NORTH SOUND MENTAL HEALTH ADMINISTRATION
BOARD OF DIRECTORS MEETING
NSMHA Conference Room
Mount Vernon, WA
October 13, 2005
1:30 PM

AGENDA

Page #/Tab

1. **Call to Order; Introductions – Chair Shelton**

2. **Revisions to Agenda – Chair Shelton 1-3**

3. **Approval of September Minutes – Chair Shelton 4-10**
   Motion # 05-077

4. **Comments & Announcements from the Chair**

5. **Reports from Board Members**

6. **Comments from the Public**

7. **Report from the Advisory Board – Marie Jubie, Chair**

8. **Report from the Executive/Personnel Committee – Dave Gossett, Chair**

9. **Report from the Quality Management Oversight Committee – Gary Williams, Chair 11-25**
   - **Committee recommending approval of revised clinical guidelines – Motion # 05-078**

10. **Report from the Planning Committee – Dave Gossett, Chair….**(will be available at the meeting)….**TAB 1**

11. **Report from the Executive Director – Chuck Benjamin, Executive Director**

12. **Report from the Finance Officer – Bill Whitlock, Fiscal Officer…**(will be available at the meeting)…**TAB 2**

13. **Report from the Finance Committee**

14. **Consent Agenda – Chair Shelton**

All matters listed with the Consent Agenda have been distributed to each Board Member for reading and study, are considered to be routine, and will be enacted by one action of the Board of Directors with no separate discussion. If separate discussion is desired, that item may be removed from the Consent Agenda and placed on the Regular Agenda by request of a Board Member.

Motion # 05-079
To review and approve North Sound Mental Health Administration's claims paid from September 1, 2005 through September 30, 2005 in the amount of $(will be available at the meeting). Payroll for the month of September in the amount of $(will be available at the meeting) and associated employer paid benefits in the amount of $(will be available at the meeting).

15. Action Items Not Yet Reviewed by the Board
Motion # 05-080
To review and approve NSMHA-UBH-04, Amendment 1. United Behavioral Health provides medical director services for NSMHA. The amendment extends the term of the contract to 12/31/06. Total maximum consideration is amended as follows: Maximum consideration in section II.A shall not exceed $30,000 for 2004, $30,000 for 2005 and $30,000 for 2006, for a total maximum consideration of $90,000.

Motion # 05-081
To review and approve contract number NSMHA-ISLAND-JAIL SERVICES-05-06. The purpose of the contract is to implement, in Island County, the Jail Services program approved by the legislature and funded, with specific terms and conditions, through NSMHA's contract with MHD. The term of the contract is September 1, 2005 to August 31, 2006. Total consideration is $45,000

Motion # 05-082
To review and approve contract number NSMHA-SAN JUAN-JAIL SERVICES-05-06. The purpose of the contract is to implement, in San Juan County, the Jail Services program approved by the legislature and funded, with specific terms and conditions, through NSMHA's contract with MHD. The term of the contract is September 1, 2005 to August 31, 2006. Total consideration is $45,000

Motion # 05-083
To review and approve contract number NSMHA-SKAGIT-JAIL SERVICES-05-06. The purpose of the contract is to implement, in Skagit County, the Jail Services program approved by the legislature and funded, with specific terms and conditions, through NSMHA's contract with MHD. The term of the contract is September 1, 2005 to August 31, 2006. Total consideration is $85,530

Motion # 05-084
To review and approve contract number NSMHA-SNOHOMISH -JAIL SERVICES-05-06. The purpose of the contract is to implement, in Snohomish County, the Jail Services program approved by the legislature and funded, with specific terms and conditions, through NSMHA's contract with MHD. The term of the contract is September 1, 2005 to August 31, 2006. Total consideration is $491,795

Motion # 05-085
To review and approve contract number NSMHA-WHATCOM-JAIL SERVICES-05-06. The purpose of the contract is to implement, in Whatcom County, the Jail Services program approved by the legislature and funded, with specific terms and conditions, through NSMHA's contract with MHD. The term of the contract is September 1, 2005 to August 31, 2006. Total consideration is $135,422

Motion # 05-086
To authorize the NSMHA Executive Director to enter into Contract #NSMHA-MAGILL-PSC-2006, between NSMHA and Sam Magill. NSMHA is purchasing consulting and facilitation services related to the 2006 Recovery and Resiliency Conference and the 2006 Board of Directors Retreat. The term of the contract is November 1, 2005 to January 31, 2006. Maximum Consideration is $7,800.

Motion # 05-087
To review and approve NSMHA-Radosevich-04, amendment 2. This contract is for legal services provided by Davis Wright Tremaine, primarily for WMIP litigation. Total maximum consideration is increased from $25,000 to $44,000.

16. Introduction Items
The contracts/items for approval listed below will be introduced at the October 13, 2005 meeting of the Board of Directors for review.

Action will be taken on the follow item at the November 10, 2005 Board of Directors meeting.
NSMHA Strategic Plan 2006-2009

Action will be taken on the following items at the December 8, 2005 Board of Directors meeting.
NSMHA Proposed Budget 2006
NSMHA-APN-Medicaid Contract
NSMHA-APN-State Mental Health Contract
NSMHA-SEA MAR-Medicaid Contract
NSMHA-SEA MAR-State Mental Health Contract
NSMHA-ISLAND COUNTY-Administrative Services Contract
NSMHA-SAN JUAN COUNTY-Administrative Services Contract
NSMHA-SKAGIT COUNTY-Administrative Services Contract
NSMHA-SNOHOMISH COUNTY-Medicaid Contract
NSMHA-SNOHOMISH COUNTY-State Mental Health Contract
NSMHA-WHATCOM COUNTY-Administrative Services Contract
NSMHA-VOLUNTEERS OF AMERICA-Medicaid Contract
NSMHA-VOLUNTEERS OF AMERICA-State Mental Health Contract

17. Executive Session

18. Adjournment – Chair

NOTE: The next Board of Directors meeting November 10, 2005, at 1:30 p.m. in the NSMHA Conference Room, 117 N. 1st Street, Suite 8, Mount Vernon, WA

NORTH SOUND MENTAL HEALTH ADMINISTRATION
BOARD OF DIRECTORS MEETING
NSMHA Conference Room
Mount Vernon, WA
September 8, 2005
1:30 PM

