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Evidenced-Based Research: Catalyst for Action and Future Paradigm for NATSAP Programs?

Dr. Michael Gass, Ph.D., LMFT

University of New Hampshire

For the past four years I have observed a new and emerging value system around the use of research to determine funding allocations, public policy decisions, and even program viability within the allied fields of mental health, substance abuse, youth development, and education. It's not that the concepts of research haven't been important in the past for these fields, but research always has been somewhat marginalized by professionals as a necessary "evil" (at best) or a rather worthless endeavor. Sort of like the interaction with your quirky cousin you put up with at the family picnic; when you run into him while waiting for the ketchup near the burgers, you search for convenient excuses to "move on" to another task as quickly as possible (e.g., "this is weird, nothing to be gained by talking to him!"). In the past, true and involved interest around research often only appeared when someone needed to write a grant and wanted required statistics to support their proposal's statements (heaven forbid if we found information that contradicted what we believed!), or a funding sponsor made research a requirement for a program (e.g., insurance company).

There are a number indicators pointing to the fact that the days of ignorance or avoidance regarding research may be gone for our allied fields. While I have previously spoken and written in the past year about this emerging phenomenon (Gass, 2005), I could not have predicted the strength and speed at which this movement is developing in certain sectors of the industry. For better or for worse, your "cousin" of research has now become the "godparent" of family rules and values in these fields under the concept of "evidenced-based practice." Decisions for programming in mental health, substance abuse, youth development, and education are being determined more and more by the existing evidence on the "outcomes" of various interventions.

Why all of the current fuss over evidenced-based practice research? And how has this differed from other previous “calls to research” efforts in the past? Probably nowhere has this been more poignantly illustrated than in the December 2004 issue of the American Psychologist, where Barlow (2002, 2004) pointed out how widely accepted healthcare practices with hormone replacement therapy (HRT) and arthroscopic knee surgery were actually found not only in failing to provide any treatment benefit, but also induced harm (e.g., evidenced-based research proved that HRT not only failed to prevent osteoporosis, coronary heart disease, and hot flash symptoms, but actually led to increased cardiovascular risks and increases in breast cancer). Combined with this “call to question” of certain health practices, additional pressure to produce valid research has increased due to greater financial accountability from government and insurance funding sources, as well as the increased speed at which health care knowledge is distributed than in the past.

This certainly was evident and “center stage” at the March 2006 Blueprints Conference I attended in Denver, Colorado. Joined by 1200 other colleagues in examining the best scientific practices in youth violence, delinquency, and drug prevention programs, we were witnesses to the “change in doing business as usual” for these fields. I want to share three indicators of this change embodied at this Conference that I believe exemplify the way NATSAP programs will be “influenced” to do business and operate programs in the future.

I. Influence of evidenced-based research on government agencies overseeing treatment agendas and protocols

First is the growing influence the evidenced-based practice movement is having on the role and interaction of government agencies overseeing treatment agendas and protocols. The introductory speaker at the Blueprints Conference was Robert Flores, current Director of the Office of Juvenile Justice and Delinquency Prevention (OJJDP). In his opening address, Flores presented four critical factors related to the influence of evidenced-based research on programs:

- (1) The need (and soon to be requirement) for many youth programs to use evidenced-based practices,

(2) Less federal and state support is going to be available for programs not using evidenced-based practices,

(3) How the OJJDP and other related government agencies are looking to evidenced-based programs to “set the agenda” for the future developments in the treatment of youth.

(4) More federal grants and RFPs (requests for proposals) would soon be available for evidenced-based programs from his agency as well as other federal agencies.

As indicated by Director Flores’ comments, overseeing agencies are becoming more and more enamored with the idea of dictating funding, government policies, and insuring positive outcomes through demonstrated program practices and outcomes. And while many NATSAP organizations may rely upon private funding and potentially feel “immune” to this influence, some programs may find themselves at a disadvantage to other organizations who can produce demonstrated outcomes similar to “medical model” outcomes expected in the fields of mental health and education.

