

***UTAH PUBLIC MENTAL HEALTH SYSTEM***

***PREFERRED PRACTICE GUIDELINES***

## **Acknowledgments**

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

In providing these guidelines, we would like to thank the following members for their contribution in reviewing and writing sections of these guidelines.

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## **Statement of Intent**

These practice guidelines are not to be construed to limit in any way, the individualization of treatment, clinician creativity, or the ability of the clinician to provide treatment in the best interests of the client. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These guidelines for practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. It is recognized that optimal outcomes will not always be obtained in treatment.

## UTAH PUBLIC MENTAL HEALTH SYSTEM Preferred Practice Guidelines

### Assessment of Adults (May include screening)

1. Assessment principles: Assessment is an on-going process including a working alliance with the client. Therefore working diagnoses may change and shall be continuously evaluated and updated consistent with new information.
2. The client is assessed and a determination is made based on the findings of the need for services. If services are clinically indicated, the client is connected with relevant treatment staff, or is facilitated to begin treatment at the agency deemed most appropriate. Immediate safety needs of the client are addressed.
3. A diagnosis is made based upon the current 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 immediate treatment/recovery goals.
4. Information for creating a person centered treatment/recovery plan shall be documented.
5. 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.
6. A written individual treatment/recovery plan shall be developed for each person being treated for mental health by the appropriate qualified health provider. The plan shall:
  - 6a. Be consistent with standard for individual treatment/recovery plans,
  - 6b. Incorporate the goals of the client and include the involvement of family and natural supports,
  - 6c. Respect the wishes and needs of the client within in funding limitations and clinical best practice.
7. Assessments shall be provided in a culturally competent manner.
8. The client's description of the presenting problem initiates the assessment. Dealing with the client in an empathetic manner shall be given equal attention to information gathering.
9. Whenever an adult is seen who has a previous psychiatric diagnosis, the assessing clinician shall re-evaluate the appropriateness of the diagnosis.
10. Individualized treatment/recovery planning is initiated based on the information gathered which connects the presenting problem to the resources or interventions available.

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11. The context of the presenting symptoms shall be gathered/obtained with special attention to the following:
  - 11a. When were the symptoms noticed and under what circumstance? (How long, how often how severe?) To what degree are the symptoms impairing daily functioning?
  - 11b. Are the psychiatric symptoms associated with physical symptoms?
  - 11c. Are the symptoms associated with the use of substances, or are substances being used to self-medicate the symptoms? This is best assessed when history taking, and again when the working alliance is fully established.
  - 11d. Are the symptoms associated with other co occurring conditions?
12. The Utah Scale for Serious and Persistent Mental Illness (SPMI) shall be completed as part of the assessment and updated annually. The assessment shall also include, but is not limited to:
  - 12a. Family or origin and current family information.
  - 12b. Current living circumstance, including: housing, access to the necessities of living, family involvement, social support, current job status and employment.
  - 12c. Relationship history, including the ability to establish and sustain satisfying relationships.
  - 12d. Physical symptoms and medical history, including medications and allergies.
  - 12e. Impulses or history toward harm to self or others.
  - 12f. Legal history, including history of personal and family psychiatric treatment.
  - 12g. Symptoms, history and current patterns of personal and family alcohol/substance abuse or dependency.
  - 12h. History of traumatic experiences.
  - 12i. Other personal history including developmental milestones and work history.
  - 12j. Indicators of potential violence towards others, including history of or impulses towards violence.
  - 12k. Mental status exam.

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## Treatment for Adults

### TREATMENT GUIDELINES

1. The treatment approach used shall be appropriate for the individual diagnoses and assessment. Co-morbid conditions shall be considered in the development of the overall treatment/recovery plan.
2. Within the limits of the resources of the client and the center, the treatment shall be provided at the level of intensity indicated by the client's condition and acuity. The 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. Outpatient visits shall vary in frequency and duration, ranging from intensive outpatient treatment (multiple visits per week) to maintenance schedules (monthly, quarterly, or PRN visits). The treatment schedule shall be part of the treatment/recovery plan.
3. The therapeutic relationship is the foundation of all effective interventions. The therapeutic relationship shall be facilitated through the use of empathic methods in addition to structured therapeutic interventions. Therapeutic alliance shall be considered in client placement and transfer decisions. When therapeutic alliance is threatened, the therapist shall consider clinical supervision. Transfer to another therapist may be indicated.
4. The primary therapist shall be aware of the psychiatric medications the client is taking and shall communicate problems to the medical staff.
5. The practitioner shall practice only in areas in which he/she possesses proper credentialing and/or training, or is developing skills with appropriate supervision.
6. Consideration of individual needs shall be primary in selecting the model of intervention to be utilized. This selection shall be made in a thoughtful manner taking into consideration the individual's assessment. Some psychiatric conditions respond best to specific therapeutic interventions, and efforts shall be made to provide those interventions.
7. Treatment shall be provided in a manner that is appropriate to the cultural background of the client. When indicated, this may include referral to, or consultation with a practitioner with specific knowledge of the culture of the client.
8. Therapeutic boundaries are the bedrock of effective therapeutic relationships.
  - 8.1. The therapist shall establish boundaries, which **include** the following:
    - empathy for the client,
    - clear and articulated roles and expectations,
    - confidentiality of treatment,

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- advocacy for the client,
- supervision by third party when indicated.

8.2 The therapist shall work to establish boundaries that **exclude** the following:

- any behavior that meets the therapist's needs at the expense of the client,
- exploitation,
- punishing/withholding behaviors of therapist which derive from counter-transference issues,
- any romantic or sexual behavior.

