UTAH'S
Recovery Oriented System of Care

PREFERRED PRACTICE GUIDELINES

Acknowledgments

The following guidelines for assessment and treatment/recovery have been developed by the Utah Preferred Practice Consensus Panel and reviewed by the Utah Division of Substance and Mental Health and approved by the Utah Behavioral Healthcare Committee.

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Table of Contents

Statement of Intent

- ENGAGEMENT Principles……………………………………………………………………………1
- ONGOING ASSESSMENT Principles……………………………………………………………3
- ONGOING PLANNING Principles…………………………………………………………………5
- TREATMENT Principles……………………………………………………………………………6
- Appendix Ongoing Assessment……………………………………………………………….8

Children and Youth Preferred Practice Guidelines ………………………………………………...9

- Co-Occurring Conditions of Mental Illness and Development Disorders…………………………..9
- Disruptive Behavior Disorders in Children and Youth………………………………………………11
- For Infants and Toddlers—Birth to Five Years of Age………………………………………………13
- Attachment Disorders in Children…………………………………………………………………..15

Children—Youth—Adults Preferred Practice Guidelines…………………………………………………17

- Anxiety Disorders…………………………………………………...…………………………17
- Borderline Personality Disorder……………………………………...…………………………20
- Medication Treatment………………...…………………………………………………………22
- Mood Disorders……………………………………………………………………………………...24
- Psychotic Disorders…………………………………………………………………………………25

Statement of Intent

These Preferred Practice Guidelines (PPGs) are intended to guide Utah Behavioral Health system providers in the selection, development and delivery of Behavioral Health practices in order to give the best possible care and services available to support individuals and families in their Recovery from addiction and mental illness. Specific practices and techniques are not given in this document. Instead, this is intended to outline the principles and guidelines upon which sound treatment and recovery support are based. The selection of specific practices, techniques and skills are left to the providers and systems; based on these principles and guidelines and the current research supporting optimal outcome for clients. Current National Preferred Practice Guidelines and Evidence Based Practices should be reviewed and followed.

These guidelines are organized under 4 headings:

- **ENGAGEMENT**
- **ONGOING ASSESSMENT**
- **ONGOING PLANNING**
- **TREATMENT**

There are three overarching principles which should be understood in relation to these headings:

1. The client remains at the center of all clinical efforts, whether they are Engagement, Assessment, Planning or Treatment. Relevance to the client and their needs should guide each provider in deciding how to engage the client, what information to gather and document, what strategies to plan and how treatment is delivered. While accurate and complete documentation of services and the gathering of information for organizational purposes and other systemic demands are important, they remain secondary to the needs of the client.

2. The separating of clinical process in to these 4 headings has been done for the ease of explanation. These clinical activities are not discreet or linear in their application. It must be understood that Engagement, Assessment, Planning and Treatment occur continuously and simultaneously.

3. An important aspect of effective treatment is the ability for providers to engage clients so that the client has hope for their recovery and desires to participate in treatment. One barrier to effective engagement is the belief that all elements of assessment and planning must be gathered at the very beginning of services. Therefore, these guidelines emphasize that assessment and planning are a process rather than an event, and should be balanced with the process of engagement. A more concerted focus on engagement will result in improvements in client retention and improved treatment outcomes.

A key principle of long-term, successful recovery is the systematic application of Continuous Recovery Support. Because mental illness and addiction are now understood as chronic conditions, it is preferred practice that providers and systems use whatever resources they have available to them to maintain contact with clients beyond the traditional active treatment phase and provide Continuous Recovery Support services to help clients sustain their recovery throughout their lives.

Recovery Support services are those services that occur prior to, during or after a treatment episode that assist an individual or family in entering into or sustaining recovery from a mental illness or substance use disorder, but are not considered to be treatment services. Continuous Recovery Support can include such activities as ongoing monitoring, ongoing peer support, recovery 'check-in' clinics, outreach via social media and regular communication of recovery topics. The hallmark of Continuous Recovery Support is active outreach to, and support of clients in their recovery efforts.

These Preferred Practice Guidelines have been written with the understanding that they may be used for auditing and the evaluation of quality.   With this in mind, there is considerably more emphasis on principles rather than specified content. It is important that quality be evaluated more in terms of adherence to the principles that have been described rather than a checklist of content items.

ENGAGEMENT

Principles

- The focus of engagement is on the immediate/pertinent needs of the client.
- Clinicians establish rapport with clients.
- Clients can expect to gain something (Relief, clarity, answers, hope) from the initial (engagement) session.
- Clinicians check that client's needs are being met.
- Clinicians gather and document relevant information in an organized way.
- Clinicians make recommendations and negotiate with the client and respect their choices.