II. Influence of evidenced-based research on what programs will be valued based on produced outcomes

Second is the central purpose of evidenced-based practices – the search for the actual “truth” or outcomes of a well-designed intervention program. This point was thoroughly outlined in the opening session of the Conference by Dr. Del Elliot, Executive Director of the Center for the Study and Prevention of Violence at the University of Colorado at Boulder. In a paradigm similar to Barlow’s investigations, he pointed out how in the 1990s large amounts of money with little supporting evidence was invested into programs addressing youth and adult violence that simply didn’t work. And in some cases these intervention programs created more harm than no program at all. Several of these well-known programs and their brief outcomes included:

(1) Gun Buyback programs (two-thirds of the guns turned in did not work, almost all of the people turning in guns had another gun at home)

(2) Bootcamp programs (failed to provide any difference in juvenile recidivism outcome rates than standard probation programs, but were four times as expensive)

(3) DARE programs (traditional 5th grade programs failed to be effective in decreasing drug use despite the fact that by 1998 the program was used in 48% of American schools with an annual budget of over \$700 million dollars) (Greenwood, 2006).

(4) Scared Straight programs (inculcated youth more directly into a criminal lifestyle, actually leading to increases in crime by participating youth and required \$203 in corrective programming to address and undo every dollar that was originally spent on programming).

Based on these ineffectual and expensive programs, Elliot called for programs to produce outcome evidenced-based research clearly demonstrating effectiveness for continued implementation. Five criteria needed to achieve this standard include:

(1) Studies with strong research design on program effectiveness – this would include randomized control trials or quasi-experimentally designed studies where the comparison groups were closely scrutinized/matched for appropriateness.

(2) Significant evidence of deterrent effects with accompanying reported effect size.

(3) Positive effects that were sustained over a long period of time, at least one year after intervention.

(4) Multiple site replication – meaning that programs operating at more than one site (i.e., multiple sites) would need to insure the same level of efficacy of treatment produced at the central location.

(5) Other factors such as cost-benefit analysis (i.e., cost per client to produce intended results) and examination of mediating effects on treatment (i.e., changes in clients are accounted for and addressed

so treatment effects will have similar positive results with client differences such as gender, race, intelligence, etc.).

In this *JTSP* issue, Dr. Ellen Behrens provides a model for residential treatment based on a contextual approach to evidence-based practice. While reading this article will provide great insight for readers, probably nowhere is an evidenced-based research value system more clearly described than the one used for evaluating program effectiveness used by the US Department of Health and Human Services' Office of Substance Abuse, Mental Health Services Administration (SAMHSA). In this value system, programs that have been appropriately researched and found to demonstrate significant benefits are viewed as effective and model programs. The research used in this process must be deemed reliable, valid, possess strong intervention fidelity, account for missing data and research attrition, address potential confounding variables, and use appropriate analyses. If open to replication and dissemination to other programs, the research model also must include a clear implementation plan, training and resource support, and strong quality improvement materials (U.S. Office of Health and Human Services Substance Abuse and Mental Health Services Administration, 2006).

One final striking comment by Dr. Elliot was the whole ethical nature of the evidenced-based research paradigm. While posited to be more of a rhetorical question than a challenging one, Dr. Elliot stated there certainly is some level of professional ethics involved to not only use research to insure treatment programs "above all else do no harm," but also to use this research paradigm to provide programs that "serve clients in the best and most effective manner possible."

III. Influence of evidenced-based research on instilling the importance of cost-benefit analyses

Third and possibly the most pragmatic for NATSAP organizations to consider is how economic (i.e., cost-benefit) analyses are becoming required in the evidenced-based research paradigm. One workshop presented on this topic was delivered by Steve Aos, Acting Director of the Washington State Institute for Public Policy, on the benefits and costs of evidenced-based prevention and intervention programs. The role of the Washington State Institute for Public Policy (WSIPP) is to

provide state legislators with the effectiveness and costs associated with programs so legislators can base their decisions on how to spend taxpayers' monies. The Washington Legislature is interested in identifying prevention and early intervention programs having evidence of being effective in: (1) reducing crime, (2) lowering substance abuse, (3) improving educational outcomes such as test scores and graduation rates, (4) decreasing teen pregnancy, (5) decreasing teen suicide, (6) lowering child abuse and neglect, and (7) reducing domestic violence (Washington State Institute for Public Policy, 2004).