8.3 In these instances, **clinical consultation shall be sought** to insure that clients are not exploited in any way or that the relationship continues to be therapeutic:

- romantic attraction,
- counter transference conditions (intense emotional reactions),
- over-involvement,
- social relationships,
- client regression/dependency,
- excessive therapist care-taking.

9. The treatment/recovery plan shall be developed in collaboration with the client in terms easily understood by the client. When appropriate, families and partnering agencies shall be included in the treatment/recovery planning process. Families shall be given the number of the local chapter of the National Alliance for the Mentally ill for information and support.
10. Access to services shall be addressed in the treatment/recovery planning. The treating agency and clinician shall work to remove all barriers possible. Examples may include scheduling accommodations, or provision of transportation or childcare.
11. The treatment shall work actively towards goal resolution. Goals shall be completed or revised actively. Termination from treatment shall be worked towards when appropriate, and shall be discussed during therapy sessions.
12. 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.
13. When appropriate, psychosocial rehabilitation, which works towards the restoration of social and occupational functioning, shall be part of the treatment/recovery plan of persons with serious and persistent mental illness.

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14. Clinical supervision by colleagues or formal supervisors is always optimal. Clinicians working towards licensure shall seek supervision in all aspects of a case. Any therapist shall seek supervision in 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,
  - the clinician is seeking licensure.

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## Anxiety Disorders in Adults

### OPTIMAL OUTCOME OF TREATMENT/RECOVERY:

The client experiences remission of anxiety symptoms that brought him/her to treatment/recovery, or returns to full interpersonal and occupational functioning (as defined by the client) by developing the ability to regulate his/her anxiety symptoms through acquired symptom management skills and psychotherapeutic/ psychopharmacologic support.

### ASSESSMENT PRINCIPLES: (See Assessment Guidelines for Adults)

1. The therapist shall be aware of the possibility that underlying medical causes may produce anxiety symptoms. Medical evaluation may be indicated to determine that there is no underlying physical problem, i.e., sleep apnea, mitral valve prolapse, thyroid conditions, etc.
2. 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.
3. Clients with anxiety disorders often self-medicate. Clinicians shall assess for use or abuse of over-the-counter, prescription, or street drugs and alcohol.
4. 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.

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5. Assessment of pre-morbid functioning and personality traits may be helpful in determining factors that predispose towards chronic effects of trauma.
6. Co-morbid conditions (such as substance abuse, personality disorders, and mood disorders) are likely to occur with this condition, and shall be assessed and diagnosed.
7. Protective factors, such as social support and self-soothing skills, shall be assessed and incorporated into the treatment/recovery plan.

**TREATMENT/RECOVERY PRINCIPLES:** (See Treatment/Recovery Guidelines for Adults)

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.
5. Efforts shall be made, when appropriate, to recruit significant others to provide increased support and coaching to the client. This shall include education concerning the condition and its treatment/recovery.
6. 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.
7. 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.
8. An essential part of treatment/recovery is education about the disorder, and helping the client accept the normal experience of anxiety. Educate the client in areas including symptom identification and management.

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### Post-Traumatic Stress Disorder (PTSD) Acute Type

1. The goal of treatment/recovery of Acute PTSD 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.

### Post Traumatic Stress Disorder (PTSD) Chronic Type

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 profound 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.

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## Borderline Personality Disorder

### OPTIMAL OUTCOME OF TREATMENT/RECOVERY:

The client attains the skills to develop and maintain stability in work, relationships and self-image, particularly through ages from 20 through 40, avoiding institutionalization, substance abuse, suicide and harm to others.

### ASSESSMENT PRINCIPLES: (See Assessment Guidelines for Adults)

1. Assessment of Borderline Personality Disorder requires alertness to overlapping Axis I and Axis II conditions. The current 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., psychotic) shall be distinguished from those that meet the current DSM criteria.

### TREATMENT/RECOVERY PRINCIPLES: (See Treatment/Recovery Guidelines for Adults)

1. The therapist shall have a well-articulated model of treatment/recovery, such as DBT, for the person with Borderline Personality Disorder, which directs treatment/recovery beyond a crisis orientation. The therapeutic relationship must model consistent, clear boundaries, and clear explicit goals set in a collaborative manner.
2. Providing education about their 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 later in life.
3. With the client, therapists shall identify specific short-term goals for each episode of treatment/recovery within the course of the chronic disorder. A clear, specific contract shall be negotiated with the client.
4. Collaboration is vital to treatment/recovery:
  - 4.1 **With team:** The intensity of the therapeutic work with this type of client often 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.

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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).

- 4.2 With other providers:** Coordination with other agencies/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. The degree of involvement of significant others in the treatment/recovery process needs to be discussed with the client.
- 4.3 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 induce dissociation or revivification of trauma. 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;

**-Or-**

A history of behavior high in lethal potential with no expectation of rescue or intervention (as opposed to gestures, minor self-injurious behavior or verbal threats).

7. Because hospitalization may encourage decompensation, in general, hospitalization shall be as brief as possible to minimize therapeutic dependency and decompensation.
8. Therapists working with clients with DBT shall emotionally join without enmeshing or over containing the client. Maintaining similar boundaries as with other clients may evidence this. The therapist shall review exceptions with the clinical supervisor (e.g.: home visits, differences in the amount or frequency of contact, phone calls at home).
9. Therapists working with clients with Borderline Personality Disorder shall provide psychoeducation about managing affect. Supportive therapy sessions include assisting the client to manage their affect and therapy disrupting behaviors, e.g., inappropriate anger.
10. Therapists deciding whether to make outreach calls after the client has failed 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.
11. Medications may be helpful in targeting specific symptoms.