ONGOING ASSESSMENT

Principles

- Assessment information is kept current.
- Clinicians gather comprehensive relevant assessment information based on the client's concerns, in an ongoing manner as part of the treatment process.
- Assessment includes an ongoing focus on strengths and supports that aid in their recovery.
- Assessment includes identifying those things that motivate the client (Life Goals) and how those motivations have been impeded (Barriers) by mental illness and/or addiction.
- Assessment information is organized coherently and available in a readable, printable format.

<u>Guidelines:</u>

1. Working diagnoses may change and shall be continuously evaluated and updated consistent with new information.
2. Immediate safety needs of the client are addressed.
3. A diagnosis is made based upon the current International Classification of Diseases (ICD) and/or Diagnostic Statistical Manual of the American Psychiatric Association (DSM) criteria. There shall be adequate justification for the diagnosis and the assessment shall clearly indicate the need for services.
4. Assessments shall consider how culture (values, traditions, family and religious practices, spiritual beliefs and beliefs about mental illness and addiction, etc.) impact recovery.
5. Providers should be aware that individual differences in culture can be misinterpreted as problems.
6. Person Centered and strengths-based questions will lead both client and therapist in a solution-oriented direction. This establishes a bridge between assessment and development of a person centered treatment/recovery plan.

7. Assessments should be provided in a manner which does not attribute blame.

8. Family/care givers are a primary source of information about the child/youth and should participate in all aspects of the assessment and subsequent treatment recovery planning and implementation.

9. In addition to family/care givers, other sources such as school teachers and physicians can provide essential/accurate information. Releases of Information should be requested when other sources are identified and efforts should be made to contact these sources.

10. The Appendix contains a list of possible areas to be considered as part of an ongoing assessment. The list is not exhaustive and does not constitute a required set of assessment items. Clinicians should keep in mind the principle of relevance (that relevant information should be gathered).

11. The setting in which and evaluation takes place can be critical to the success of the interview. For children and youth the setting should accommodate the child's cognitive, language and emotional status.

12. With children and youth, evaluation may incorporate specific techniques that may include interactive play, projective approaches, direct discussion, structured observations or other means of seeking information.

13. With children and youth care should be taken to avoid questions that lead a child to answer in a particular way.

14. If the client has dependent children, appropriate referral for evaluation or services shall be made.

15. Therapists shall continually assess for substance use disorders and encourage appropriate treatment/recovery supports as needed. If there is evidence that the individual is dependent upon and/or under the influence of a chemical substance, an evaluation for the need for medical detoxification shall be made.

ONGOING PLANNING

Principles

- The client and primary caregiver is involved in ongoing and responsive recovery planning.
- Plans incorporate strategies based on the client's strengths and motivations.
- Where possible, the plan represents a negotiated agreement.
- The plan is kept current and up to date.
- Short term goals/objectives are measureable, achievable and within a timeframe.
- Planning anticipates developing and maintaining independence.

Guidelines

1. Information for creating a person centered treatment/recovery plan shall be documented.

2. A written plan shall be developed for each person.

3. Where children are in state custody and parent's rights have not been terminated, families of origin should be included in recovery planning when clinically indicated and approved by primary care giver.

4. Recovery plans should identify indicators of progress (e.g. response to medication, school status report, etc.) which include time-frames for accomplishment.

5. Frequency and duration of services should be anticipated and documented as part of the planning process.

6. As clinically indicated, crisis and safety intervention planning should be considered as part of the overall recovery plan or developed as a separate document with the relevant parties.

TREATMENT
Principles

- Treatment is individualized and adjusts according to feedback and concerns of the client
- Treatment is recovery focused and based on outcome, practice and sound evidence.
- Family and other informal and natural supports are involved as approved by the client.
- Treatment is provided in a culturally competent, gender specific and trauma informed manner

Guidelines

1. Co-morbid conditions (developmental, environmental, physical health, behavioral health, substance use) shall be considered in the development of the overall treatment/recovery plan.

2. The recommended treatment setting shall represent the level of care that is both the least restrictive setting, and that can provide treatment intensive enough to optimally treat the client's condition.

3. With youth, family therapy, including siblings and extended family members, and parent training should be considered.

4. Providers recommend formal and informal support organizations to assist the client and family in Recovery.

5. In addition to goals for symptom change, the treatment shall address environmental interventions that would benefit the client's quality of life. Examples include communicating with landlords, facilitating a change in housing, or working for family accommodations with the client. The therapist shall possess a working knowledge of community resources. The therapist shall refer the client to case management, as appropriate.