MINUTES

Members Present:
Mike Shelton, Island County Commissioner
Regina Delahunt, designated alternate for Whatcom County Executive, Pete Kremen
Janelle Sgrignoli, designated alternate for Snohomish County Executive, Aaron Reardon
Gary Williams, designated alternate for Whatcom County Council member, Ward Nelson
Sharie Freemantle, designated alternate for Snohomish County Council member, John Koster
Kirke Sievers, Snohomish County Council member
John Manning, designated alternate for San Juan County Commissioner vacant position
Marie Jubie, NSMHA Advisory Board Chair person
Ken Dahlstedt, Skagit County Commissioner
June LaMarr, The Tulalip Tribes

Staff Present:
Chuck Benjamin, Greg Long, Annette Calder, Bill Whitlock, Wendy Klamp, Deirdre Ridgway, Margaret Rojas, Chuck Davis, Deborah Moskowitz

Guests:
Mike Manley, Tom MacIntyre, Andy Byrne, Laurel Britt, Kristen Stout, Sheryl Petrie, Patrick Murphy, James Cooper, Andrew Davis, Matt Wood, John Coy

1. Call to Order; Introductions – Chair Shelton
Chair Shelton called the meeting to order at 1:30 p.m.; introductions were made.

2. Revisions to Agenda – Chair Shelton
None.

3. Approval of August Minutes – Chair Shelton
Chair Shelton asked if there were any changes to the August minutes; there were none. Motion by Ms. Delahunt, seconded by Ms. Sgrignoli, all in favor, **Motion Carried (# 05-062).**

4. Comments & Announcements from the Chair

- **Poster Contest Awards**

  Chair Shelton addressed the group regarding the NSMHA annual Poster Contest. He stated the three winners would be presented with certificates and prizes today. Chair Shelton read a description of each poster and awarded each winner with certificates. Chuck Benjamin echoed Chair Shelton's comments about the poster contest being one of the highlights of the year every year.

5. Reports from Board Members
None.

6. Comments from the Public
John Coy, Clinician from Whatcom Counseling and Psychiatric Clinic (WCPC) stated he was here to comment on the WMIP and the impact it is having on Whatcom Counseling and the mental health consumers of Whatcom County. He said he was excited when he heard of a project such as WMIP integrating medical and mental health services. It is clear that the separation of medical services and mental health services causes impairments for clients receiving services. He said when the details of WMIP came out he was discouraged to learn that there is no real level integration in those services; that Molina is providing the medical services and subcontracting mental health services to Compass Health. He said instead of integration we have status quo. There are further problems with the project, specifically in the area of funding. Mr. Coy addressed all in the room and asked if any of his facts were incorrect to please correct him. At the full level of enrollment the WMIP project could serve about 5% of the enrolled consumers, NSMHA is losing approximately 14% of its funding. Mr. Coy stated that the funding will come out of the total RSN budget. The impact on Whatcom County, even though they have no consumers enrolling in the WMIP project, WCPC could lose up to 14% of its funding at the current allocation of Medicaid funding. He said this will cause staff layoffs within his agency and increased caseloads for the remaining clinicians and a decrease in services to all consumers the clinicians are providing services for. Mr. Coy said he would like NSMHA to use its influence to mitigate the financial impact this project will have on WCPC and Whatcom County's mental health consumers. Chair Shelton thanked Mr. Coy for his comments and said the Board of Directors also share Mr. Coy's concerns.

Matt Wood, SEIU 1199 Northwest the union that represents Whatcom Counseling and Psychiatric Clinic as well as Compass Health. Mr. Wood said he is here today on behalf of 1,000 mental health workers throughout the state of Washington kind of echoing Mr. Coy's comments. Mr. Wood said he understands that agencies throughout the North Sound RSN are about to receive funding cuts due to the implementation of the WMIP project. SEIU 1199 urges members of the Board of Directors to work closely with the APN and individual providers to ensure that any distribution of cuts is carried out in such a way that minimizes the impacts to the clients that we serve in this region. Secondly, SEIU 1199 Northwest urges all join the union within their organization and other mental health stakeholders in lobbying the legislature in the supplemental budget of 2006. Chair Shelton thanked Mr. Wood for his comments and asked if there were any others who would like to address the Board of Directors; there were none.

7. Report from the Advisory Board – Marie Jubie, Chair
Marie Jubie reported on the September 6, 2005 NSMHA Advisory Board meeting stating they had a presentation from Whatcom Counseling and Psychiatric Clinic on PATH. The Advisory Board approved the minutes of their August meeting, had a presentation on transitional housing in Whatcom County, approved financial claims, raised money for Hurricane Katrina victims and donated it to the Red Cross, reviewed the new structure of DSHS, and are organizing a coalition of people to go to Olympia and lobby for mental health. The Advisory Board approved the action items before this Board today. Need new representatives from San Juan County on the NSMHA Advisory Board. Ms. Jubie was thanked for her report.

8. Report from the Executive/Personnel Committee – Dave Gossett, Chair
Chair Shelton said the Executive Personnel Committee met today and there is one issue he would like Chuck Benjamin to present.

Mr. Benjamin said the issue has to do with a Quality Specialist position and provided some background information stating this was a position that was contracted from Snohomish County to the NSMHA. Snohomish County was unable to fill and fund the position so it was decided to transfer the position back to NSMHA. One of the conditions placed on the transfer of the position by the Executive Personnel Committee was that it did not increase the NSMHA budget. Mr. Benjamin said a plan has been developed to move this position to NSMHA. NSMHA has a vacant Quality Review Team position. The Ombuds and QRT that are remaining are being transferred to Skagit County (pending approval of Skagit County Commissioners) per new laws passed by the legislature. Mr. Benjamin asked the Executive Committee to approve the Quality Specialist position adding an FTE to our budget, with no budget increase. Chair Shelton asked what the pleasure of the Board was. Mr. Sievers made a motion to approve the hiring of one FTE in the Quality Management Department, seconded by Ms. Sgrignoli, no further discussion, all in favor, **Motion Carried (#05-063).**

9. Report from the Quality Management Oversight Committee – Gary Williams, Chair

Mr. Williams stated that the Quality Management Oversight Committee did not meet in August.