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## Mood Disorders in Adults

### OPTIMAL OUTCOME OF TREATMENT/RECOVERY

The client attains an agreed upon level of functioning and 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 GUIDELINES (See Assessment Guidelines for Adults)

1. Clients with mood disorders shall be assessed at intake for danger to self (and others when appropriate.) Crisis intervention shall be provided as needed. 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, as appropriate, for case management, peer support specialist, psychosocial rehabilitation and/or support services.
3. Clients with mood disorders shall 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.

### TREATMENT/RECOVERY GUIDELINES (See Treatment/Recovery Guidelines for Adults)

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. An individualized treatment/recovery plan shall be developed with the client and progress shall be continuously evaluated. Treatment/recovery shall be time-effective and focused.
3. 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.
4. A medication evaluation shall be considered for all clients with recurrent depression, Bipolar Disorder, and clients with symptoms of, but not limited to:
  - 4a. A sense of hopelessness, suicidal ideation or behavior,
  - 4b. Psychotic symptoms, including delusions, hallucinations,

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- 4c. Severe disturbance in sleep, appetite, weight, concentration, or libido,
- 4d. Severe obsessional somatic concerns.
- 5. Clients with a positive response to medication shall be advised to continue medication for an appropriate length of time given the age of onset, severity of symptoms, and number of episodes. Medical staff have the primary responsibility to periodically review medication with the client. Therapists shall review medication use with the client and refer concerns to the medical staff as indicated.
- 6. When a client misses a scheduled appointment, outreach shall be initiated as clinically determined.
- 7. An assigned staff person shall assume primary responsibility for the coordination of treatment/recovery between care providers. All providers shall work collaboratively in the treatment/recovery. Each provider assumes responsibility for appropriate documentation for the services they provide, e.g., group, individual, and family psychotherapy, skills development, medication management, etc.

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## Psychotic Disorders in Adults

### OPTIMAL OUTCOME OF TREATMENT/RECOVERY

The client learns to manage his/her own illness, developing awareness of the illness and learning skills, which enable him/her to overcome or accommodate symptom fluctuations. The optimal outcome for the client is recovery of meaningful life activities, to live independently, and engage in productive activities with minimal need for support or treatment/recovery.

### ASSESSMENT GUIDELINES (See Assessment Guidelines for Adults)

All staff shall provide services, which are perceived as non-threatening and affirming of the client's rights and personhood. Staff shall provide the services needed with extreme sensitivity and patience, especially during periods of confusion and disorientation.

Clients with psychotic disorders shall be carefully evaluated and prioritized regarding their need for services. This shall include evaluation of danger to self or others and need for involuntary hospitalization.

The assessment shall include a determination of current living conditions and circumstances to specifically address housing, health care access, relationships, daily life activities, finances, transportation, etc. If the client has dependent children, appropriate referral for evaluation or services shall be made. As client needs are identified, refer to appropriate services, e.g., case management.

Clients shall be encouraged, where appropriate, to sign a release of information form so that the family and/or support system can be contacted and offered information about the client's psychotic disorder. If a release is signed, the family/support system shall be invited to be actively involved in treatment/recovery and relapse prevention. Information about psychotic disorders and the Utah Alliance for the Mentally Ill may be provided to the families without a release of information.

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. Inquiring about substance abuse is an essential part of the initial assessment. Because substance abuse often coexists with psychotic conditions, therapists shall continually assess for substance abuse and encourage appropriate treatment/recovery as needed.

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## **TREATMENT/RECOVERY GUIDELINES** (See Treatment/Recovery Guidelines for Adults)

Recovery treatment includes psychopharmacology, pharmacotherapy to alter the neurochemical aspects of vulnerability, and also flexible individual and group psychotherapies, psychoeducation, and assertive case management to mitigate the impact of stress; and social, cognitive, and vocational skills and learning strategies to enhance coping capacity. Particular attention shall be given to the stability and sufficiency of the client's living arrangements. All of these services must incorporate the client's life history and experiences, values and interests.

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 involved in appropriate services.

Therapists shall assess the client's understanding or interpretation of their symptoms. Therapists shall provide or assure that education about the psychotic disorder is available and is complimentary with the client's own personal understanding of his/her symptoms whenever possible. The therapist shall assist in providing current information about symptom management.

Medication is critical in the treatment/recovery of psychotic disorders. Medication arrangements shall be made in accordance with the client's assessed needs. Medical staff have primary responsibility to periodically review medication use with the client. Therapists shall review medication use and refer concerns to the medical staff as indicated.

The therapist shall engage the client in relapse prevention. This may include discussion with the client regarding preferences for people to contact, with whom he/she feels the safest, and alternatives to hospitalization in times of crisis may include the Mental Health Advanced Directive (UCA-62A-12-504), Wellness Recovery Action Plan (WRAP) or other appropriate documents.

A collaborative team approach to treatment/recovery is essential. The team may include the client, therapist, case manager, other psychosocial rehabilitation team staff, peer support specialist, medical staff, and other appropriate individuals. Involvement of family and other community/social supports is also highly recommended when appropriate. Cooperation, coordination, and communication are critical for good care and treatment/recovery.

Therapy with clients with psychotic disorders shall include assisting the client to address issues of loss, previous treatment/recovery experiences, relationship issues, parenting skills, self-image, and depression as appropriate. Therapy need not focus solely on psychotic symptoms unless that is the client's choice.

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.

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Clients with psychotic disorders shall be given appointments, which are flexible in duration and frequency to meet the needs of the client.

Medical providers are responsible for providing information to the client about medication, including potential benefits and side effects for both short and long term. Medical providers shall conduct a yearly assessment for involuntary movement, i.e., AIMS or DISCUS, with all clients receiving neuroleptics for longer than six months.

