Program Philosophy Day Treatment Program: This program is organized around several well established principles:

1. That the brain, and personality emanating out of it, is autoplastic and can change through a scientifically recognized process called “neurogenesis”. This process of brain change has been called many things; growth, maturation, learning, and the development of insight, wisdom, rational choosing, and individual evolution. This process indicates that “all can change at some level and in some degree”, and therefore there is “hope”, and “reason to be positive” about human potential.
2. That organized positive experience in healthy relationships, environments, and within positive alliances can create “brain change”, “personality growth”, and resultant changes in behaviors, habits, choices, relationships and social and institutional supports and alliances, and lifestyle.
3. That change can be facilitated and speeded with leadership and guidance and engineered experiences led by highly qualified and skilled “change experts” arrayed in “multi-disciplinary staffs and settings” (e.g., treatment works).
4. That change is best facilitated by input from the patient, a multi-disciplinary staff, and engagement of the family and stakeholders.
5. That implementing the philosophies 1-4 assists with treatment in the least restrictive settings and with lower social, emotional, and financial costs to the patient, family, and society.
6. That medications can be helpful in controlling some behaviors, cravings and the short and long-term detoxification from substance dependence, and increasing the patient’s ability to learn and participate, but that “medication only approaches” are not scientifically supported or utilized at CMHC, Inc.
7. That local services in the context of where the patient lives, where family and stakeholders are available, and where coping skills generalize is the best configuration for treatment.
8. That, when addiction is a primary or secondary component of the patients problem, “adopting sobriety as a goal” is the “best” approach to optimizing recovery from addiction and related harmful consequences.
9. That addiction is a family and social disease and therefore contexts and contextual interventions are important.
10. That the most predictive indicator of positive outcome to treatment is “engagement and length of treatment” so programs that have qualified staff who have good bonding, alliance building and maintenance, and phase of treatment specific programming and skills are likely to be the most successful.
11. That therapeutic interventions and techniques should be based upon scientifically tested and validated research and replication.
12. That clinical and support staff represent potential objects of identification, re-parenting, and socialization and therefore have a responsibility to present themselves (professionally, as

clean and neat and well dressed, as kind and patient and realistic and respectful, as flexible and appropriately tolerant, and as well informed; Adults).

The Child and Adolescent Program Philosophy:

1. That the brain, and personality emanating out of it, is autoplastic and can change through a scientifically recognized process called "neurogenesis". This process of brain change has been called many things; growth, maturation, learning, and the development of insight, wisdom, rational choosing, and individual evolution. This process indicates that "all can change at some level and in some degree", and therefore there is "hope", and "reason to be positive" about human potential. That much of the brain is programmed by parents and significant others during formative years. That enduring "family projection processes" and "seminal or traumatic experiences" become solidified and requires much effort to change. That children and adolescents develop and change in context and therefore contextual interventions and changes (sometimes necessitating individual psychotherapy of adults) are necessary to modify emotional disorders and behavioral disorders. (blocked old learning and complexes and facilitation of new vision of self and others and the world).
2. That organized positive experience in healthy relationships, environments, and within positive alliances can create "brain change", "personality growth", and resultant changes in behaviors, habits, choices, relationships and social and institutional supports and alliances, and lifestyle.
3. That change can be facilitated and speeded with leadership and guidance and engineered experiences led by highly qualified and skilled "change experts" arrayed in "multi-disciplinary staffs and settings" (e.g., treatment works).
4. That change is best facilitated by input from the patient, a multi-disciplinary staff, and engagement of the family and stakeholders.
5. That implementing the philosophies 1-4 assists with treatment in the least restrictive settings and with lower social, emotional, and financial costs to the patient, family, and society.
6. That medications can be helpful in controlling some behaviors and increasing the patient's ability to learn and participate, but that "medication only approaches" are not scientifically supported or utilized at CMHC, Inc.
7. That local services in the context of where the patient lives, where family and stakeholders are available, and where coping skills generalize is the best configuration for treatment.
8. That children and adolescents feel welcome in healthy and realistic, flexible, friendly, and positive and hopeful adult relationships which facilitate self-exploration, individuation, and maturation.
9. That a major component of emotional illness is a family and social disease and therefore contexts and contextual interventions are important (children and adolescents can't be oversimplified in unscientific ways such as "biologically imbalanced", "genetically

predispositioned", or "dichotomous thinking such as Bad Kid" and these fallacies are to be avoided and challenged.