- **Committee recommending approval of revised clinical guidelines**

Mr. Williams stated two new guidelines have been added to the Clinical Guidelines; due to some misunderstanding the new Guidelines were not included in the meeting packet. The motion to approve the revised NSMHA Clinical Guidelines was postponed until the October 13, 2005 meeting of the Board of Directors.

10. Report from the Planning Committee – Dave Gossett, Chair

Greg Long reported that the Planning Committee has a meeting scheduled for Friday, September 16th at 9:00 in Everett. The principle issues will be Crisis Services in Snohomish County and the development of the NSMHA Strategic Plan. A workgroup of the Planning Committee met twice studying crisis services in Snohomish County. The online survey regarding services to be funded with State Funding is completed and the data is being analyzed. The two top priorities of the survey are increasing residential and housing options and re-opening some services to low income people without Medicaid. Mr. Long was thanked for his report.

11. Report from the Executive Director – Chuck Benjamin, Executive Director

Chuck Benjamin said he always likes to start out with a Vision of Hope and Path to Recovery noting it was much easier to do that today with the Poster Contest winners present and thanked them for being here. He reported that NSMHA has signed its contract with MHD and are currently negotiating contracts with the providers and counties.

Mr. Benjamin said regarding the Washington Medicaid Integration Partnership (WMIP) project and stated that NSMHA lost its lawsuit against DSHS. He said now we need to change our direction and work with Molina and DSHS to minimize any impacts this will have on the consumers. He said the funding impacts could be anywhere from $2.6 million up to $7 million or higher depending on the number of enrollees in the program. Mr. Benjamin said he would continue updating the Board of Directors as information is received.

Mr. Benjamin said he is very happy about the chemical dependency/mental health crisis response pilot that NSMHA is involved in. He said this adds a resource of an addition 16 beds for our region.

Mr. Benjamin said the Mental Health Task Force (MHTF) is continuing and he will be attending another meeting this in October. Mr. Benjamin distributed information on Medicaid Services that he had received from the Bazelon Center an alert about the federal government proposing changing case management from a

service to an administrative provision; this would have a tremendous impact and decreased funding if this passes.

Mr. Benjamin discussed the NSMHA Recovery Conference scheduled for January 2006 and shared the background of the keynote speaker. He said NSMHA is receiving increased funding for jail services and he has been working with the County Coordinators regarding the use and distribution of the funding.

Mr. Benjamin referenced Hurricane Katrina, its victims and first responders, asking all to keep everyone in their prayers, as this will be a long, ongoing process. Mr. Benjamin was thanked for his report.

12. Report from the Finance Officer – Bill Whitlock, Fiscal Officer

Bill Whitlock reported that the August financial statements show our revenue budget is in line with expectations. The Federal Grants are $11,388 under budget and the DDD grant is $50 under budget. The expenditures all have positive variances except for insurance and miscellaneous expense. Insurance is a timing difference. Miscellaneous has a negative variance of $8,034. The agency, county and other service budget is over by $47,054. The $66,000 budget reduction passed at the May 2005 Board of Directors meeting is shown in red as an administrative reserve on the NSMHA operating budget.

The Enhanced Community Services (ECS) contracts have been changed. The Older Adult contract has been cancelled as of June 30, 2005. The state Aging and Adult Services Administration (AASA) is contracting directly with the providers for these services. The MHD ECS contract reduced the monthly payment from $54,368 to $15,630. The new amount represents the State-only portion of the ECS service.

The WMIP reductions for the 2006 calendar year are estimated to be $2,872,632. This assumes 2,294 current enrollees. A loss of $7,053,000 would be estimated if the maximum 6,000 enrollees were used.

In September we received our first installment of the Hospital Rate increase payment. These funds are supposed to offset the increased inpatient costs associated with raising the minimum daily hospital bed rate. However, we are receiving the payment now and the state is not increasing its "estimated utilization" deduction. This is the amount they deduct each month for inpatient costs. The State suggested we reserve the funds and pay them out when we incur the increased expense. The rates went up in July 2005 and the first expense reconciliation period would be in February 2007; 18 months from now. Mr. Whitlock was thanked for his report.

13. Report from the Finance Committee

Gary Williams stated the Finance Committee met today and is recommending approval of the consent agenda. A motion to approve the consent agenda, motion #05-064 by Mr. Sievers, seconded by Mr. Manning, all in favor, **Motion Carried.**

A motion (**#05-075**) was made by Mr. Williams to put the Hospital Rate Increase funding into an inpatient reserve and use the funds to offset the increase in inpatient costs. The funds would be paid out on a 1/12 basis starting with the 18-month close out for the period of July 2005. Motion seconded by Mr. Sievers, opened for discussion, Chair called for the vote, all in favor, **Motion Carried.**

14. Consent Agenda – Chair Shelton

All matters listed with the Consent Agenda have been distributed to each Board Member for reading and study, are considered to be routine, and will be enacted by one action of the Board of Directors with no separate discussion. If separate discussion is desired, that item may be removed from the Consent Agenda and placed on the Regular Agenda by request of a Board Member.

Motion # 05-064
To review and approve North Sound Mental Health Administration's claims paid from August 1, 2005 through August 31, 2005 in the amount of $3,158,797.48. Payroll for the month of August in the amount of $74,465.13 and associated employer paid benefits in the amount of $(not available at time of the meeting) estimated at $22,842.00.

15. Action Items Not Yet Reviewed by the Board
Motion # 05-065
To review and approve amendment #4 to contract number NSMHA-APN-04-05. This amendment removes responsibilities for inpatient certification and includes a carve out from APN funding to pay for the services to be provided by another vendor.

Motion # 05-066
To review and approve amendment #3 to contract number NSMHA-VOA-04-05. This amendment adds responsibilities and funding for the provision of inpatient certification services.

Mr. Benjamin stated motions 05-065 and 05-066 were related and explained due to new laws this change needs to be made. Motion by Ms. Delahunt to approve motions 05-065 and 05-066, seconded by Mr. Manning, all in favor, **Motion Carried.**

Motion # 05-067
To review and approve the amended NSMHA Advisory Board Bylaws.