When substance abuse co-exists with a psychotic condition, attention needs to be paid to the treatment of the substance abuse problem. Concurrent treatment/recovery provides the most effective approach. Substance abuse treatment shall be specifically tailored for the individual with a psychotic disorder and documented in the clinical record.

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## Assessment of Children and Youth

### OPTIMAL OUTCOME OF ASSESSMENT

The assessment results in the identification of reasons and factors leading to referral, current level of functioning, significant changes in functioning over time, nature and extent of behavioral and subjective difficulties, and individual, family and/or environmental factors, strengths, challenges and resources, which lead to appropriate DSM diagnoses and individualized, child/youth guided treatment goals. During this process, a mutually trusting working relationship with the child/youth, family, and significant others is established for continued planning and treatment.

### ASSESSMENT PRINCIPLES

1. Assessment of children and youth is an ongoing process. Initially, based upon presenting information, the evaluator should develop an assessment plan including identification of strategies for collecting information and possible assessment instruments to be utilized. These should be adapted as information becomes available. Assessments will be strength-based and person centered. Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s) as well as other pertinent factors should form the basis for all assessment and subsequent treatment.
2. The assessment should be provided in a manner, which does not attribute blame to families. Staff should provide the services needed with sensitivity and patience building on the strengths and culture of the child/youth and family.
3. The assessment process will result in an initial diagnosis and development of treatment goals and strategies. As further data is gathered, the diagnosis and subsequent treatment goals and strategies will be revisited and revised, as appropriate.
4. Whenever a child/adolescent is seen who has a previous psychiatric diagnosis, the assessing clinician should re-evaluate the appropriateness of the diagnosis(es).
5. Diagnosis(es) should be made with adherence to the current DSM diagnostic criteria and not based on idiosyncratic/anecdotal impressions. Full use should be made of the current DSM criteria for co-morbid conditions, atypical presentations, V codes, deferred and provisional diagnoses.
6. Family/care givers are a primary source of information about the child/youth and should be involved in all aspects of the assessment and subsequent treatment planning and implementation.
7. Mental Health staff should encourage and facilitate parents in signing appropriate "release of information" forms in order to gather critical data from multiple individuals and sources

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significant to the child/youth. This data is essential in forming an accurate picture of the child/youth's functioning. Whenever possible, the clinician should directly contact the primary source of information, i.e., current school teacher for school functioning, family physician for health status, etc.

8. A thorough assessment of a child/youth should include the following areas:
  - Developmental milestones to include receptive and expressive language development
  - Psychiatric and medical history, including vision and hearing problems
  - School functioning and performance including any formal testing conducted by the school
  - Emotional development and temperament
  - Peer relations
  - Family relationships, responsibilities, and perceptions of the child/youth and his/her difficulty and the subsequent impact on the family
  - Strengths, interests, and hobbies
  - Natural supports
  - Cultural influences, religious beliefs, spiritual beliefs
  - Unusual family or environmental circumstances
  - Parental/family medical and behavioral health history and impact on child/youth
  - Substance use
  - Traumatic circumstances including child abuse, domestic violence, family substance abuse
  - Legal involvement
  - Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, and 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
9. Assessment will be provided in a culturally sensitive and appropriate manner consistent with the unique characteristics of the child and family, taking into consideration factors including, but not limited to: language, socio-economic factors, family and extended family structure, religious practices, geographic location, immediate community, etc. When indicated, the assessor will seek assistance in order to assure that the assessment will be conducted consistent with the language and culture of the child/youth and family.
10. Standardized behavioral assessments from parents, teachers, for school-age children or youth may be useful. All evaluation instruments will be selected and administered by appropriately trained personnel in compliance with administration standards provided by their producer(s) as being appropriate for the sex, age, and race of the child/youth.

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Conclusions derived from any instrument should be made in the context of all information gathered.

11. Depending upon age and developmental factors, the child/youth should be interviewed individually and with the parent(s)/significant others. The setting is critical to the success of the interview and must be sensitive to the need to accommodate for the child's cognitive, language and emotional status. Specific techniques may include interactive play, projective approaches, and direct discussion. Structured observations or other means of seeking information should be utilized. Care should be taken to avoid questions that lead a child to answer in a particular way.
12. The Serious Emotional Disorders (SED) form should be completed.
13. Information about the results of this assessment process, diagnosis(es), and implications for subsequent treatment for the child/youth and family should be shared with the parent(s) or guardian. Plans for subsequent treatment interventions should be developed with the child (as appropriate), youth and family and/or other caregiver.

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## Treatment of Disorders in Children and Youth

### OPTIMAL OUTCOME OF TREATMENT

The child/youth attains a level of wellness that is seen as appropriate by the child/youth, primary care-givers, family, therapist, and other systems of care representatives. The child/youth achieves healthy development and growth, and is better able to manage future episodes of illness and engage in meaningful activities of life.

### TREATMENT PRINCIPLES

1. The family/ primary care-giver provides support and nurturance for each child/youth and, as such, should be involved in a working partnership with the mental health professional in all aspects of treatment development, implementation, and evaluation. In instances where children are in state custody and parent's rights have not been terminated, families of origin should be included in treatment planning when clinically indicated.
2. Treatment goals and strategies should be collaboratively derived and based on reasons for referral, data collected during the assessment process (per assessment guidelines), and responsive to the needs of the child/youth as she or he functions across daily living environments and situations. Discharge criteria should be addressed at this time.
3. Treatment plans should be individualized to support the recovery process and consider the following:
  - Cognitive, developmental, and personally differentiating characteristics
  - of the child/youth
  - Unique family characteristics
  - Cultural customs
  - Community expectations
  - Environmental demands, including care giver and school standards
4. Treatment plans should identify indicators of progress to include time-frames and responsibility for data collection and analysis. Progress data should be collected from multiple sources across the settings and environments in which the child/youth functions. This should include response to medication and compliance.
5. Family therapy, including siblings and extended family members, and parent training should be considered in treatment planning.
6. Crisis and safety intervention planning should be considered as part of the overall treatment plan and/or developed as a separate document with the relevant parties.

