "recovery elements are entirely compatible with the System of Care philosophy and reliance framework". That is to say that the 10 Fundamental Components of Recovery generally support philosophical practice when working with children and families. However other "**resilience concepts bring added value"** to System of Care Principles such as: **Focus on hope and future planning and the importance of addressing trauma.** Other recovery oriented terms such as "personal responsibility" and "personal determination" are confusing and not easily applied when working with children. For these reasons, it is preferred in the field of children's mental health to use the term "**resilience and recovery".**

It is important that all staff working predominantly with children, youth and families understand comparison core concepts in resiliency, recovery and system of care framework. See Table 1 below for a comparison of key concepts (Friesen, 2007).

NSMHA has assembled a **System of Care Primer and Toolkit** to assist in understanding this philosophy. This document provides **valuable information** and greatly expands this section including the provision of the definitions for **Family-Driven** and **Youth-Guided**. This document is referenced below and available on the NSMHA website.

Additionally, NSMHA recommends that all staff working predominantly with children, youth and families read and refer to the **summer 2005 issue of Focal Point: Resiliency and Recovery**. This issue is dedicated to examining the concepts of resiliency and recovery in children's mental health. All articles therein are available **free of charge** on the web at http://www.rtc.pdx.edu/pgFPS05TOC.php.

Table 1—Comparison of Key Ideas: System of Care, Resilience, and Recovery

Resilience Core Concepts	System of Care Principles	Recovery Elements*
	1. Comprehensive services	1. Holistic (C)
Specification of Elements: (V) Reducing Risk Enhancing Protective Factors	2. Individualized services	2. Individualized & person centered (C) 3. Strengths Based (C)
	3. Community based	(Assumed)
Racial Socialization Healing Historical Trauma (V)	4. Culturally & linguistically competent	Healing historical trauma (V)
Solid Basic and Applied Research Base for Prevention and Early Intervention (V)	5. Early intervention	
	6. Family & youth participation family-driven youth-guided	4. Empowerment (C) 5. Self-direction (C)
	7. Service coordination	
	8. Interagency coordination	
	9. Protective of rights	6. Respect, stigma reduction (V)
	10. Transition	(Life planning) (C)
Future Orientation, Optimism (V)		7. Hope, optimism (V)
		8. Non-linear (acceptance of setbacks)
		9. Personal responsibility
		10. Peer support

*Note. These "Recovery Elements" are the "10 Fundamental Components of Recovery" identified in the National Consensus Statement on Mental Health Recovery at the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16–17, 2004. The conference was convened by the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies.

To read the complete the full statement, see: www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/.

Works Cited

Adams, N., & Grieder, D. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery.* Arlington, VA: American Psychiatric Association.

Department of Social and Health Services, Health and Recovery. (2010, April 19). *Rule Making Order.* Retrieved May 2010, from http://www.dshs.wa.gov/pdf/ms/rpau/103P-10-09-061.pdf

Friesen, B. (2007). Recovery and Resilience in Children's Mental Health: Views from the Field. *Psychiatric Rehabilitation Journal* , 38-48.

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

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/

SAMHSA. (2004, December). *National Concensus Statement on Mental Health Recovery.* Retrieved March 2010, from SAMHSA's National Mental Health Information Center: http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

Technical Assistance Partnership for Child and Family Mental Health. (2010, June). *System of Care Values and Principles* . Retrieved June 4, 2010, from Technical Assistance Partnership: http://www.tapartnership.org/SOC/SOCvalues.php

Other Resources

Implementing Person Centered Care, Practices and Planning:
http://www.personcenteredtreatmentplanning.com/

National Alliance on Mental Illness:
http://www.nami.org/

National Wraparound Initiative:
http://www.nwi.pdx.edu/
http://wrapinfo.org/

National Center for Cultural Competence:
http://www.clcpa.info/
http://nccc.georgetown.edu/foundations/policies.html

Substance Abuse and Mental Health Administration (SAMHSA)
http://www.samhsa.gov/

Systems of Care
http://systemsofcare.samhsa.gov/
http://systemsofcare.samhsa.gov/headermenus/deffamilydriven.aspx

Resiliency and Recovery http://www.rtc.pdx.edu/pgFPS05TOC.php.

Differential Diagnosis Guideline for Childhood and Adolescent Behavioral Disturbances

Introduction

Children and adolescents are often referred into mental health services for behavioral issues. Diagnostic clarification can be challenging, many behavioral problems in children or adolescents are not due to a mental disorders and must be differentiated from developmental issues and family/situational conflicts. A thorough diagnostic assessment is needed to translate those behaviors into symptoms**.**

An adequate diagnostic justification, done through the assessment, is also needed to determine current access into statewide mental health services. Assessors need to gather enough supportive information to consider authorization for ongoing Medicaid services. Components of an intake assessment should

- Be culturally and age relevant
- Document sufficient information to demonstrate medical necessity, as defined in the state plan
- Include presenting problem(s) as described by the individual and those who provide active support to the individual
- Include current physical health status, including any medications
- Include current substance use and abuse and treatment status
- Provide sufficient clinical information to **justify the provisional diagnosis** using diagnostic and statistical manual (DSM IV TR) criteria, or its successor
- Include and identify risk to self or others, including suicide/homicide. A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, (which assures that community support service providers have the availability of staff to handle the crisis, or refer to staff who will handle the crisis) must be made if indicated in the risk assessment
- A recommendation of a course of treatment

Differential diagnosis

A critical evaluation tool in the diagnostic assessment is the use of a differential diagnosis, defined as a "systematic approach to evaluating an individual's medical, psychiatric, psychological history and the presenting symptoms to identify the underlying causes. A differential diagnosis helps sort out any and all contributing factors."