Mr. Benjamin said the Advisory Board revised and approved their Bylaws and is recommending approval by the Board of Directors. A motion to approve was made by Mr. Sievers, seconded by Mr. Williams, all in favor, **Motion Carried.**

Motion # 05-068
To review and approve NSMHA-Skagit County-Mediation-2005 contract. This was originally approved in August 2005 under motion # 05-057 as an amendment to the current Skagit County contract. Since that time Skagit County has requested a separate contract. The maximum total consideration is $51,419 for September 1, 2005 to December 31, 2005.

Mr. Benjamin said this motion is pending approval of the Skagit County Commissioners and provided some background. Motion by Mr. Sievers, seconded by Ms. Sgrignoli, all in favor, **Motion Carried.**

Motion # 05-069
To authorize NSMHA Executive Director to enter into contract 0569-81757 between NSMHA and DDD effective 10/01/05 to 6/30/07. This contract continues the Department of Social and Health Services Division of Developmental Disabilities (DDD) and Mental Health Division Collaborative Work Plan – improve short-term, episodic crisis prevention, interventions and stabilization mental health services to

registered DDD clients. Via this contract DDD is purchasing enhanced services for DDD clients. The funding breaks down as follows:

Crisis stabilization services = 19,013.89/month
Medication monitoring = $5,505.56/ month
Psychiatric/medication consultation services = $5,105.56/month

Approved under motion #05-071

Motion # 05-070
To review and approve NSMHA-APN-DD contract between NSMHA and APN effective 10/01/05 to 06/30/07. This contract continues the Department of Social and Health Services Division of Developmental Disabilities (DDD) and Mental Health Division Collaborative Work Plan – improve short-term, episodic crisis prevention, interventions and stabilization mental health services to registered DDD clients. Via this contract DDD is purchasing enhanced services for DDD clients.

Approved under motion # 05-071

Motion # 05-071
To review and approve NSMHA-VOA-DD contract between NSMHA and Volunteers of America effective 10/01/05 to 06/30/07. This contract continues the Department of Social and Health Services Division of Developmental Disabilities (DDD) and Mental Health Division Collaborative Work Plan – improve short-term, episodic crisis prevention, interventions and stabilization mental health services to registered DDD clients. Via this contract DDD is purchasing enhanced services for DDD clients.

Mr. Benjamin stated Motions 05-069, 05-070 and 05-071 are all related; he provided background information on the motions. Chair Shelton asked the Board of Directors how they would like to proceed on these motions. A motion was made by Mr. Sievers, seconded by Mr. Dahlstedt to approve motions 05-069, 05-070 and 05-071, all in favor, **Motion Carried.**

Motion # 05-072
To review and approve the Interlocal Agreement # 0569-82559 Transition From Homelessness (PATH) contract between North Sound Mental Health Administration and the Department of Social and Health Services.

Approved under motion #05-074

Motion # 05-073
To review and approve NSMHA-Compass Health-PATH 06, providing PATH funding in accordance with the DSHS grant from 10/01/05 through 9/30/2006.

Approved under motion #05-074

Motion # 05-074
To review and approve NSMHA-Whatcom Counseling & Psychiatric Clinic-PATH 06, providing PATH funding in accordance with the DSHS grant from 10/01/05 through 9/30/2006.

Mr. Benjamin stated motions 05-072, 05-073 and 05-074 were all related. Mr. Long provided some background information. Chair Shelton asked the Board of Director how they would like to proceed. A

motion was made by Mr. Manning to approve motions 05-072, 05-073 and 05-074, seconded by Mr. Williams, all in favor, **Motion Carried.**

16. Introduction Items
None.

17. Executive Session
None.

18. Adjournment – Chair
Chair Shelton adjourned the meeting at 2:20 p.m.

Respectfully submitted:

Annette Calder
Executive Assistant

NOTE: The next Board of Directors meeting October 13, 2005, at 1:30 p.m. in the NSMHA Conference Room, 117 N. 1st Street, Suite 8, Mount Vernon, WA

North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
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North Sound Mental Health Administration

Clinical Guidelines

Effective October 1, 2005

Table of Contents

North Sound Mental Health Administration
Statement of Intent, Mission and Values

The North Sound Mental Health Administration mission statement is as follows: "*We join together to enhance our community's mental health and support recovery for people with mental illness served in the North Sound region, through high quality culturally competent services.*"

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

These clinical guidelines are **not** to be construed to limit the individualization of treatment, clinician judgment or the ability of the clinician to provide treatment in the best interests of the client. Provision of treatment may be qualified by limitations of payment sources and funding.

The basis for these guidelines is the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) however we recognize that symptoms and clinical presentation do not always meet clear DSM IV-TR diagnostic criteria and response to clinical intervention is not uniform.

Any clinical intervention requires the clinician to adapt a treatment program based on medical necessity and individualized for each client. Guidelines are based on evolving scientific research and experience. Consequently, these guidelines will be reviewed and updated periodically.

All should be considered guidelines only, and we realize that adherence to them does not guarantee a successful outcome, nor should they be construed as including all the proper methods of care or excluding other acceptable methods of care aimed at the same results.

Please note that these guidelines are qualified by the limitations of payment sources and funding as designated through current contracts, state WAC and RCW standards and Federal requirements.

These clinical guidelines have been developed for the predominant diagnosis categories served in our region in collaboration with the Associated Provider Network, Compass Health, Sea Mar, Lake Whatcom RTC, Whatcom Counseling and Psychiatric Clinic, bridgeways, Snohomish County ITA, Volunteers of America and the Tulalip Tribe, our contracted providers.