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7. Services must be frequent enough and of appropriate duration to benefit the child/youth and family. Flexibility will be required in scheduling and in being responsive during emergencies.
8. The setting for treatment should be child/youth and family friendly. The setting should be accessible and not place undue stress upon the family. Treatment in the child/youth's natural environment should be sought whenever appropriate.
9. Wrap-around services should be extended beyond the child/youth to include family members and other natural supports, which may include: collaborative consultation, respite care, family support, mentoring, boy/girl scouts and recreational activities not limited to the mental health center. In areas where available, referrals should be made to parent and youth support organizations.
10. Each treatment plan should identify a contact person for the child/youth and family who will coordinate the treatment within the agency as well as with other service providers.
11. Staff working with children/youth should be competent in specialized skills. Complex treatment issues may benefit from a second opinion. In areas where a child/youth specialist is not available, on-going supervision, training, and support should be provided to the generalist practitioner.
12. After-care and follow-up services are a critical component of planning treatment transitions in order to anticipate the natural maturation and developmental processes.

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## **Disruptive Behavior Disorders in Child 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 GUIDELINES** (See Assessment Guidelines for Children/Youth.)

1. Children/youth should be assessed at intake for possible danger to self and others:
  - 1.1 Assess for suicide risk since it is as high with these diagnoses as with depression.
  - 1.2 Assess risk of violence, including but not limited to: gang involvement, access to weapons, violence towards family members, substance use, etc.
2. Assessment should include the ability to: 1) empathize with others, 2) control impulses, and 3) feel guilt and remorse. Assessment should also address traumatic events such as prolonged separation, sickness, head injury, etc. The mental status exam should be age appropriate. Hallucinations are often missed in youth and should be included in the mental status evaluation. Comments of feeling extremely bored should cue further evaluation for depression.
3. Drug screens should be recommended when substance use is suspected, and when hallucinations are present. Standardized screening tools may be helpful in identifying substance abuse.
4. Assess for co-morbidity with mood disorders, substance abuse, developmental disorders, learning disabilities, communication disorders, intellectual impairment, and psychosis. The presence of one disruptive behavior disorder increases the likelihood of other disorders being present.
5. Care must be taken to accurately distinguish oppositional defiant disorder from conduct disorder. The treatment prognosis is often very different.
6. Standardized behavioral instruments from parents and teachers for school-age children or youth may be useful.
7. 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. These are also important prognostic indicators. For conduct disorder youth, prognosis worsens with early onset.

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8. Assess the family, including discipline patterns and beliefs; age appropriateness of behavioral expectations for the child; substance abuse 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, Children/youth with disruptive disorders are more likely to be/have been abused than the general population, and this requires careful evaluation. Also, families with domestic violence have a greater likelihood of children being abused.

### **TREATMENT GUIDELINES** (See Treatment Guidelines for Children and Youth)

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
  - consideration of multiple environmental factors

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7. Wrap-around services such as respite, in-home, or in-school interventions and behavioral aide (trackers, youth proctors, mentors, etc.) are often very useful interventions.
8. Close coordination with partners, including direct contact with the school, is highly recommended. This coordination is important initially, and for ongoing evaluation of treatment progress. Advocacy for services to the child/youth may be needed.

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## Mood Disorders in Children and Youth

### OPTIMAL OUTCOME OF TREATMENT

The child/youth attains an agreed upon level of functioning; the child/youth and primary care giver(s) learn 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 behavior and thinking about themselves, their environment, and their future, which facilitate health.

### ASSESSMENT GUIDELINES (See Assessment Guidelines for Children/Youth)

Assessment of children and youth involves gathering data from multiple sources, which may include schools, family, caseworkers, and child care providers.

1. Children/youth with mood disorders should be assessed at intake for possible danger to self and others when appropriate, and crisis intervention provided as needed. Families should be informed of serious concerns regarding possible danger to self or others. Age appropriate instruments may be helpful to aid in the evaluation of symptoms. When clinically indicated, a crisis and/or safety plan will be developed and documented at both the initial assessment and throughout treatment. The client and his/her caretakers will help develop and receive a copy of the crisis/safety plan.
2. Children/youth who are SED with a mood disorder should be screened and prioritized for necessary services. Depending upon the individual needs of the child and his/her family, services to be considered in addition to the traditional outpatient services may include, but not be limited to, case management, respite care, and in-home services.
3. Children/Youth with a mood disorder should be referred, as indicated, to a medical provider for evaluation for the presence of general medical conditions contributing to the mood disorder.

**TREATMENT GUIDELINES** (See Treatment Guidelines for Children/Youth) Appropriate psychotherapy, family and child/youth education, as well as medication management are important factors in the effective treatment of mood disorders.

1. Therapists working with children/youth who are mood disordered should actively involve the family, school, and others as appropriate. Focus should be on collaboratively-developed goals and the use of effective, age appropriate treatment methods for children/youth. Individualized approaches outside the traditional office setting are encouraged when therapeutically indicated. Such services may include, but not be limited to, respite care, in-home and on-site services, and case management.
2. Education about mood disorders in children and youth and the options for treatment should be provided to children/youth and families. This is a valuable aid to treatment. Therapists

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should provide families and the child/youth the opportunity to discuss the information provided.