6. With youth, wrap-around services should be considered and include the child/youth, family members, schools, and other natural and informal supports (e.g. collaborative consultation, respite care, family support, mentoring, boy/girl scouts and recreational activities.)

7. All clinicians shall engage in clinical supervision/consultation with colleagues or formal supervisors in any of the following instances:

   - The client is overwhelming the resources/abilities of the clinician.
   - The clinician is required to make decisions about the immediate safety of the client (when time allows for supervision).
   - The client has not progressed towards treatment/recovery goals and assistance is needed to develop revisions.
   - The clinician is experiencing intense "counter transference" feelings of anger, attraction, or responsibility for the client.
   - The clinician needs resource assistance from the team.
   - When directed by a supervisor.
   - When indicated by a practice model being used by the clinician/program.

8. Clinicians working towards licensure shall seek supervision in all aspects of a case.

9. Client education about his/her illness and treatment/recovery options is an essential part of treatment/recovery. Clients shall be provided information about their illness and have opportunities to discuss this information. Family members and significant others shall be included in this process whenever appropriate and possible.

10. When a client misses a scheduled appointment and other anticipated services, outreach shall be initiated as clinically determined.

11. An assigned staff person shall assume primary responsibility for the coordination of treatment/recovery between care providers.

12. Each provider assumes responsibility for appropriate documentation for the services they provide, e.g., group, individual, and family psychotherapy, skills development, medication management, etc., involving the client through concurrent documentation when possible and appropriate.

13. Clients and family should be educated about the process of treatment and recovery to help them have realistic expectations and maintain engagement with services to develop enduring recovery. Often the client will need to rely on others to see the beneficial effects of medication and treatment.

Appendix
Ongoing Assessment

Areas to be considered as part of an ongoing Assessment. These should be considered and explored in the context of the presenting problem and not considered a required "check list" that must be completed in all cases.

1. Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, consequences of the problem(s), mental status examination, including thought (content and process), perception, mood, level of suicidal risk, affect, memory, judgment, appearance, and orientation.

2. Developmental milestones (e.g. receptive and expressive language development);

3. Psychiatric, learning disability, developmental/intellectual disability and medical history (e.g. vision and hearing problems);

4. Substance use History;

5. Academic functioning and performance;

6. Employment history, desire for future employment;

7. Any relevant information or testing from outside agencies;

8. Emotional development and temperament;

9. Peer relations;

10. Family relationships, responsibilities, and perceptions of the child/youth and his/her difficulty and the subsequent impact on the family;

11. Strengths, interests, and hobbies;

12. Natural and informal supports;

13. Cultural/Religious/Spiritual influences, practices, values, and beliefs;

14. Family or environmental circumstances, living situation and housing;

15. Parental/family medical, behavioral health, substance use history and impact on child/youth;

16. Child's/youth's substance use, including in-utero, birth, and second hand exposure, traumatic circumstances (e.g. child abuse, domestic violence, family substance use);

17. Trauma

18. Legal involvement including juvenile court dependency or custody hearings; and involvement with outside agencies.

Co-Occurring Conditions of Mental Illness and Developmental Disorders

OPTIMAL OUTCOME OF TREATMENT

In the recovery process, the client and family will experience a sense of emotionally rewarding interactions and stability while simultaneously accommodating for the client's illness with minimal need for support or treatment.

ASSESSMENT

1. Developmental and intellectual disabilities do not preclude mental illness. People with disabilities may meet criteria for any DSM diagnosis. Diagnostic criteria are not different for persons with different cognitive capacities.

2. Diagnostic approaches may need to be modified, depending on the person's communication skills and the poorer the communication skills, the more a provider may need to rely on information provided by care-givers.

3. Clinicians should be alert to developmental and medical history, past etiological assessments, and coexisting general medical disorders and their treatment. It is not uncommon for even simple problems like constipation, infection, to set the stage for behavioral problems. A physician consultation should be sought as indicated.

4. Within a given IQ range, language ability may vary significantly. Both receptive and expressive language abilities should be assessed (either formally through psychometric assessment or informally through clinical observation and review of historical and collateral information). It is not uncommon for receptive language ability to exceed expressive ability, or for the client who displays verbal fluency to not understand the meaning of the words. The use of a support person may be required to assist in communication with the client. If a support person is required, the clinician should consider the influence that person may have on the communication.

5. Mental Status may be assessed in the context of conversation, rather than in a formal examination. It is often helpful to start the interview with a discussion of a patient's strengths and interests rather than problems and later focus on the patient's understanding of disability, limitations, and reasons for the referral.