CORE VALUES AND PRINCIPLES – KEY ELEMENTS OF CONSUMER CARE

Eligibility / Access

- Eligible Consumers shall have timely access to medically necessary Mental Health Services and supports.
- NSMHA requires a no decline policy that assures the provision of medically necessary mental health services to eligible consumers.
- There shall be a single entry point by which services are most easily accessed. Such entry point shall be provided on a 24 hour, 365-day basis throughout the region (including regional crisis line).
- All parts of the mental health system will assist consumers in obtaining access to appropriate services.
- Consumer access to specific mental health support or treatment services shall not be dependent on consumer willingness to participate in other (concurrent) treatment options. *Exception: Shelter Plus Care*

Consumer Services / Consumer Rights

- Consumer services shall, at all times, be provided with dignity, respect, courtesy, and fairness.
- Consumer participation, voice, and satisfaction with services shall be a valued goal.
- Consumer's individual and cultural differences shall be honored through culturally competent service provision.
- Continuity of care shall be provided with seamless access.
- Consumer confidentiality shall be respected and preserved.
- Consumers shall be provided with maximum alternatives and choice in matters of their care.
- There shall be an integrated inpatient/outpatient system.
- Homeless consumers shall be provided with mental health services.
- The NSMHA supports the Mental Health Division Consumer Rights at the provider level
- Active provider outreach and engagement for enrolled or unserved consumers are required.
- Mental Health crisis workers shall have access to current crisis plans and individual treatment plans at all times. The NSMHA supports a meaningful information system for all mental health professionals that provides ready access to information regarding the specific consumer's crisis plans and individualized treatment plans.
- There shall be comprehensive complaint and grievance service made available (and tracked) at all levels of the system.

Strength Based Services

- Consumers' skills, capabilities, strengths, and assets will be recognized and utilized in the individual service plan. Services provided in partnership between consumer, provider and other systems.
- Families, communities, and natural supports will be valued and utilized in serving the needs of consumers.
- It is in the best interest for consumers to live as independently as possible in communities and settings of their choice. Consumers' mental health improves when they participate in and increasingly assume responsibility for their own care.
- A range of residential services and housing supports shall be provided, emphasizing least restrictive, stable living options that are age, culturally, and linguistically appropriate. "Housing" is defined in WAC 388.
- Consumers shall be assisted with engaging in meaningful daily activities. This could include volunteerism and active participation in their community and proactive assistance in educational and employment services.

Mental health systems and services improve when consumers participate in planning and quality assurance at all levels.

- People with mental illness are best served by people who care about them.

The NSMHA and its providers are committed to safety of:

  - Public
  - Consumer
  - Staff

Collaboration

- NSMHA and its contractors will work in collaboration with other systems to meet the needs of the whole person.
- Services shall proactively follow mental health consumers, regardless of setting (wherever they are) in the mental health or physical health system.
- Mentally ill consumers in the justice system shall have access to mental health services.

Education

- The importance of community education programs about mental health issues is a core value.
- NSMHA and its providers will educate the public about the scope of available services, service locations, crisis response services, client rights and responsibilities.
- The NSMHA and its providers shall actively promote public education regarding mental health and stigma reduction.

Consumers, family members, NSMHA and its contractors shall advocate for consumer rights, funding for services, and quality

- Both NSMHA and its Member Counties provide technical assistance to all parties in the Region.

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

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

Adult-Bipolar Disorders (DSM IV-TR codes 296.xx, 296.89, 301.13, 296.80)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Bipolar disorder is characterized by disturbances in mood polarity with associated changes in cognition, affect, concentration, psychomotor behaviors, neuro-vegetative symptoms, self-esteem, interest and judgment.** **2. Bipolar disorder is characterized by one or more Manic or Mixed Episodes and often includes on or more Major Depressive episodes. Cyclothymia is characterized by fewer less severe periods of depressive and manic symptoms over at least a 2 year period.** **3. Disorder is equally common in both sexes.** **4. Onset is usually during adolescence or early adulthood. A first manic episode after forty indicates a possible medical or substance-related etiology.** **5. Higher prevalence of the disorder for people who have first degree biological relatives with Bipolar Disorder.** **6. Screen for other conditions that are co-morbid or may be confused with Bipolar disorder (e. g. substance use, medical conditions like Multiple Sclerosis, hypothyroidism, other mood disorders and psychotic disorders.** **7. Assess suicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Treatment plan includes interventions consistent with the level of risk for self-harm.** **3. Case management services may be helpful for coordination and family support and advocacy.** **4. Individual and/or group psychotherapy can be provided to promote mood stabilization and build on mood management skills, provide skill building and support.** **5. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **6. Varied employment strategies including prevocational and supported employment to assist clients ready to pursue employment.** **7. Co-occurring disorder treatment as indicated.** **8. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **9. Because of the chronic nature of the disorder, treatment may be long term. Relapse prevention should be included in treatment planning.** **10. Residential Treatment/Housing/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing.** **11. Inpatient services for acute stabilization as necessary.**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **Associated Provider Network** **Wyoming Public Mental health System Guidelines**

Adult- Depressive Disorders (DSM IV-TR codes 296.2x-296.3x)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Major Depression: Characterized by disturbances in affect, interest, neuro-vegetative symptoms, concentration, psychomotor behavior and self-esteem** **2. Average age of onset is mid-twenties** **3. Disorder is more common in women** **4. Number of past episodes is predictive of likelihood of subsequent episodes (e.g. 50-60% chance of second episode after a first episode, 70% chance of third episode after a second and 90% chance of fourth episode after a third)** **5. Higher prevalence of the disorder for people with first degree biological relatives with Major Depression** **6. Screen for other conditions that may be co-morbid or may be confused with Major Depressive Disorder (e.g. substance abuse, organic conditions, dementia with older adults, other mood disorder and schizoaffective or other psychotic disorders** **7. Assess suicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Treatment plan includes interventions consistent with the level of risk for self-harm.** **3. Case management services may be helpful for coordination and family support and advocacy.** **4. Individual and/or group psychotherapy can be provided.** **5. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **6. Varied employment strategies including prevocational and supported employment to assist clients ready to pursue employment.** **7. Co-occurring disorder treatment as indicated.** **8. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **9. Residential Treatment/Housing Support/Respite/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing.** **10. Inpatient services for acute stabilization as necessary**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **American Academy of Family Physicians** **Associated Provider Network** **Wyoming Public Mental health System Guidelines**

