



T H U R S T O N M A S O N
Behavioral Health Organization

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Clinical Practice Guidelines

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Table of Contents

Introduction and Scope	3
Clinical Practice Guidelines – Adults	4
Adult Anxiety Disorders	
Adult ADHD	
Adult Bipolar Disorder	
Adult Borderline Personality	
Adult Co-Occurring Disorders	
Adult Dissociative Disorder	
Adult Eating Disorders	
Adult Major Depressive Disorder	
Adult Neurocognitive Disorder (Dementia)	
Adult Obsessive Compulsive Disorder	
Adult Schizophrenia	
Adult Trauma Disorders	
Adult Suicidal Behaviors	
Clinical Practice Guidelines – Youth/Adolescent	5
Child & Youth ADHD	
Child & Youth Anxiety Disorders	
Child & Youth Bipolar Disorder	
Child & Youth Conduct Disorder	
Child & Youth Co-Occurring Disorders	
Child & Youth Dissociative Disorder	
Child & Youth Eating Disorder	
Child & Youth Major Depressive Disorder	
Child & Youth Obsessive Compulsive Disorder	
Child & Youth Trauma Disorders	
Child & Youth Psychotic Disorders	
Child & Youth Suicidal Behaviors	
Guidelines for Person-Centered Recovery & Resiliency Approaches	6
Person-Centered Treatment Planning	6
Cultural Competency	9
Special Considerations for Children, Youth and Families	10
System of Care	10
Family Driven Care	11
Resiliency and Recovery in Children’s Mental Health	13
References	14
Other Resources	15

The intent of the Thurston Mason Behavioral Health Organization's (TMBHO'S) Clinical Practice Guidelines is to provide a foundation to assist its **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 consumer. Provision of some treatment interventions may be tempered by limitations in payment sources and funding.

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.

The basis for these guidelines is the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), however it recognized 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 an individualized treatment program based on medical necessity for each consumer. Guidelines are based on evolving scientific research and experience. Consequently, these guidelines will be reviewed and updated annually.

The TMBHO Clinical Practice Guidelines should **not** be confused with Evidence-Based Practices (EBPs) or Promising Practices (PPs). While TMBHO whole-heartedly endorses the use of these Practice Guidelines as a resource for a better-informed and better-equipped behavioral health system, they in no way substitute or replace a fully modularized EBP/PP. In some instances TMBHO will initiate and/or encourage the development of an EBP/PP, which includes the oftentimes stringent adherence guidelines associated with them. These guidelines associated with EBPs/PPs will, at times, contradict literature presented within the Practice Guidelines.

The Practice Guidelines should be considered guidelines only, and TMBHO realizes 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.

These Clinical Practice Guidelines include 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. These guidelines have been brought before the Clinical Quality Improvement Committee of TMBHO and the TMBHO Advisory Board. Ultimately the Quality Management Committee recommended to utilize this format as the APA and AACAP websites are self-updating. Therefore, this version of the Clinical Practice Guidelines reflects this decision, approved by TMBHO administration, to identify the internet address where the delineated guidelines can be found.

All TMBHO mental health 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 TMBHO Level of Care and Access to Care Standards Guidelines which establish access to care, continued stay and discharge criteria.

ADULT DIAGNOSES

For full Practice Guideline click on link <http://psychiatryonline.org/guidelines.aspx>

1	Adult Anxiety Disorders <ul style="list-style-type: none"> • 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. 	2	Adult ADHD <ul style="list-style-type: none"> • 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.
3	Adult Bipolar Disorder <ul style="list-style-type: none"> • 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. 	4	Adult Borderline Personality <ul style="list-style-type: none"> • 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.
5	Adult Co-occurring Disorders <ul style="list-style-type: none"> • The MH provider must coordinate care with substance abuse provider. 	6	Adult Dissociative Disorder <ul style="list-style-type: none"> • There is a form of psychotherapy which is focused on integration of personality.
7	Adult Eating Disorders <ul style="list-style-type: none"> • 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. 	8	Adult Major Depressive Disorder <ul style="list-style-type: none"> • 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
9	Adult Neurocognitive Disorder (Dementia) <ul style="list-style-type: none"> • <i>This group demonstrate behaviors that are aggressive, psychotic or depressed.</i> 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. 	10	Adult Obsessive Compulsive Disorder <ul style="list-style-type: none"> • 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.
11	Adult Schizophrenia <ul style="list-style-type: none"> • 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. 	12	Adult Trauma Disorders <ul style="list-style-type: none"> • 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.
13	Adult Suicidal Behaviors <ul style="list-style-type: none"> • 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 AND ADOLESCENT DIAGNOSES