6. Consider the possibility of sexual, physical, and emotional abuse that the client cannot report or has not reported.

TREATMENT / RECOVERY

1. The treatment setting or placement does not relieve any agency from responsibility to be active participants in the team.

2. The Developmental and Intellectual Disability condition neither indicates nor contraindicates the need for psychotherapy, some clients with lower IQs can benefit from psychotherapy. Group, individual, family, play therapy, or expressive therapy may be of benefit to the person. Both chronological and developmental age should be considered in determining a therapeutic choice appropriate to the client.

3. Psychopharmacology:
   - Symptom suppression should not be at the expense of habilitative function or overall quality of life.
   - In documentation, medications prescribed are linked to target symptoms, which are linked to supported diagnosis(es).

Disruptive Behavior Disorders in Children and Youth

(Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional/Defiant Disorder, Disruptive Behavior Disorder NOS)

OPTIMAL OUTCOME OF TREATMENT

The child/youth attains a level of functioning in the areas of education, social situations, family relationships, peer relationships, leisure time, and/or legal involvement, as agreed upon by parents/guardian, youth, clinical team and involved others.

ASSESSMENT

1. The on-going assessment should assess the ability to: 1) empathize with others, 2) control impulses, 3) feel guilt and remorse and (4) address traumatic events such as prolonged separation, sickness, head injury, etc.
2. Drug screens should be recommended when substance use is suspected, and when hallucinations are present. Standardized screening tools may be helpful in identifying substance use.
3. Assess for co-morbidity with mood disorders, substance abuse, developmental disorders, learning disabilities, communication disorders, intellectual impairment, psychosis, and PTSD. The presence of one disruptive behavior disorder increases the likelihood of other disorders being present.
4. Care must be taken to accurately distinguish oppositional defiant disorder from conduct disorder.
5. Standardized behavioral instruments from parents and teachers for school-age children or youth may be useful.
6. Assess the context and severity of the disruptive behavior and settings in which it occurs (home, school, community). The context includes whether problem behaviors occur when alone or with peers, frequency of behaviors, intent to do harm, and whether actual damage occurred.
7. Assess the family, including discipline patterns and beliefs; age appropriateness of behavioral expectations for the child; substance use and attitudes of family members; marital discord and/or domestic violence; current and past maltreatment (including sexual/physical/emotional abuse and neglect); the child's role in the family.

TREATMENT/RECOVERY

1. Disruptive disorders often manifest in uncooperative and angry behavior. Intense negative reactions towards these children/youth are common. Clinical staff members have the responsibility to be aware of and manage these reactions, and should seek supervision when appropriate.

2. Families should be informed of serious concerns regarding possible danger to self or others. Legal standards regarding duty to warn also apply.

3. Special skills are needed by families and others involved with children/youth with these conditions. Providing such skills to the family should be emphasized. Therapists may need to teach families how to independently access supportive community resources and other natural supports. All team members should avoid language that blames parents. Collaboratively developed behavior management plans are a critical element of treatment.

4. Family, group, social, and self-management skills development interventions are highly recommended treatment modalities. Individual therapy is generally not effective as the only treatment, especially for conduct disordered youth. Group process therapy with other conduct disordered youth is contraindicated.

5. Medication may be effective in management of specific symptoms and symptom clusters, especially when other interventions have failed and the child/youth is at risk of placement in a more restrictive environment. Medications are usually effective in assisting ADHD children and youth with school, home, and peer functioning. Psychosocial interventions are generally also necessary.

6. Important elements of treatment include:
    - building on strengths
    - focusing on specific behaviors
    - symptom management and/or control
    - child/youth accountability

For Infants and Toddlers - Birth to Five Years of Age

OPTIMAL OUTCOME OF TREATMENT

The goal of treatment for children from birth to five years of age is to achieve the healthy development of:

- parent-child interactions
- secure attachments
- positive relationships
- confidence and curiosity
- effective communication
- increasing self-regulation
- social competence and self-awareness

ASSESSMENT

A brief screening is typically conducted for the primary purpose of determining if further assessment is needed.

1. In addition to the current ICD and/or DSM, the use of the DC 0-3 may provide additional developmentally relevant diagnostic guidance.

2. A thorough knowledge of the numerous and rapid developmental milestones is essential to an effective on-going assessment.

3. Assessment strategies for diagnosing trauma and maltreatment in children should be developmentally appropriate and should use a variety of techniques and settings, such as observing interactive play, caregiver-child interaction across situations and/or settings such as school and independent play.