Adult-Schizophrenia and other Psychotic Disorders (DSM IV-TR codes 295.xx, 295.4x)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Schizophrenia is not characterized by a single feature but by many disturbances in the following areas: content and form of thought, perception, affect, sense of self, volition, relationships to the external world, psychomotor behaviors.** **2. Typically there is no disturbance in the level of consciousness.** **3. Onset is usually during adolescence or early adulthood, however it may also begin in middle or late adult life.** **4. Disorder is equally common in both sexes.** **5. Higher prevalence of the disorder for people who have first degree biological relatives with Schizophrenia.** **6. Screen for other conditions that are co-morbid or may be confused with Schizophrenia (e.g. Delirium, dementia, substance use, pervasive developmental disorder and other psychotic disorders.)** **7. Clients need to be periodically assessed for substance abuse.** **8. Assess risk to self and others at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. The treatment plan includes a strategy to prevent psychotic episodes. The strategy includes assisting the client and support persons in recognizing early signs and symptoms of an episode, adhering to the treatment plan (including taking prescribed medication) and accessing timely assistance. The strategy is updated as needed.** **2. The treatment plan includes at a minimum assessment of the need for medication.** **3. Case management services may be helpful for coordination and family support and advocacy.** **4. The client will be monitored for side effects and/or medication non-compliance. Should these problems occur the treatment plan will address them.** **5. For persons at risk of tardive dyskinesia, there is ongoing assessment for involuntary movements.** **6. Clients hesitant to stay engaged in mental health services may need specialized outreach sensitive to their needs and preferences.** **7. Individual intervention: Case management interventions of varying degrees of intensity based upon medical necessity to build skills and symptom management. Therapy with clients may include assisting the client to address issues of loss, previous treatment experiences, relationship issues, parenting skills, self-image and co-occurring conditions.** **8. Group Intervention: Combinations of skill building, support and educational groups to promote skill building and symptom management.** **9. Employment/Vocational Services: Varied employment strategies including pre-vocational activities to assist clients wishing to pursue employment** **10. Residential Treatment/Housing Support/Respite/Crisis beds: For those requiring 24 hour care or access to appropriate community-based housing resources.** **11. Co-occurring Disorder Treatment: Integrated treatment into a standard chemical dependency program or standard chemical dependency treatment plus separate program for schizophrenia.** **12. Education: For client and significant others or support persons regarding schizophrenia, symptoms, treatment and prognosis. Referral to NAMI or similar programs or groups may assist clients, families and significant others to obtain specific training programs and support.** **13. Crisis Planning: Individualized crisis plan focusing on early symptoms of decompensation, safety and management strategies.** **14. Inpatient Services for acute stabilization as needed.**
Optimal Outcome of Treatment	**As a result of treatment, clients learn to manage their illness, live independently in their environment of choice and engage in activities of choice which are integrated in the community with minimal need for support or treatment. Ongoing satisfaction with quality of life is important to the recovery process.**
References	**DSM IV-TR Wyoming Public Mental health System Guidelines** **American Psychiatric Association** **King County Mental Health Plan** **Associated Provider Network** **The Expert Consensus Guideline Series: Treatment of Schizophrenia, The Journal of Clinical Psychiatry, 1996** **Surviving Schizophrenia: A Family Manual by E. Fuller Torrey**

Adult-Anxiety Disorders (DSM IV-TR 300.00, 300.01, 300.02, 300.3, 300.21, 300.22, 300.23, 300.29, 308.3 309.81,)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Clients with Anxiety Disorders often self-medicate. Clinicians should assess for use or abuse of over-the-counter, prescription, or street drugs and alcohol.** **2. Clients with anxiety symptoms should also be assessed for depression.** **3. Many anxiety disorders run in families. For example, first-degree biological relatives of individuals with Panic Disorder are up to 8 times more likely to develop Panic Disorder.** **4. There is considerable cultural variation in the expression of anxiety.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Many clients, due to the discomfort of the anxiety symptoms become avoidant of anxiety-inducing situations, including mental health treatment. A priority of treatment is to establish a collaborative relationship which emphasizes rapport building and hope.** **3. Treatment plan includes interventions consistent with the level of risk for self-harm.** **4. Case management services may be helpful for coordination and family support and advocacy.** **5. Individual and/or group psychotherapy can be provided to promote mood stabilization and build on anxiety management skills, and provide support.** **6. Cognitive-behavioral approaches should be considered.** **7. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **8. Co-occurring disorder treatment as indicated** **9. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **10. Inpatient services for acute stabilization as necessary.**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **Associated Provider Network** **Wyoming Public Mental health System Guidelines**

Adult Dementia (DSM IV codes – 290.1x – 290.4x, 294.x) PAGE ONE	
Diagnostic Features	**Consistent with DSM IV –TR criteria.** **Dementia is a complex and multi-dimensional neuro-biological disorder with many symptoms common to other conditions such as depression, anxiety, psychosis, etc.** **The essential feature of dementia is the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: aphasia, apraxia, agnosia, or a disturbance in executive functioning. (More complex presentations can include memory impairment plus fluctuations in cognition, recurrent visual hallucinations, agitation, motor rigidity or restlessness and fluctuations in motor function.) The disturbances must be sufficiently severe to cause impairment in functioning and represent a decline from a previously higher level of functioning. Some types of dementia include Alzheimer's, Vascular, Dementia due to Parkinson's, Dementia due to Lewy Body Disease.**
Assessment Components and Considerations	**A. The age at onset of dementia depends on the etiology, but is usually late in life, with the highest prevalence above age 85. Dementia is uncommon in children but can occur as the result of general medical conditions such as head trauma, brain tumors, etc.** **B. Because of the difficulty of obtaining direct pathological evidence of the presence of Alzheimer's disease, the diagnosis can be made only when other etiologies for the dementia have been ruled out.** **C. Screen for other conditions that are co-morbid or may be confused with dementia, such as Major Depressive Disorder, Schizophrenia, and delirium.** **D. The course of dementia varies based on etiology. Alzheimer's type tends to be slowly progressive, and may include personality changes or increased irritability in the early stages. Vascular dementia usually has an abrupt onset, with step-like changes, although it can present with an insidious onset and gradual decline, similar to Alzheimer's.** **E. Dementia can result from causes other than Alzheimer's or vascular disease. Other causes of dementia coded in the DSM-IV include HIV Disease, Head Trauma, Parkinson's Disease, Huntington's Disease, Pick's Disease, Creutzfeldt-Jakob Disease, and Other General Medical Conditions. Differential diagnosis requires a corresponding medical diagnosis, from which the dementia is judged to originate.** **F. Substance-induced Persisting Dementia carries the same set of cognitive deficits but there is evidence from history, physical examination, or laboratory findings that the deficits are etiologically related to the persisting effects of substance use. In such cases pre-existing developmental or organic deficits should be ruled out. Dementia-related symptoms in individuals with known substance use/abuse must be assessed differentially to distinguish transient symptomatology from residual dementia which may be persistent.** **G. In some cases, dementia may result from multiple etiologies.**
	Dementia (DSM IV codes – 290.1x – 290.4x, 294.x) PAGE TWO