Equally as important to the Washington Legislators are the costs of such programs. Since 1980, the State of Washington had been successful in reducing crime (i.e., violent and property crimes) by more than 20%, but the cost to the average household in Washington to implement these programs had risen almost 100%, making the current "portfolio" of intervention programs economically impractical. The question posed to WSIPP from the Legislature became "Can the State implement a portfolio of evidenced-based, cost-beneficial program to give taxpayers a better return on their criminal justice dollars?"

While this situation is within the context of state government, this evidenced-base research paradigm of achieving client outcomes and appropriate/acceptable costs is obviously gaining greater acceptance in many disciplines. For the State of Washington this has meant creating a benefit/cost ratio, reporting for every dollar invested how many "benefit dollars" are returned. For example, with regard to 18 month felony recidivism rates, the Functional Family Therapy treatment program in Washington resulted in a \$9.07 b/c ratio (i.e., the benefits of a youth not recidivating is \$20,501 whereas delivering treatment costs the State is \$2,260 per individual). From this approach, not only has the State of Washington found evidence that some programs are effective and others are not, but also with effective programs some achieve significantly more benefits than costs whereas others don't fiscally make sense.

Does such a paradigm affect NATSAP organizations? Certainly a NATSAP program could find itself in jeopardy if the treatment it produces is unable to demonstrate its effectiveness when compared to another comparable yet "evidenced-based" treatment program.

Or even if a treatment is effective, does it provide a cost effective alternative for the client group it serves?

Such developments may provide a catalyst for programs, individually or collectively, to invest in this outcome-based research effort. Or possibly like the quirky cousin at the family picnic, we will skip the ketchup and avoid the whole interaction. Right now this may be a choice for many NATSAP programs. It remains to be seen if this will continue in this way.

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Keynote Address
2006 NATSAP Annual Conference
Clearwater, Florida

Jared U. Balmer, Ph.D.

Please be aware that much of what I am covering today represents my opinion. In that sense, I am not a spokesperson for the organization. I leave that up to very capable people like John Santa, the Board, and Jan Moss.

As I prepared this address, I determined that there are a number of issues, concerns, and challenges I believe are in the forefront of our professional landscape. I am not presenting them in a particular order of priority. However, the topics I have selected to address could be classified as going from the specific to the global, or from micro to macro.

Topic 1

*“When the moon hits your eyes
like a great pizza pie, it’s amore”*

**Placing the right child in the right
program for the right reason**

Throughout most of my professional career, I have been involved in residential care, ranging from foster homes to psychiatric hospitalization and all the variety of programs in-between. A mixture of providence and fate afforded me the incredible opportunity to be involved in the creation and formulation of a variety of programs, both day-treatment and residential based. As part of this process, innumerable hours were spent in writing policies and procedure.

However, the most critical thinking and writing was always devoted to the *core* aspects of the program, which included such topics as: a mission statement, the service philosophy, the goals and objectives of the program, the theoretical foundation of treatment, a description of the population served, an exclusion and discharge criteria, and a

rationale and delineation of the core therapeutic services upon which the change process was pivoting. All other policies and procedures flowed from this core. Such aspects as staffing patterns, admission procedures, behavioral management techniques, and many others had to “wash” with the core. Everything flowed from the core. The core defined the program. If the program is a family, the core represents the parents. As it were, the core is mother earth, the planet.

As a value added feature, many programs offer adjunct programming. This may include programming elements like spiritual discovery or value clarification, equestrian programming, volunteer work and community involvement, specific sport and recreation activities, technology and vocational programming, or exotic excursions abroad. All such activities are adjunctive in nature. They do not represent the core. They enhance the core and may provide a platform for the core to unfold. However, they are not the core. If the core represents the planet, adjunctive programs could represent the moons circling the planet.