INTERVENTION/TREATMENT

1. When a possible disruption in social-emotional development has been identified, effective mental health strategies for infants and toddlers will be based on the following principles:
   - Infant and early childhood mental health services focus on the parent-child relationship and are accessible in a variety of settings;
   - Interventions strengthen the optimal social/emotional development of the infant or young child, and enhance the emotional well-being of the family;
   - The importance of fathers or other male caregiver's involvement in the care and nurturance of their children beginning at birth, is recognized, supported, and facilitated; and
   - Families have opportunities within their communities to share parenting experiences and concerns.

2. Mental health professionals provide education to team members to encourage

understanding that individual differences in Infant/toddlers, cultures, communities, family structures, and languages can sometimes be misinterpreted as evidence of a problem.

3. Specialized training in infant and early childhood mental health is encouraged.

PROMOTION & PROACTIVE INTERVENTION GUIDELINES

Promotion and proactive intervention are the activities and strategies that agencies participate in to support and promote positive social-emotional development in infants/toddlers birth to five.

1. Promotion activities include:

   - person-center care
   - parent education
   - solution-focused counseling
   - case management
   - information and support to promote positive social-emotional development

2. Proactive intervention includes:

   - mental health consultation services for children birth to five and their families;
   - services to pregnant women with biological, medical or environmental concerns;
   - services for at risk infants/toddlers;
   - development of interagency agreements;
   - access to tools for screening, referrals and response to risk factors; and
   - access to training of biological, medical or environmental concerns.

Attachment Disorders in Children

Problems associated with attachment difficulties and disruptions occurring in early years may persist throughout childhood and adolescence. It is imperative that treatment be provided with full cognizance of the history of early attachment difficulties and actively includes a caregiver or parent figure. Treatment must be highly individualized to the child and his/her family.

OPTIMAL OUTCOME OF TREATMENT

The child shall attain a level of functioning that enables him/her to develop positive attachments and engage in meaningful life experiences. Family members will gain skills to implement behavioral interventions within a supportive structure that provides nurturing guidance. In the recovery process, the family will experience a sense of emotionally rewarding interactions and stability while simultaneously accommodating for the child's illness with minimal need for support or treatment.

ASSESSMENT

Unless the diagnosis was made prior to age five, symptoms, profile, and history must exist before the age of five. Older children should receive a diagnosis based on their current emotional and behavioral symptoms.

1. In order to make the diagnosis, a history of situations with a consequent adverse impact on the child's ability to form trusting relationships must be established.

2. The family plays a vital role in diagnosis and treatment. Efforts should be made to obtain as much information as possible about the child to include:

   - developmental milestones;
   - psychiatric and medical history;
   - parental/family medical, psychiatric, genetic history and their impact on child/youth;
   - placement history;
   - traumatic circumstances including, but not limited to, child abuse, domestic violence, removals from the home, disrupted placements, prolonged separations;
   - family substance use history;
   - family perceptions of the child/youth and his/her difficulty;
   - perceptions of the parent's role relative to the child's difficulty; and
   - history of maltreatment or neglect.

3. Assessment strategies for diagnosing trauma and maltreatment in children should be developmentally appropriate and should use a variety of techniques and settings, such as observing interactive play, caregiver-child interaction across situations and/or settings such as school and independent play.

4. The on-going assessment should assess the ability to: 1) empathize with others, 2) control impulses, 3) feel guilt and remorse and (4) address traumatic events such as prolonged separation, sickness, head injury, etc.

5. Assessment of parent-child dynamic to determine the need for parental supports.

TREATMENT / RECOVERY

1. Treatment strategies need to focus on helping the child develop trusting, secure relationships with significant others. A multimode approach should be utilized to achieve optimal outcomes including but not limited to: parent-child treatment, psychodynamic therapy, play therapy, filial therapy, family therapy, cognitive therapy, and behavioral strategies. The treatment goals should be based on the developmental age of the child.

2. No coercive methods of treatment will be approved, whether performed by a therapist or caregiver (e.g., when the treatment involves the use of coercive physical constraints to evoke a child's rage or cause a child to undergo a "rebirth" experience). Such coercive treatment methods are not to be confused with appropriate treatment methods used to intervene with a child who has become a danger to him/herself or others in a therapeutic environment.

3. Parents/caregivers should be provided education on the following:
   - A child's acting out is directed at testing the parent-child relationship due to the child's history of mistrust and neglect;
   - Acting out is not actually a vendetta against the parent;
   - Neutral responses to acting out minimizes negative attention seeking behavior;
   - Families may require high levels of support and respite services using formal and informal supports;
   - Support/education groups that address positive and negative experiences may be helpful; and
   - Multiple family placements and institutional care of the child should be strongly discouraged.