10. That the most predictive indicator of positive outcome to treatment is "engagement and length of treatment" so programs that have qualified staff who have good bonding, alliance building and maintenance, and phase of treatment specific programming and skills are likely to be the most successful.
11. That therapeutic interventions and techniques should be based upon scientifically tested and validated research and replication.
12. That clinical and support staff represent potential objects of identification, re-parenting, and socialization and therefore have a responsibility to present themselves (professionally, as clean and neat and well dressed, as kind and patient and realistic and respectful, as flexible and appropriately tolerant, and as well informed; Adults).
13. That early interventions and prevention save human and economic resources and are therefore rational, humane, and efficient.
14. One size does not fit all. Especially with families, children, and adolescents, clinical staff must be flexible, "join families" in manners that are acceptable to them and highly skilled and trained in eclectic approaches to intervention.

Outpatient Adult Services Philosophy:

1. That the brain, and personality emanating out of it, is autoplastic and can change through a scientifically recognized process called "neurogenesis". This process of brain change has been called many things; growth, maturation, learning, and the development of insight, wisdom, rational choosing, and individual evolution. This process indicates that "all can change at some level and in some degree", and therefore there is "hope", and "reason to be positive" about human potential. NIMH studies show that even elderly individuals brains can change, grow, and learn. Science tells us "you can teach old dogs new tricks" and that all have capacity to change at some rate, depth, and in some areas of their personality and choices.
2. That organized positive experience in healthy relationships, environments, and within positive alliances can create "brain change", "personality growth", and resultant changes in behaviors, habits, choices, relationships and social and institutional supports and alliances, and lifestyle.
3. That change can be facilitated and speeded with leadership and guidance and engineered experiences led by highly qualified and skilled "change experts" arrayed in "multi-disciplinary staffs and settings" (e.g., treatment works).
4. That change is best facilitated by input from the patient, a multi-disciplinary staff, and engagement of the family and stakeholders.
5. That implementing the philosophies 1-4 assists with treatment in the least restrictive settings and with lower social, emotional, and financial costs to the patient, family, and

society. These costs are significant in individuals that have given up, or their providers have given up on brain change and resorted to long-term medication techniques (with long-term debilitating effects), non-change case management only approaches, and failure to invest resources in change that create hope and optimism.

6. That medications can be helpful in controlling some behaviors and increasing the patient's ability to learn and participate, but that "medication only approaches" are not scientifically supported or utilized at CMHC, Inc. This philosophy is not published by the FDA Science Committee, the World Health Association, and The Institute of Medicine and shared by several national practitioner associations and Universities.
7. That local services in the context of where the patient lives, where family and stakeholders are available, and where coping skills generalize is the best configuration for treatment.
8. That engagement in positive social systems and positive institution facilitates hope, encouragement, access to intrinsic reinforcers, structural and time blocking of regressive triggers, and maturation and should be encouraged as components of treatment plans.
9. That mental illness is a family and social disease and therefore contexts and contextual interventions are important in treatment plans when available, and when they are not- substitutes should be arranged.
10. That the most predictive indicator of positive outcome to treatment is "engagement and length of treatment" so programs that have qualified staff who have good bonding, alliance building and maintenance, and phase of treatment specific programming and skills are likely to be the most successful.
11. That therapeutic interventions and techniques should be based upon scientifically tested and validated research and replication.
12. That clinical and support staff represent potential objects of identification, re-parenting, and socialization and therefore have a responsibility to present themselves (professionally, as clean and neat and well dressed, as kind and patient and realistic and respectful, as flexible and appropriately tolerant, and as well informed; Adults).