Yet some consumers look at the moon and fall in love. Such romance is well and good if the child has been placed in a program for the core offerings. However, such love can turn to tragedy if the child is placed in the program simply because the adjunctive program is so appealing. Clinical placement decisions should consider the core elements of a program first and not the attractiveness of the moon. The core of a program must meet the child’s fundamental clinical needs. Whether a program has a ballet or equestrian program, this cannot serve as the decisive factor in the placement decision.

Is it possible for such “moon struck” placements to occur? Certainly. There are a number of scenarios where a placement occurs for the wrong reason. Some parents feel guilty for sending their child away from home. Trying to “ease the pain,” they sell themselves and the child on the notion that the youngster can be on the lacrosse team, or is able to travel abroad as part of a foreign language curriculum offered at the program.

In the minds of such parents, the planet is tangential to its moon. Hence if the child is unable to play on the lacrosse team because of

inappropriate behavior, the fault is placed at the feet of the program while the child is absolved of any natural consequences. Others count on the hope that a value added program component will be the magic potion propelling the child in the change progress. While this is entirely possible, to place a child in a program for that reason alone is riddled with thinking errors.

Long before value added programming becomes part of the placement decision, the core of a program must address the core issues of the differentiated diagnosis of the child. Referring professionals can be invaluable in preventing parents from getting “moon struck.” Conversely, programs and schools have an ethical obligation to communicate the core of the program long before showcasing the equestrian, sports, spirituality component, or other such moons.

Topic 2

Small verses big: When it comes to treatment facilities, does size matter?

When faced with a decision to place a child in an out-of-home environment, both parents and professionals aim to place the child in a nurturing and supportive environment. Virtually all programs attempt to provide a healing experience for both child and parent. In the minds of some consumers, however, a program that has more than a certain number of clients automatically turns into an “institution” that can’t possibly be nurturing and individually oriented. To them, big is bad and small is good.

To suggest that such variables (e.g., nurturing, individualized attention, support, intimate therapeutic environment, one-on-one time, professional expertise, support for a brittle resident) are jeopardized when the program reaches a certain magical number of participants is simply not the case. This perception of an inverse relationship between nurturing environment and program size can be a myopic evaluation of a program, or a lack of understanding of the professional literature.

A study published in the late 1970s in the popular magazine “Psychology Today” alleged an inverse relationship between family

size and the richness of the family environment. A series of studies published following this assertion found there was no correlation between family size and IQ, social adjustment, and self-esteem among the children. While these studies were limited to family settings, it dismissed the notion that richness of the family environment is diminished with family size and as a result has a negative impact on social adjustment.

The perception that a nurturing environment is at risk with increased program participants may, at times, lead to placements that are not in the best interest of the client. Unfortunately for the client, this problem is applied to both “small” and “big” programs. Some youngsters are referred to small programs, while others are referred to a big programs, all perhaps for the wrong reasons. To categorically assume that a small program is more nurturing than a large program; or worse, place a child in a small program because “it is an easy sell to parents,” may not be the most clinically prudent rationale.

Most professionals agree that a living group size of residents can reach a “critical mass” where optimal programming is jeopardized. Hence, the issue is not overall program size, but *how* the program creates and maintains a living group of participants. A program may have 150 clients, however if these clients are divided into smaller living groups, the overall size of the program may never reach the “critical mass.” As a result, it is entirely possible that a “large” program may have a living environment surpassing the “nurturing factor” of a small program – and vice versa.

This line of reasoning - namely that a small program inherently provides a more intimate, nurturing living environment - begs the question about what makes people change. Are we sacrificing everything we know from decades of research about the change process on the “altar of the perception” that a big program cannot possibly provide a nurturing living environment? Moreover, to sacrifice optimal therapeutics and clinical delivery systems over a number of enrollments is reminiscent of the “tail wagging the dog.”