4. Behavioral interventions must be used judiciously with an understanding that the underlying emotional problems must also be carefully addressed. Focusing solely on the behavior may result in high levels of frustration for the child and the parent.

5. Skills development for both the child and family members should be incorporated. Observing the child/parent interaction and then coaching the parent in providing corrective behavioral interventions is recommended while utilizing an understanding, empathic approach to the child.

6. Role models with peer and adult mentors for the child are recommended.

Anxiety Disorders

ASSESSMENT:

1. Clients with anxiety disorders may be at increased risk for suicide. Clients shall be assessed for possible danger to self or others and crisis intervention shall be provided as needed.

2. Clients with anxiety disorders often self-medicate. Clinicians shall assess for use or abuse of over-the-counter, prescription, or street drugs and alcohol.

3. Clients with anxiety symptoms shall be assessed for depressive features. If the symptoms of depression meet the full criteria for the current diagnosis, this diagnosis shall also be made.

Post-Traumatic Stress Disorder (PTSD)

1. The clinician shall differentiate between Acute and Chronic PTSD, utilizing the current criteria, to determine treatment/recovery approach.

2. The relative prominence of dissociative features shall be assessed. Predominately dissociative symptoms are often an index of severity and may be predictive of chronicity.

3. The meaning of the traumatic circumstance shall be assessed according to the individual's interpretation. Ethnic and cultural factors may be important in this assessment.

4. Generally, it is not the role of the clinician to seek substantiation of reported trauma. However, in specific cases, seeking substantiation may be effective to rule out factitious disorder or malingering. Clinical indications shall be used to determine the necessity of seeking substantiation.

5. Assessment of pre-morbid functioning and personality traits may be helpful in determining factors that predispose towards chronic effects of trauma.

6. Protective factors, such as social support and self-soothing skills, shall be assessed and incorporated into the treatment/recovery plan.

TREATMENT/ RECOVERY

1. Many clients, due to the discomfort of the anxiety symptoms, become avoidant of anxiety-inducing situations, including therapy. The first priority of treatment/recovery is to establish a collaborative relationship that supports the client through the discomfort of coping with their anxiety. It is critical that the first therapeutic contact emphasizes rapport-building and expression of hope.

2. Anxiety disorders such as panic disorders, phobias and obsessive-compulsive disorder are often best treated by the application of a specific cognitive-behavioral component. The therapist shall be proficient with such a model or shall seek consultation/ referral. Post-traumatic stress disorders often require a more comprehensive treatment/recovery approach including supportive therapy, individual and/or group settings, and psychosocial rehabilitation as indicated.

3. Referral for medication evaluation shall be considered. Long-term use of anti-anxiety medications for chronic forms of anxiety disorder may be appropriate for some clients. Non-addictive medications shall be considered.

4. The progression of treatment/recovery shall emphasize early skill-building success to reduce the likelihood of loss of hope and early termination from treatment.

5. Therapy shall address the avoidance patterns of the anxious client. Encouragement and specific skills-coaching shall work towards the client successfully confronting anxiety inducing situations.

6. Relapse potential may be high with some clients with anxiety disorders. Stress inoculation training (which helps the client anticipate stressors that they confront, and practice coping skills) may be helpful prior to discharge. The therapist may convey to the client that "booster sessions" can be used to reduce the likelihood of relapse.

7. An essential part of treatment/recovery is education about the disorder, and helping the client and family accept the normal experience of anxiety.

<u>Post-Traumatic Stress Disorder (PTSD) Acute Type</u>

The goal of treatment/recovery of Acute PTSD in adults is to desensitize the client to the traumatic stimuli, which requires rapid exposure therapy over a short course. Low doses of neuroleptics may assist the client in tolerating the distress in the short-term.

<u>Post Traumatic Stress Disorder (PTSD) Chronic Type</u>

1. The treatment/recovery approach shall include both skills training and development of the capacity to employ these skills under times of duress.

2. When working with clients with <u>profound</u> dissociative symptoms, specialized skills or supervision are necessary.

3. Exposure therapy for PTSD chronic type has a high-risk of producing decompensation and is rarely indicated.

4. The treatment/recovery focus shall be on use of supportive psychotherapy, which emphasizes the establishment of a strong therapeutic alliance relationship, which facilitates the development of self-soothing skills, boundary development, and safety issues. Although trauma issues may be a periodic focus of treatment/recovery, therapy aimed at "resolving" the trauma is unlikely to result in direct therapeutic benefit for a client with chronic type PTSD.