Treatment Guidelines	**Although a diagnosis of dementia does not by default indicate that mental health services are necessary or appropriate, a number of symptoms associated with dementia may be present which require intervention. These symptoms may include sleep disturbances, psychosis, anger and aggression, depression, and anxiety, among others.** **A. Medical Referral: Confirm with the individual's primary physician that a screening for medical issues has been completed to rule out alternative causes of confusion, behavior changes and memory loss. Screening may include B-12 level, thyroid function panel including TSH, serum electrolytes, urinalysis for UTI, CBC with differential to check for other signs of infectious or metabolic disease, and CT scan or MRI, among others. If screening has not occurred, request that the individual's primary physician do so.** **B. Individual Intervention: Except in the earliest stages of the disease, individual therapy is rarely indicated, as the dementia tends to rob the individual of insight into their own condition, as well as the ability to process new information and modify their own behavior. Reminiscence therapy and validation therapy have been shown to be effective approaches.** **C. Behavior-oriented approaches: Although there are limited data from formal assessments of these treatments, there is widespread agreement that behavioral approaches can be effective in lessening or abolishing problem behaviors.** **D. Family/Caregiver Consultation: The individual's natural supports, if any, are a significant part of treatment. Educate the family and caregivers regarding dementia, symptoms, treatment and prognosis. Help them connect to community resources. Provide information about behavioral and environmental interventions designed to support the individual with dementia. Educate family/caregivers to the risks to themselves for mood disorders, i.e. "caregiver burnout," and the need to maintain their own health for the stability and longevity of both themselves and the individual with dementia. Help family/caregivers locate support services for themselves as appropriate.** **E. Group Intervention: Support groups are appropriate for both the client and the family/caregivers, although it is preferable that these groups be separate to allow a free expression of concerns, especially by family/caregivers.** **F. Psychiatric Assessment: As appropriate to determine indication for medication or for medical stabilization.** **G. Employment/Vocational Services: Vocational services are rarely indicated for these clients. For individuals still working, information about planning for retirement may be appropriate.** **H. Residential Treatment/Housing/Crisis Beds: Assess appropriateness of current housing for safety and supervision needs. If individual lives alone, assess environment for hazards, i.e. decaying food, pet feces, fall risk, firearms, kitchen and home heating safety, etc. If individual lives with family or caregivers, educate them to potential hazards and how these hazards might be mitigated. Assist client and family/caregivers with planning for future housing needs in anticipation of disease progression.** **I. Co-Occurring Disorder Treatment: Chemical dependency treatment is rarely indicated for the same reasons that individual therapy is not. Management of a chemical dependency is best accomplished through the use of environmental interventions, i.e. limiting access to the substance and providing significant amounts of supervision.** **J. Crisis Planning: Individualized crisis plan focusing on early symptoms of decompensation, safety and management strategies.** **K. Inpatient Services: For acute stabilization as necessary.**
Optimal Outcome of Treatment	**The client will remain as functionally independent as the disease progression allows, and will experience a minimal amount of emotional and behavioral disturbance related to the disorder.**
References	**Associated Provider Network** **Diagnostic and Statistical Manual of Mental Disorders, fourth edition.** **Treatment of Agitation in Older Persons with Dementia; The Expert Consensus Guideline Series; Alexopoulos et al; April 1998** **Dictionary of Psychology; Chaplin (1985)** **American Psychiatric Association Dementia Practice Guideline**

Youth-Depressive Disorders	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. Higher prevalence of the disorder for people with first degree biological relatives with Major Depression.** **2. Screen for other conditions that may be co-morbid or may be confused with Depressive Disorders (e.g. substance abuse, organic conditions , other mood disorder or other psychotic disorders.** **3. Family/caregivers should be involved in the assessment process whenever possible. Family systems should be assessed to determine needs that can be met that may be contributing to the mood disorder.** **4. Assess suicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Treatment plan includes interventions consistent with the level of risk for self-harm. Interventions may need to involve others beyond the youth and family, such as school personnel.** **3. Case management services may be helpful for coordination and family support and advocacy.** **4. Individual, family and/or group psychotherapy can be provided.** **5. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **6. Co-occurring disorder treatment as indicated.** **7. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **8. Inpatient services for acute stabilization as necessary**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **American Academy of Family Physicians** **Associated Provider Network** **Wyoming Public Mental Health Guidelines**

Youth-Bipolar Disorders (296.xx-301.13)	
Diagnostic Features	**Consistent with DSM IV –TR criteria. In cases where the client is not benefiting from treatment the diagnosis will be reassessed.**
Assessment Components and Considerations	**1. The presentation of Bipolar Disorder in youth often differs from the presentation in adults. Youth with mania frequently present with symptoms that are considered atypical. Changes in mood, mental excitement and psychomotor agitation are often erratic. Irritability, belligerence, and mixed states are more common than euphoria. Reckless behaviors typical of Bipolar Disorder in adults may present as behavioral problems, school failure, fighting, dangerous play, and overly sexualized behaviors.** **2. Discriminating between manic symptoms and normal childhood behavior may be difficult. Therefore, consideration of current and past history regarding symptom presentation, treatment response, and psychosocial stressors is important to gain a historical perspective on the youth's behavior.** **3. A family history of Bipolar Disorder should alert the clinician to consider that diagnosis.** **4. Differentiating between Bipolar Disorder and ADHD is frequently difficult. ADHD usually has an onset before age 7 and is a consistent characteristic of the youth's behavior pattern. Bipolar Disorder is usually episodic.** **5. Early onset** **6. Screen for other conditions that may be co-morbid or may be confused with Bipolar Disorder (e.g. substance abuse, organic conditions, other mood disorder and schizoaffective or other psychotic disorders.)** **7. Assess suicide risk at intake and when signs, symptoms or circumstances change such that the client is at increased risk.**
Treatment Guidelines	**1. Initial and periodic psychiatric screening to determine need for consultation, evaluation and/or medications.** **2. Youth with Bipolar Disorder are at increased risk for suicide.** **3. Treatment plan includes interventions consistent with the level of risk for self-harm.** **4. Individual, family and/or group psychotherapy can be provided.** **5. Education about the illness, incidence and treatment options are important. Family members and significant others may be included in this process whenever appropriate and possible.** **6. Case management services may be helpful for coordination and family support and advocacy.** **7. Co-occurring disorder treatment as indicated.** **8. Crisis planning focusing on early signs of decompensation, safety and management strategies.** **9. Because of the chronic nature of the disorder, treatment may be long term. Relapse prevention should be included in treatment planning.** **10. Inpatient services for acute stabilization as necessary**
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **King County Mental Health Plan** **American Academy of Family Physicians** **Associated Provider Network** **Wyoming Public Mental health System Guidelines**