My experience is that many of you have attempted to assemble a number of building blocks that, in your minds, bring together essential

and optimal elements for a change experience. These building blocks bring together the best of both “small” and “large.” I believe placements should be made on the inherent qualitative variables of a program and the profile of students they serve best, and not made exclusively on the variable of program size.

Perhaps the best example is the Boys Town Program. Boys Town is based on the family teaching model. A group of 6-8 boys live with surrogate parents, where everybody is involved in the daily tasks of living such as cooking, cleaning, recreation, etc. Meals are served family style and many other tasks and events follow the “family” approach. Yet the Boys Town program has thousands of children involved in their programs nationwide. In some additional sites they have multiple cottages in one single location, administering the same “family model” program. They are a large program, but administer a small therapeutic environment model.

Again, the therapeutic model should drive the placement, not the program size. When saddled with the task of placing a particular child in a program, factors such as qualitative and quantitative variables in milieu, education, therapy, activity and psychiatry offerings are critical to the task – not size alone.

Topic 3

Transportability: The minefield of our industry

When I was in the 6th grade, our family moved from a relatively small town to a big town some 60 miles to the north. For me, many aspects of this transfer from one school to the other looked as non-eventful as going from one aisle in the grocery store to another. Yet I was very uneasy about this move. My mother accompanied me the first day to the new school and I can still remember her questioning me as to why I was acting so strange and non-communicative. I know that this comes as a shock to those of you who know me, but I was scared, unsure of myself, and temporarily depressed. I knew that I was leaving something predictable behind, and was now facing a new world that lacked predictability.

Later on when I finished high school at the tender age of 16 and moved some 80 miles away from home to attend college, I had similar feelings. The simple fact that all of us know - at least intellectually - is that transition is typically associated with regression. The landscape of transportability between program to school, and school and program to “normalized settings” is a minefield. This minefield is consciously and/or unconsciously planted by the client, the parent, and by us, the school and program providers. Unfortunately, too many students become casualties of that minefield.

The brevity of this address does not allow for a thorough examination of these issues. Therefore, I will make an attempt to scratch the surface. I hope that it may (in a small way) contribute to the continuation of this discussion for those of us who have struggled with it for some time, and urge others to start thinking about it.

Let us first briefly examine the issues that may confront the student. Much of my first hand experience comes from the Oakley School, where students from less restrictive or more restrictive previous placements are enrolled.

- *Regression.* Whenever a student moves from a more restrictive to a less restrictive setting, he/she typically experiences some measure of regression. The etiology for this phenomenon is related to issues such as loss of support, fear of the unknown, disorientation, lack of trust, change in routine, fear of rejection by new peers, increased academic pressure, treatment fatigue, homesickness etc.
- *Transfer Spin.* It is my experience that when a student is transferred from a less restrictive to a more restrictive environment, he/she typically engages in an activity which I call “Transfer Spin.” In their minds, such a move is unsatisfying and they engage in the time-tested defense mechanism of projection. The blame is placed on the previous program, the previous therapists, the parent, the teachers and others. Never is it related to the behavior of the transferring student.
- *Parent “Contribution.”* Parents often contribute to the “minefield” of regression through unrealistic expectations. These may include a demand for an uninterrupted course of

progress or an instant “fix” of the maladaptive behaviors. Such parents are impatient with the progress of the child, while others are enmeshed and interfere with the developmental growth process of the child. If progress is not forthcoming according to their design, like the child these parents will use projection as a way to explain the set-back.

- *Sending Program/School “Contribution.”* The school or program where the child transfers may also contribute to the “minefield.” The school may lack in the proactive education of the transferring student regarding the underlying reasons for the transfer, or assume that set-backs in the new program must be a manifestation of inadequate programming. Moreover, if the receiving program/school contacts the sending program and implies that the child is not doing as well as indicated on the referral information, the sending therapist often is silently offended and manifests the “don’t criticize my artwork” syndrome.
- *Receiving Program/School “Contribution.”* Receiving programs are not proactive enough in seeking referral information from the sending program and fail to recognize the new student for the work he/she has done in the previous setting. It is not atypical to blame a student’s set-back on the previous program without examining etiological factors for the set-back in the current setting.