Borderline Personality Disorder

ASSESSMENT

1. Assessment of Borderline Personality Disorder is ongoing and requires alertness to overlapping Axis I and Axis II conditions. The ICD/DSM criteria must be fully met to make the diagnosis of Borderline Personality Disorder. The diagnosis of Borderline Personality Disorder shall be made when the criteria are met. Consultation is often helpful in establishing the diagnosis.

2. The clinician shall be alert to the existence of co-morbid Axis I disorders, especially substance abuse and depression. Appropriate treatment/recovery shall be provided or arranged for these co-occurring disorders. Transient co-morbid symptoms (e.g. psychosis) shall be distinguished from those that meet the ICD/DSM criteria.

TREATMENT/ RECOVERY

1. The therapist shall have a well-articulated model of treatment/recovery, such as DBT, that is individualized; recovery focused, and is based on sound practice and evidence. The therapeutic relationship must model consistent boundaries with clear, explicit goals set in a collaborative manner.

2. Providing education about the disorder empowers clients to better participate in treatment/recovery. Over the course of treatment/recovery, therapists shall educate the client about his/her disorder, including its chronicity, aspects of self-care, which affect the course of the disorder, and the prognosis for improvement. This shall be done in a manner that instills hope for recovery and a desire to participate in treatment.

3. The client, with the assistance of the therapist, shall identify specific short-term goals for each episode of treatment/recovery. A clear, specific contract shall be negotiated with the client taking into account individual strengths and motivations.

4. Collaboration is vital to treatment/recovery:

   a. With team: The intensity of the therapeutic work makes clinical consultation a necessity. The boundaries of the therapeutic relationship shall extend beyond the dyad to the treatment/recovery team. Neutral, third party clinicians may have the best perspective on recommending changes in the course of treatment/recovery.

   In some cases, it shall be necessary to accept consultation that the therapist has not sought, and to offer consultation when it has not been requested. The role of the team is to provide support to the treating clinician to assist him/her in dealing with the intensity of feelings according to clinical description rather than reactively or pejoratively (Linehan).

   b. With family and other providers*:* Coordination with other family and other providers may be critical to an effective treatment/recovery plan. Therapists shall discuss the importance of this collaboration with the client and collaborate when

release of information is given. Family and other supports shall be involved as approved by the client.

   c. **With support staff:** During certain phases of the disorder, it may be important to communicate the treatment/recovery contract to support staff, including the crisis team and office staff.

5. Treatment/recovery needs to encourage optimal functioning. Therapists shall not encourage regression; purposefully induced dissociation or revivification of trauma. Treatment shall be provided in a culturally competent, gender specific, and trauma informed manner. Exceptions to this guideline shall be reviewed with the clinical team.

6. Hospitalization is indicated when there is: 1) imminent danger, 2) lack of available social support, and 3) a history of good response to hospitalization or expected positive response to hospitalization;

   NOTE: Because hospitalization may encourage decompensation, in general, hospitalization shall be as brief as possible to minimize therapeutic dependency and decompensation.

7. Therapists working with clients with DBT shall emotionally engage without enmeshing or over containing the client. Boundaries will be maintained according to the therapeutic model (such as DBT). The therapist shall review exceptions with the clinical consultation model.

8. Therapists deciding whether to make outreach calls after the client has missed an appointment shall consider the following factors: Is the client an active suicide risk? Is there reason to believe their alliance with the therapist has been threatened? Is there any disruption in their primary relationship(s)? These factors may increase risk of harm.

9. Medications may be helpful in targeting specific symptoms.

Medication Treatment

COLLABORATION

1. In all phases of care the prescriber should seek to involve significant others.

2. Collaboration between physical and behavioral health staff working on the same case should be done and documented.

ASSESMENT

1. A current list of all medications is part of the ongoing assessment of the client. Prescribers should review the list of medications and comment on possible medication interactions and side effects when indicated.

2. Informed consent should be sought and documented with all medication treatments.

    a. Clients and care givers have the right to change their consent decisions.
    b. Involuntary medication treatment may be provided if a client is imminently dangerous to self or others and/or is under an order of civil commitment and under a forced medication order. Involuntary medication clients should be helped to become voluntary through education and support.

3. Clients on psychotropic medications should have appropriate testing/labs in order to monitor those medications.

4. Ongoing assessments should record a list of current physical health disorders and document their impact on the care provided.

5. It is recommended that prescribers carefully evaluate medications for clients who may be using drugs and/or alcohol.

6. Prescribers should prescribe or refer clients with substance use disorders for medication assisted therapies as indicated.

TREATMENT / RECOVERY

1. Medication shall be modified/changed at appropriate intervals until optimal results have been achieved.

2. Poly-pharmacy within drug classes should be avoided unless all appropriate monotherapies have been considered and documentation so indicates.