For full Practice Guideline click on link

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

1	Child & Youth ADHD <ul style="list-style-type: none"> • 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. 	2	Child & Youth Anxiety Disorders <ul style="list-style-type: none"> • 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.
3	Child & Youth Bipolar Disorder <ul style="list-style-type: none"> • 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 	4	Child & Youth Conduct Disorder <ul style="list-style-type: none"> • 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.
5	Child & Youth Co-occurring Disorders <ul style="list-style-type: none"> • The MH provider must coordinate care with substance abuse provider 	6	Child & Youth Dissociative Disorder <ul style="list-style-type: none"> • There is a form of psychotherapy which is focused on integration of personality.
7	Child & Youth Eating Disorders <ul style="list-style-type: none"> • 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. 	8	Child & Youth Major Depressive Disorder <ul style="list-style-type: none"> • 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
9	Child & Youth Obsessive Compulsive Disorder <ul style="list-style-type: none"> • 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. 	10	Child & Youth Trauma Disorders <ul style="list-style-type: none"> • 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.
11	Child & Youth Psychotic Disorders <ul style="list-style-type: none"> • 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. 	12	Child & Youth Suicidal Behaviors <ul style="list-style-type: none"> • 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.

Guidelines for Person-Centered Recovery and Resiliency Approaches

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 (10) fundamental components to recovery have been identified (SAMHSA, 2004):

1. Self-Direction
2. Individualized and Person-Centered Care
3. Empowerment
4. Holistic
5. Non-Linear
6. Strengths-Based
7. Peer Support
8. Respect
9. Responsibility
10. Hope.

With this guidance in mind, the Thurston Mason Behavioral Health Organization (TMBHO) supports and encourages **Person-Centered Recovery Planning**; a process that serves as a working and dynamic roadmap to help individuals achieve personally meaningful goals, as well as assists Network Providers in quality and risk management practices.

TMBHO also supports the use of Wellness Recovery Action Plans (WRAP) to assist individuals and Network Providers increase their own (and their community's) 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, TMBHO also strongly supports the use 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. Today, Wraparound services can most closely be seen in the Wraparound with Intensive Services (WiSe) programs that operate within the region.

On May 31, 2013, Washington State Department of Social and Health Services (DSHS) adopted new and revised Washington Administrative Codes (WACs) 388-877A-0120; 0130; and 0135 related to Assessment (intake) Standards, Individual Service Plans and Clinical Records (Department of Social and Health Services, Health and Recovery, 2013). These revisions allowed mental health providers more flexibility in meeting the needs of individuals while still meeting the statutory requirements for collecting consumer 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 Network Providers operate to execute the Laws enacted by the Legislature. They represent the **minimum** requirements. With this guideline, TMBHO endeavors 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.

Person-Centered Treatment and Recovery Planning

Historically, a treatment plan was considered to be a "professionally-driven" document that was oftentimes considered to be a time-consuming exercise conducted to meet the requirements external auditors or mandates. The individual – who was referred to as the consumer, yet had very little consumer-voice – was requested to provide "input" into the development of the treatment plan. However, far too often the document itself did not

include genuine consumer-voice, was not written in consumer-friendly language, and was created as a stagnant (non-living) documents. Individuals often reported that they knew they had a treatment plan, but were unaware of the content. Therefore, consumers were often unaware of both their responsibilities and the professionals' responsibilities to the plan.

In contrast, a Person-Centered Treatment and Recovery Plan (often referred to simply as 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 person-centered treatment and 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; and
7. Protects the Network Provider and clinicians against litigation (Risk Management).

Core Principals

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; and
5. The ability to view the provider-as-person and not cast him/her into a position of power or undue authority.

Key Components

According to WAC 388-877A-0135, the Community Mental Health Agency (CMHA) must develop a treatment plan that is “consumer-driven, strength-based and meet 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 elements required in WAC, TMBHO recommends integration of the ten (10) Fundamental Components of Recovery as found in the National Consensus Statement on Mental Health with the Recovery Plan. These fundamentals greatly assist the philosophical and practice shift from a standard treatment plan or “treatment plan” development to a more Person-Centered Recovery Plan. These ten (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.

Cultural Competency

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 – to include factors beyond race and ethnicity? For example:
 - Language
 - Gender
 - Sexual orientation
 - Socioeconomic status
 - Family roles
 - Housing status
 - 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?

Special Considerations for Children, Youth, and Families

The information presented in the sections above is applicable when providing services and supports to individuals of any age. However, TMBHO 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

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 ten 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.

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. TMBHO 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. <http://www.rtc.pdx.edu/pgFPS05TOC.php>.

References

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SAMHSA. (2004, December). *National Consensus 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>.