We all know that when we remove the training wheels from the bicycle the child stands a greater chance of falling down. That is to say that there is an inverse relationship between the restrictiveness of the program and the probability of set-backs for the client. The easiest place to effectuate change is in a highly controlled environment where a large portion of all the variables are under the direct control of the program. The larger that “box” (i.e., the more open or transparent a program is), the higher the probability for set-backs.

Since we all know the hurdles associated with generalization across settings, the obvious question is, “How can we mitigate the inherent problems of transferability?” The time restriction of this address does not allow me to fully explore these issues, but an overview of the “obvious” may lead us in the right direction.

- *Increase Communication Between Programs/Schools.*
 - Forward a discharge summary to the new placement.
 - Conduct a telephonic “hands-off” meeting, involving student, receiving and sending professionals.
 - Transition telephone calls between the parents and both therapists (sending and receiving).
 - Letter from therapist, including a list of accomplishments from the sending program.
- *Receiving Program/School.*
 - Provide a forum for the new resident to list his/her accomplishments in the previous setting.
 - Have a follow up-session with the therapist from previous settings.
- *Sending Program/School.*
 - Encouraging letter sent by the receiving program (introduction of key staff members).
 - Request orientation materials from the receiving school to give the student.

Topic 4

“The great tragedy of science- the slaying of a beautiful hypothesis by an ugly fact”

Our obligation to research

I vividly recall a class discussion in graduate school. The professor asserted the behavioral sciences were in reality not a science, but an art form. He indicated that science had provided us with some hard facts about memory, perception, and behavior in animals and humans. However, the theory of change (i.e., the reason why people change and the methodology applied to effect such a change) had little or no basis in scientific fact. Hence, we continue to speak of the “healing arts.” He then proceeded to tell us that our only hope in rising from the primeval slime of “art form” to true science was to embrace B.F. Skinner’s work of shaping behavior through operant conditioning.

To give us a demonstration of how this works, he asked us to observe him through the one-way mirror conducting a family therapy session. He sat down with the family and started to count behaviors

with a mechanical counter he held in his left hand. With his right hand he took notes on a legal pad. He explained to the family that he needed to establish a baseline. Unfortunately, at the end of the session the family made it very clear to our professor that they were not going to be treated like a Skinnerian pigeon and would not return. It occurred to me that his attempts to solve the family's presenting problems were ineffective at best, and may have added to the family's pathology at worst. It is hard to operate on a patient when the patient is scared by the surgical tools and refuses to enter the hospital.

My first job out of graduate school was to implement a family therapy program attached to the St. Louis Juvenile Court. A federal demonstration grant was aimed at allowing juvenile court judges to order juveniles and their family into family therapy. Such services were directly available at the Juvenile Court building, thereby avoiding any excuses associated with scheduling family therapy with a private or community treatment provider and most importantly, avoiding excuses for funding.

I hired four therapists and we went to work on a new model of family therapy which we termed "Multi-Impact Family Therapy" (Balmer et al., 1979). The framework for our therapeutic intervention was based on a multi-model approach drawing from the theoretical frameworks of Behaviorism, Strategic Therapy, and approaches based on the Milan Group, Gestalt Therapy, Family Sculpting, Social Learning Theory, Hypnotherapy, Adlerian and Cognitive Behavioral Therapy, and others.

We truly achieved some remarkable changes in these families. We had families experience a perpetual, two day epiphany. They cried, hugged each other, and communicated like never before. We presented our video tapes at two national conferences, with the audience in a "shock and awe" mode. We were therapeutic geniuses - at least for one day. A six month follow-up study of our families revealed the epiphany they experienced at our hands for two days was relatively short lived. Our young status offenders experienced a recidivism rate of over 70% along with all the etiological pathology of status offenses rooted in the family dynamics.