3. Medication is frequently an effective component in the treatment of children and youth with mood disorders. Medication evaluation should be considered for those children/youth whose symptoms meet the diagnostic criteria for a mood disorder. In addition to diagnostic criteria, some indicators are:
  - Suicidality
  - Psychosis
  - Severe disruptive behaviors
  - Marked decrease in academic performance
  - Sense of boredom
  - Withdrawal from friends
  - Increased irritability
  - Obsessional somatic concerns
4. The medical provider is responsible for providing the child/youth and families with information about medication, including potential benefits and side effects for children/youth. Families and the child/youth should be encouraged to ask questions and discuss concerns.
5. When a client misses a scheduled appointment, the intensity and immediacy of outreach should be clinically determined.
6. An assigned staff person should assume primary responsibility for the coordination of treatment between care providers. All providers should work collaboratively and each provider assumes responsibility for appropriate documentation of their services.
7. Wrap around services should be considered.

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## Psychotic Disorders in Children and Youth

### OPTIMAL OUTCOME OF TREATMENT

The child/youth and family learns to manage the illness through developing an awareness of the illness, and acquires skills to overcome or accommodate to symptom fluctuations. The child/youth develops age appropriate living, educational and social skills, and interacts and functions appropriately within the family. 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 GUIDELINES** (See Assessment Guidelines for Children/Youth) All staff should provide services which are non-threatening and affirming of the child/youth's rights.

1. While the primary source of information in this diagnosis is the observation of the child/youth, it is important that parents/care givers be actively involved in the assessment process. Collateral sources of information may include, but not be limited to, school, significant others, screening tools and medical information.
2. Children/youth 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.
3. Children/youth with Psychotic Disorders should be assessed for the need for a neurological, psychiatric, substance abuse and medical evaluation.
4. Assessment of the family system is a critical component in determining appropriate treatment.

### TREATMENT GUIDELINES (See Treatment Guidelines for Children/Youth)

1. 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 child/youth.
2. Psychoeducational information should be provided for family members. The family should be helped in understanding the child's illness may not disappear, but symptoms may be managed and controlled.
3. Family support including, but not limited to, respite services for the primary care giver, are critical areas to be addressed in treatment planning.
4. Collaborative exchanges of information from all agencies or individuals involved with the child/youth is essential in evaluating the efficacy of treatment, e.g., parents, care givers, teachers, respite care providers, case managers, etc.

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5. Medication is critical in the treatment of psychotic disorders. Medication arrangements should be made in accordance with the child/youth's 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. With direction from the medical staff, all team members should work collaboratively in the ongoing medication management and follow-up process.
6. Family should be made aware of support groups and other community resources.
7. A safety plan will be developed and documented at both the initial assessment and throughout treatment. In times of active psychosis, a crisis plan will also be developed. The client and his/her caretakers will help develop and receive a copy of the crisis/safety plans.
8. Wrap around services should be considered.

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## Reactive 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.

### ASSESSMENT GUIDELINES (See Assessment Guidelines for Children/Youth)

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. Assessment of children under age five, as well as older children who experienced early attachment difficulties or disruptions, involves gathering data from multiple sources. The assessment must focus on family and extended family relationships, responsibilities, and upon the naturally occurring community supports.

1. In order to make the diagnosis, a history of maltreatment or neglect 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;
  - family substance abuse history;
  - traumatic circumstances including but not limited to child abuse, domestic violence, removals from the home, disrupted placements, prolonged separations;
  - family perceptions of the child/youth and his/her difficulty;
  - perceptions of the parent's role relative to the child's difficulty; and
  - the degree of "victimization" felt by the parent(s)/caregivers of the child.
3. Assess for co-morbidity with other disorders and disabilities and medical conditions.

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4. When clinically indicated, a crisis and/or safety plan will be developed and documented at both the initial assessment and throughout treatment. The client and his/her caretakers will help develop and receive a copy of the crisis/safety plan.
5. 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.
6. The assessment should include the ability to 1) empathize with others, 2) control impulses, and 3) feel remorse.

### **TREATMENT GUIDELINES (See Treatment Guidelines for Children and Youth)**

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 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 themselves 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.
  - 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 of the child should be strongly discouraged.
4. Treatment goals should be based on the developmental age of the child.
5. Behavioral interventions must be used judiciously with an understanding that the underlying emotional problems must be carefully addressed. Focusing solely on the behavior may result in high levels of frustration for the child and the parent.
6. 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

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behavioral interventions is recommended while utilizing an understanding, empathic approach to the child.

7. Role models with peer and adult mentors for the child are recommended.
8. The following are treatment considerations:
  - Structure and consistency;
  - Parent-child interaction therapy;
  - Wraparound planning and delivery should help with containment for safety;
  - Medicate only for co-morbid conditions, not attachment issues;
  - Case management with school for continuity is helpful;
  - Look for environmental antecedents to troubling behaviors and make direct interventions; and
  - Teach parent(s) about redirecting behavior and utilizing natural consequences.

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## For Infants and Toddlers - Birth to Five Years of Age

### OPTIMAL OUTCOME OF TREATMENT

Infant mental health is reflected in appropriate cognitive, social, emotional, and physical development. Recognizing the unique characteristics of each infant and family's healthy mental development for children, birth-five can be characterized as:

- Parent-child interaction secure attachments and positive relationships
- Confidence and curiosity
- Effective communication
- Increasing self-regulation
- Social competence and self-awareness

### SCREENING GUIDELINES

1. Screening is a relatively brief process designed to identify infants/toddlers who are at increased risk of having disorders that warrant immediate attention, including a more comprehensive assessment and subsequent intervention/treatment.
2. Identifying the need for further assessment is the primary purpose for screening. Mental health screenings are never used to diagnose a child and, therefore, a wide range of people may administer screening instruments. Screening results are used to inform families, caregivers and other formal and informal supports.
3. Children who need further evaluation should be referred for a systematic and comprehensive assessment including the specific areas of concern.