3. When changing from one medication to another, cross tapering is completed rather than maintaining treatment with two drugs.

4. If two or more medications from the same class are used simultaneously, the prescriber shall initially and periodically document the necessity for doing so.

5. Reasons for changing medications shall be documented.

6. Inquiry about medication adherence will be made and education/support efforts made to maximize adherence.

7. The prescriber should be aware of the costs and benefits of treatment.

   a. The cost of medication and source of payment are some of many factors considered when choosing an appropriate agent.

   b. Indigent clients should be assisted, when possible, to obtain medications.

8. If medications are used off label or at non-standard doses, an explanation for doing so should be documented.

DOCUMENTATION

In documentation, medications prescribed are linked to target symptoms, which are linked to supported diagnosis(es).

Mood Disorders

OPTIMAL OUTCOME OF TREATMENT

The client attains an agreed upon level of functioning. The client and caregivers learns skills to prevent or manage future episodes of illness. These skills can include increased awareness of mood disorder symptoms, continuation of preventative medication, and changes in thinking and behavior, which facilitate health.

ASSESSMENT

Clients with mood disorders shall be assessed for danger to self (and others when appropriate.) Crisis intervention shall be provided as needed. Family members and/or caregivers should be informed of serious concerns regarding possible danger to self or others. When clinically indicated, a crisis and/or safety plan will be developed, documented and reviewed/updated regularly. The client and his/her caretakers can help develop and receive a copy of the crisis/safety plan.

1. Appropriate clinical instruments to evaluate the severity of mood disruption and suicidality, may be helpful.

2. Clients who are affected by a mood disorder shall be screened and referred for appropriate services.

3. Clients with mood disorders may be referred to a medical provider, as indicated, for evaluation for general medical conditions, which may contribute to the mood disorder or medication that may be useful in ameliorating symptoms.

4. A medication evaluation may be considered for all clients with Major Depression or Bipolar Disorder and clients with symptoms of, but not limited to:

    a. A sense of hopelessness, suicidal ideation or behavior.
    b. Psychotic symptoms, including delusions, hallucinations.
    c. Severe disruptive behaviors.
    d. Marked decrease in academic performance.
    e. Sense of boredom.
    f. Withdrawal from friends.
    g. Increased irritability.

TREATMENT/ RECOVERY

1. Psychotherapy, education, and medication are the foundations for effective treatment/recovery of mood disorders.

2. Therapists providing psychotherapy with mood-disordered clients shall use cognitive, interpersonal, or other effective treatment/recovery methods and focus on collaborative goals.

Psychotic Disorders

OPTIMAL OUTCOME OF TREATMENT

The client learns to manage the illness through developing an awareness, understanding and skills. In the recovery process, the client and family will experience a sense of emotionally rewarding interactions and stability while simultaneously accommodating for the client's illness with minimal need for support or treatment.

ASSESSMENT

1. Clients with psychotic disorders should be carefully triaged to establish the immediacy of need for services. This should include evaluation of possible danger to self or others, with referrals and follow-up to the appropriate levels of care.
2. Clients with Psychotic Disorders should have a functional assessment as well as the need for neurological, psychiatric, substance use and medical evaluations.
3. Inquiring about substance abuse is an essential part of the initial assessment. Because substance abuse often coexists with other conditions, therapists shall continually assess for substance abuse and encourage appropriate treatment/recovery supports as needed. If there is evidence that the individual is dependent upon and/or under the influence of a chemical substance, an evaluation for the need for medical detoxification shall be made.

TREATMENT/ RECOVERY

1. The chronic nature of many psychotic disorders may require varying level intensity of services over the course of an individual's lifetime. This shall require diligence on the part of the treatment/recovery team to keep the client and family engaged in appropriate services.
2. Treatment of the family system is essential with particular emphasis on techniques that will encourage and strengthen the family's ability to have positive interactions with their family member.
3. Medication is critical in the treatment of psychotic disorders. Medication arrangements should be made in accordance with the clients assessed needs. Medical staff have primary responsibility to obtain informed consent from the parent(s)/legal guardians and periodically review medication with the child/youth and caregiver.
4. Assertive case management, as well as social, cognitive, functional, and vocational skills and learning strategies to enhance quality of life are often needed.
5. The therapist shall engage the client and/or family in a relapse prevention and management plan.
6. Because of the often unpredictable and/or slow process of recovery, staff shall communicate hope to clients, and assess progress by improved quality of life (as measured in family/friend relationships, living situation, work, health status) as well as remission of symptoms.