YOUTH-Attention Deficit Hyperactivity Disorder (DSM IV code = 314.xx) PAGE ONE	
Diagnostic Features	**Consistent with DSM IV –TR criteria.** **ADHD is a complex and multi-dimensional neuro-biological mental health disorder with many symptoms common to other conditions such as depression, anxiety, post-traumatic stress disorder, etc. As such, there is no one physical or psychological test for ADHD. The diagnosis is further complicated by the fact that the primary symptoms of inattention, impulsivity, and /or hyperactivity are not always apparent in all situations. Therefore, the evaluation and diagnosis is best when it involves multiple informants or data representing a variety of setting and situations.** **The following are subtypes of the Attention-Deficit/Hyperactivity Disorder diagnosis:** **A. Combined Type: Essential feature is 6 plus symptoms of inattention and 6 plus symptoms of hyperactivity-impulsivity.** **B. Inattentive type: Essential feature is 6 plus symptoms of inattention but fewer than 6 symptoms of hyperactivity-impulsivity.** **C. Hyperactive-Impulsive Type: Essential feature is 6 plus symptoms of hyperactivity-impulsivity but fewer than 6 symptoms of inattention.**
Assessment Components and Considerations	**1. Structured diagnostic interview with client or, in the case of children, include parents/caretakers to obtain symptoms, age of onset and stability of symptoms.** **2. Developmental, family and other relevant histories (academic, medical, psychiatric, substance abuse).** **3. Data regarding school or occupational performance as appropriate or requested to verify presence of symptoms in these settings.** **4. Diagnostic interview with the client (mental status evaluation, client description of the problems, etc.). Note: Many clients may not display problematic behavior in a clinic office setting, one to one with a stranger/adult.** **5. Psychometric assessment may assist in the differential diagnosis using standard rating scales. Two types are recommended: a "broadband" mental health instrument such as the Behavior Assessment Scale for Children (BASC) or the Achenbach Children's Behavior Checklist (CBCL), and a second instrument that is ADHD specific such as the Conners or the ADHD Rating Scale IV.** **6. Screen for other conditions that are co-morbid or may be confused with ADHD (e.g. substance abuse, learning disability, adjustment disorder, organic conditions, oppositional/conduct disorder, mood disorder, neurological problem, mental retardation, pervasive development disorder, abuse, etc.).** **7. Requests for previous records such as tests, previous treatment from other professionals who have worked with the client will be helpful (e.g. therapists, teacher, school counselors, primary physician).** **8. Referral for a physical examination if none has been conducted in the past year should be considered.**
YOUTH	**Attention Deficit Hyperactivity Disorder (DSM IV code = 314.xx) PAGE TWO**
Diagnostic Criteria	**1. Persistent pattern of inattention, hyperactivity, and/or impulsivity which is more**

	frequent and severe than is typically observed in an individual with a comparable level of development and intellectual ability. **2. Some symptoms causing impairment were present before seven (7) years of age.** **3. Symptoms are present in two (2) or more settings (e.g., at school and at home).** **4. Clear evidence of clinically significant impairment in social or academic functioning.** **5. Symptoms do not occur exclusively during a course of a psychotic disorder (e.g., schizophrenia) and are not better accounted for by another disorder (e.g., mood disorder, anxiety, dissociative disorder, or personality disorder).**
Treatment Guidelines	**1 Treatment plan determined by severity of symptoms and includes interventions consistent with the level of risk for self-harm.** **12. Multi-modal approaches have been shown to have best support by the 2005 Washington Report of the Children's Evidence Based Practices Expert Panel. Team approaches are also recommended.** **13. Individual interventions: Based on medical necessity to build skills and promote stabilization. Utilizing behavior management techniques may be beneficial toward desired outcome through changing the child/youth's environment to help improve behavior. Include parent/caregivers/schools in treatment regarding children/youth whenever possible.** **14. Group Interventions: Skill building group and/or parent education as appropriate** **15. Psychiatric Assessment: As appropriate to determine indication for medication or for medication stabilization. For most children, stimulant medications are a safe and effective way to relieve ADHD symptoms.** **16. Employment/Vocational/Academic Services: Varied employment and academic strategies including behavioral consultation/support, pre-vocational and supported employment to assist clients wishing to pursue employment or academic objectives.** **17. Co-Occurring Disorder Treatment: Integrated treatment into a standard chemical dependency treatment program, or standard chemical dependency treatment plus separate treatment services for ADHD.** **18. Educate the client, parents and significant others as appropriate regarding ADHD symptoms, treatment and prognosis as well as specific training on how to deal with behavior issues in a positive way.** **19. Crisis Planning: Individualized crisis plan as necessary focusing on early symptoms of decompensation, safety and management** **20. Residential Treatment/Housing/Crisis beds for those requiring 24 hour care or access to appropriate community-based housing.** **21. Inpatient services for acute stabilization as necessary.**
Other Resources, Information	**A. Coordination of treatment efforts with the school and a referral as needed for further psycho-educational testing and/or Section 504 special education services and/or accommodations are recommended for consideration** B. Referral to local CHAD organizations are a potential for parents whose children have ADHD. CHAD offers information, resources and support and are located in chapters around the state.
Optimal Outcome of Treatment	**The client will attain symptom relief, learn skills to prevent or manage future episodes and improve functioning in daily life.**
References	**DSM IV-TR** **Associated Provider Network** 2005 Washington State Report of the Children's Evidence Based Practices Expert Panel **American Academy of Pediatrics ADHD Practice Guideline.**