### ASSESSMENT GUIDELINES (see assessment guidelines for Children/Youth)

1. The purpose of a diagnostic assessment is to define the infant/toddlers problems and use the information to develop a comprehensive treatment plan. The assessment results in the identification of reasons and factors leading to treatment and/or referral.
2. Assessment using the current DSM is an acceptable tool to use for diagnosis. However, use of the DC: 0-3 may provide more developmentally relevant diagnostic guidance. A thorough assessment of a child birth to five should include the following areas:
  - Developmental milestones;
  - Psychiatric and medical history, including vision and hearing problems;
  - A mental status exam;
  - Pre-School reports including any formal testing;
  - Emotional development, temperament, strengths, and interests;

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- Family relationships, responsibilities, difficulties and perceptions of the child and the subsequent impact on the family;
  - Unusual family or environmental circumstances;
  - Family medical, psychiatric history, substance use/abuse, history of child abuse including neglect, or domestic violence in the home;
  - Involvement with outside agencies including juvenile court dependency or custody hearings; and
  - Reason for referral and present concerns, including the nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s).
3. Family/care givers are a primary source of information about the child/youth and should be involved in all aspects of the assessment and subsequent treatment planning and implementation.
  4. Mental Health staff should encourage and facilitate parents in signing appropriate "release of information" forms in order to gather critical data from multiple individuals and sources significant to the infant/toddler.

## **INTERVENTION/TREATMENT GUIDELINES**

1. Effective infant and early childhood mental health services are based on a multi-disciplinary approach and involve collaboration across the multiple systems of health care, human services, education, and mental health. Mental health intervention/treatment is warranted when:
  - A child demonstrates a significant delay in emotional, behavioral and temperamental functioning;
  - The parent/child relationship is disturbed; and/or
  - A screening and subsequent assessment tool administered to the child would indicate further intervention.
2. 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;
  - Families are partners in determining quality/science-based interventions that are provided in a non-stigmatizing, affordable, culturally competent, individualized, timely manner;
  - 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;

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- Families have opportunities within their communities to share parenting experiences and concerns;
  - All early childhood providers have access to information and training related to social-emotional mental health issues.
3. Mental health professionals provide education to team members to encourage understanding that individual differences in children, cultures, communities, family structures, and languages can sometimes be misinterpreted as evidence of a problem.
  4. Utah law requires that licensed mental health professionals provide mental health services. 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:
  - Individualized care
  - Parent education
  - Problem-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.

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## **Co-Occurring Conditions of Serious Emotional Disturbance and Developmental Disorders/Mental Retardation/Disabilities of Cognitive/Adaptive Functioning in Children and Youth**

### **DEFINITION**

The guidelines apply to children and youth who meet criteria for serious emotional disturbance (SED) and who require specific treatment considerations due to disabilities of cognitive/adaptive functioning.

### **OPTIMAL OUTCOME OF TREATMENT**

The client and his/her family manage the illness and disability by learning skills to compensate for or accommodate symptom fluctuations. Client and family report satisfaction with quality of life.

### **ASSESSMENT**

- 1) Mental retardation does not preclude mental illness. Mental illness is frequently co-morbid with mental retardation, with the prevalence estimated at 30% to 75%. People with disabilities may meet criteria for any DSM diagnosis. Diagnostic criteria are not different for persons with different cognitive capacities.
- 2) “The psychiatric diagnostic evaluation of persons who have MR(DD) is in principle the same as for persons who do not... The diagnostic approaches are modified, depending on the person’s communication skills... The poorer the communication skills, the more one has to depend on information provided by care-givers...”\*
- 3) “The clinician 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, or even occult [not readily observable] injury, to set the stage for behavioral problems.” A physician consultation should be sought as indicated.
- 4) Identify agencies that have previously or are currently providing services for the child/adolescent in order to obtain historical information pertinent to understanding previous assessments and interventions.
- 5) 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 child/youth who displays verbal fluency to not understand

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the meaning of the words. The use of a support person may be required to assist in communication with the child/adolescent. If a support person is required, the clinician should consider the influence that person may have on the communication.

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

## TREATMENT GUIDELINES

- 1) "The principles of psychiatric treatment are the same as for persons without (cognitive dysfunction), but modification of techniques may be necessary according to the individual's communication skills....Mental Health clinicians should actively work with other professionals in the development of the various treatment interventions."
- 2) The treatment setting or placement does not relieve any agency from responsibility to be active participants in the team.
- 3) An assigned staff person should assume primary responsibility for the coordination of treatment between care providers. All providers should work collaboratively and each provider assumes responsibility for appropriate documentation of their services.
- 4) The MR/DD condition neither indicates nor contraindicates the need for psychotherapy, some children/adolescents 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. (The clinician should consider using the approach that he/she would use for a child who is the age that corresponds to the client's developmental age.)
- 5) Psychopharmacology: (Adapted from AACAP guidelines)
  - "The adage "start low, go slow", reflects the observation that [the mechanism of action of a medication is likely to be the same as for any other person, but the dose-response may be different]. For example, persons with Down syndrome may be exquisitely sensitive to anticholinergic drugs, and some persons with MR may be more sensitive to the disinhibiting effects of sedative/hypnotic agents."
  - Symptom suppression should not be at the expense of habilitative function or overall quality of life.
  - Medication should be part of an integrated comprehensive treatment plan.
  - Medication should be appropriate to the diagnosis of record as well as the targeted symptoms.