Diagnostic Assessment

In addition to the components required in the WAC, the assessment should clearly address the differential diagnosis(es) the assessor considered or is considering in the formulation of the clinical impression. Two tools utilized in the Diagnostic and Statistical Manual of Mental Disorders, Handbook of Differential Diagnosis to document consideration for differential diagnoses are decision trees or decision tables. These tools assist the clinician in "establishing boundaries between disorders".

These tools, or similar diagnostic tools, are helpful suggestions in assisting the clinician with ruling out differential diagnoses.

Use of decision trees

Decision trees, noted from the start with a symptom and provide decision points for diagnostic determination, and can assist the clinician in making a diagnostic determination.

- The first step is to determine which trees apply to the clinical presentation
- The second step is to cover the primary mental disorders that may account for the symptom

Use of decision tables

Decision tables, noted in the handbook "help the clinician ensure that they are evaluating the symptoms in a systematic and comprehensive manner".

- Assist in listing the differential diagnoses that must be ruled out
- Offer distinguishing features that help in ruling out the differential diagnoses

The clinical evaluation, to include any differential diagnosis, should be documented in the multi-axial assessment. If current information only supports a provisional diagnosis, the assessment should include a plan to continue to evaluate the provisional diagnosis, to include referrals to other programs to assist with the evaluations needed to complete the assessment.

Differential diagnoses to consider when there are behavioral symptoms

Other diagnoses and/or conditions to be considered when a child presents with behavioral symptoms include: substance usage, general medical conditions, low IQ and impairments, antisocial behavior, defiant behavior, inattentive and hyperactive behaviors, mood changes, psychotic symptoms in absence of mood changes, stereotyped movements, maladaptive responses to stressors, illegal behavior, and what is age appropriate behavior.

Differential diagnoses with disruptive behaviors

Three disruptive behavioral disorders commonly diagnosed in children and adolescents are:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Oppositional Defiant Disorder (ODD)
- Conduct Disorder

When considering **ADHD** as a diagnosis, these other diagnoses should be given consideration and ruled out as a differential diagnosis:

- age appropriate behaviors
- under-stimulating environments
- in-attention in Oppositional Defiant Disorder
- impulsivity in conduct disorder
- inattention or hyperactivity associated with pervasive developmental disorders
- inattention or hyperactivity caused by drugs or medications
- symptoms of inattention due to other mental disorders
- inattention occurring during the course of pervasive developmental disorders, schizophrenia, or other psychotic disorder, or if better accounted by another mental disorder

When considering **ODD** as a diagnosis, these other diagnoses should be given consideration and ruled out as a differential diagnosis:

- non-pathological oppositional behavior
- adjustment disorder with disturbance of conduct
- conduct disorder
- oppositional behavior related to mood or psychotic disorders
- oppositional behavior related to ADHD
- oppositional behavior in mental retardation
- failure to follow directions due to impairment in language comprehension
- antisocial personality disorder which can be diagnosed only in individuals over 18 years of age

When considering C**onduct Disorder** as a diagnosis, these other diagnoses should be given consideration and ruled out as a differential diagnosis:

- disruptive behavior in ODD
- disruptive behavior in ADHD
- anti-social behavior occurring during a manic episode
- anti-social behavior related to psychotic disorder
- adjustment disorder
- adolescent antisocial behavior
- antisocial personality disorder, which can be diagnosed only over 18

When making a differential or provisional diagnosis, consideration should always be given to other co-existing diagnoses, as described in the Diagnostic and Statistical Manual of Mental Disorders.

Reviewing provisional and differential diagnoses

Clinicians should consider the assessment as only the beginning of an evaluation process. Caution should be used in the formulation of a diagnosis too early in the assessment. Provisional diagnoses are a valuable tool in the evaluation "when there is a strong presumption that the full criteria will ultimately be met for the disorder, but not enough information is available to make a firm diagnosis". With any initial diagnostic impression, a review of the provisional diagnosis, to include differential diagnoses, should be done when time and/or further information clarifies symptoms and/or re-evaluated at six month intervals.

The updated diagnosis, to include the justification, should be reflected in an updated assessment, as well as, treatment plans and other documentation. If a provisional or differential diagnosis remains unclear, a consultation with a prescriber should be considered to assist with the clarification of the diagnosis. This should be considered when there is further information and/or at six month intervals, or there should be documentation why that has not occurred.

If further assessment clarifies that a provisional or differential diagnosis does not meet statewide access standards, appropriate referrals to other services should be made and the individual should be discharged from services. Documentation to support that assessment decision should be provided in the chart.

REFERENCES:

1. DSHS Washington State Access to Care Standards 1/1/2006 Authorization of Services for Medicaid Children and Youth
2. 2010 Washington State Code 865- 0420 Intake evaluation
3. Yikshak Shnaps, Princeton, N.J. American board of Psychiatry and Neurology, web publication
4. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, text revision, Handbook of Differential Diagnosis, American Psychiatric Publishing, 2000, authors Michael B First, MD, Allen Frances, MD, Harold Alan Pincus, MD
5. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, text revision, Washington, D.C. American Psychiatric Association, 2000

APPENDIX I: Guideline Adoption/Review Chronology

(Numbers correspond with diagnoses listed in the Table of Contents)

YEAR	GUIDELINES REVIEWED/REVISED
2004	1,3,8,11,12,14,16,21,23, & 24
2005	9
2006	2 &15
2008	5 &18
2010	26 & 27
2013	4,6,7,10,13,17,19,20,22 & 25