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- Medication should be regularly reviewed and consideration should be given to the possibility that other active treatment or environmental supports could alter the need for medication.
  - Risks and benefits for the medication should be fully considered within the context of informed consent.
- 6) “A common problem in the treatment of persons with MR(DD) is assessing its effectiveness which may be viewed differently by various [service providers] and caregivers.” Therefore, target symptoms and indicators and treatment goals should be collaborative and reviewed frequently.
- 7) *The client should be helped to understand his/her disability, to the extent possible, while focusing on strengths and abilities.*

*\*Note: Guidelines in quotation are from the American Academy of Child and Adolescent Psychiatry Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Mental Retardation and Comorbid Mental Disorders, 1999. Those cited have been ratified as preferred practices by the UPMHS consensus panel.*

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## **Medication Treatment Services In Utah Public Substance Abuse And Mental Health Agencies**

### **I. Credentials**

1. Prescribers shall be appropriately licensed. They should have advanced experience /training in mental health services.
2. A record of the credentials of mental health prescribers shall be available upon reviewer request.

### **II. Collaboration**

1. In all phases of care the prescriber should seek to involve significant others.
2. Intra-agency collaboration between licensed staff working on the same case shall be done and documented.
3. Extra-agency collaboration efforts with other prescribers should be documented as indicated.

### **III. Assessment**

1. Before prescribing, a prescriber shall document or review a current psychiatric assessment, which includes chief complaint, history of present illness, medical history, family history, substance abuse or dependence problems (including differential diagnoses), and recommended treatment plan including the goals of the medication treatment. The assessment should address the presence of any substantial risk of dangerousness.
2. The prescriber shall make reasonable efforts to keep an updated list of all medications the patient is using, and to comment on possible medication interactions when indicated.
3. Patients on psychotropic medications shall have appropriate testing in order to monitor those medications. For example, patients on anti-psychotic drugs shall have an AIMS test, weight measurement, and blood glucose measurement done and documented no less often than once per year.
4. Ongoing assessments should record a list of current Axis III disorders and document their impact on the care provided.

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#### **IV. Treatment Planning**

1. Collaboration between the prescriber and the patient with a mutual goal of recovery is expected.
2. Informed consent shall be sought and documented with all medication treatments.
  - a. A patient should understand the nature of their illness, the purpose of treatment the potential benefits and material risks involved and the possible consequences of various treatment choices, including psychosocial treatments either in conjunction with medication treatment or as an alternative. Patients should be asked to independently express their own decisions regarding care. It is the prescriber's duty to document this.
  - b. Patients have the right to change their consent decisions and to receive the most efficacious clinical care that can be provided, consistent with their consent decisions.
  - c. Involuntary medication treatment may be provided if a patient is under an order of civil commitment and under a forced medication order. Involuntary medication patients shall be helped to become voluntary through education and support.
3. Provision of medication treatment is a cornerstone of the treatment plan for persons with bipolar disorder, major depression, schizophrenia, and schizoaffective disorder.
4. The use of medications should be considered for a number of other mental disorders including ADHD, various anxiety disorders, substance abuse disorders, impulse control disorders, certain personality traits, etc.
5. It is recommended that patients abusing drugs and alcohol be kept on their antipsychotic and antidepressant medication if those medications would otherwise be prescribed and are not medically contraindicated.
6. Prescribers shall strongly encourage substance-abusing patients to obtain specific treatment for their substance abuse.

#### **V. Treatment Procedures**

1. A prescriber shall see the patient frequently enough to appropriately manage treatment and document progress.
2. Observed medication benefits and side effects shall be charted and communicated to the patient as appropriate.

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3. The prescriber teaches the patient regarding the processes involved in treatment such as how the diagnoses is substantiated, how the medications are monitored, and how decisions are made regarding the recommendation to continue or change treatment.
4. Medication shall be modified / changed at appropriate intervals until optimal results have been achieved. Settling for marginal improvement is undesirable.
5. Poly-pharmacy within drug classes should be avoided unless all appropriate monotherapies have been considered and documentation so indicates.
6. When changing from one medication to another, cross tapering is completed, rather than maintaining treatment with two drugs.
7. If two or more medications from the same class are used simultaneously, the prescriber shall initially and periodically document the necessity for doing so.
8. Reasons for changing medications shall be documented.
9. Inquiry about medication adherence will be made and education / support efforts made to maximize adherence.
10. 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 patients should be assisted, when possible, to obtain medications.
11. If medications are used off label or at non-standard doses, an explanation for doing so should be documented.

## **VI. Documentation**

1. In documentation, medications prescribed are linked to target symptoms, which are linked to supported diagnoses.
2. Chart documentation should be organized so that basic information is readily available to a prescriber during a medication visit.
  - a. The chart indicates the patient's demographics.
  - b. The chart includes a complete history of treatment including what medications were prescribed, when, for how long, and with what effect.

- c. Efforts should be made to obtain all relevant clinical history.
  - d. Current medications prescribed are listed, including:
    - i) target symptoms, date begun, beneficial and adverse effects, dates and reasons for dosage adjustments.
3. An efficient medication record-keeping format, which provides this information, should be developed and implemented by agencies.

## **VII. Review and Quality Improvement**

- 1. Prescribers should be available to quality improvement personnel and reviewers so that they may work together collaboratively to improve care.
- 2. A recommended approach for Agencies to assist their prescribers is that data are collected on practice patterns. These data are used to compare individual prescribers with others in ways that may lead to meaningful quality improvement.
- 3. Prescribers should participate in agency quality improvement activities.