It occurred to us that the tremendous short term changes we achieved with our families were not attributable to any scientifically based intervention, but was likely the result of good “theater” we created by getting them involved in a “Broadway play.” The problems with a Broadway play however, is that it lasts on an average about two hours. While it certainly did no harm, the long term effectiveness was questionable. So the hypotheses of change (i.e., the applied method of therapy), both for our old professor and for us as young professionals, ran like sand through our hands.

The reported results of the scientific literature brought us out of our ego-induced state of grandiosity. We were beginning to ask new and different questions as opposed to the perennial inquiry into the “Dodo Bird Verdict” where all theories are equal in their effectiveness to bring about change.

Before we rush to add findings to the established literature, it may be helpful to know what the literature says about psychotherapy, so that we as a professional group can then take better aim at adding to the body of literature.

The brevity of this presentation will only allow me to briefly summarize what we know from empirically tested evidence about psychotherapy and point us in the right direction. The direction of improving the calculated odds for predicting a child’s needs includes considerations such as: what treatment, for how long, in what setting, with what kinds of therapists, utilizing what kind of modality, with what kind of support and ancillary services.

Volumes have been written of what we know. Here are a few distilled empirically tested facts:

- Therapy is effective - Treated patients fare much better than the untreated. Evidence supporting outpatient psychotherapy is now well established.
- Patterns of change examined during therapy have suggested that different symptom clusters improve at different times during treatment - First is restoration of morale, followed by symptomatic improvement, and finally characterological changes.

- Psychotherapy has lasting effects and most clients can be expected to maintain their gains over time
- Certain groups of clients may be more vulnerable to relapse
 - This includes those with substance abuse problems, eating disorders, recurrent depression, and those diagnosed with a personality disorder.
- Maintenance effect can be enhanced if the client attributes the change to their own efforts
- Clients, like adolescents, who are poorly motivated and hostile, with a history of poor relationships are likely to fail at brief therapy
- “Painting-by-numbers” (i.e. prescribed treatment protocols) can produce good results with certain clients, but rigid adherence to manuals and guidelines are not a proven way to get the best results
- Most reviews conclude there is little evidence to indicate differences in effectiveness among the various schools of psychotherapy - The recurrent findings of all the professional literature indicate theories and their associated technical operations do not significantly contribute to outcomes.
- Meta-research shows that 40% of therapeutic change is attributable to extra therapeutic change, 30% to the therapeutic alliance, 15% to placebo and 15% to therapeutic techniques
 - These are referred to as the common factors of therapeutic change.
- Focusing on common factors is more valuable than endless inquiries into the “Dodo bird verdict” - Although some practitioners (especially the inexperienced) imagine they or their techniques are the most important factors contributing to outcome, the research literature does not support this contention. On the contrary, outcome is determined to a great degree by the client and outside events, not the therapist.

Hence to answer the questions I posed earlier, it may be much more productive to conduct inquiries into the common factors as opposed to searching for the “holy grail” of the most effective brand of therapy. Our contribution to the literature may include the following:

- Begin with some basic consumer satisfaction surveys as to the client’s experience of the process of change and what was

helpful or distracting from the process.

- Focus on out-of-home placement research. Much of the literature I have referred to is based on outpatient treatment. While there are critical parallels that can be drawn from outpatient to residential settings, our particular industry of privately funded residential care has added little to this body of knowledge.
- Begin, and in some cases continue, to accumulate empirical data into the effectiveness of residential treatment.
- Establish credibility by publishing these inquiries and findings and make them available to consumers at all levels. I would like to applaud Dr. John Santa who has been the driving force behind the NATSAP Journal. The Journal represents a credible format for us to ask intelligent questions and make attempts to answer them.

Topic 5

Standardization vs. Creativity

Can we reconcile the apparent conflict?

When I first emerged from graduate school, I suffered from the delusion of grandeur that I could help everybody that showed up at my office. Having been trained in strategic therapy by the likes of Milton Erickson, Paul Watzlawick, Jay Hailey, and Bandler and Grinder, I felt invincible in my skill to bring about change within my clients by throwing the entire collection of all the “therapeutic tricks” at them.

My partner, Dr. Ray Becvar, a renowned Marriage and Family Therapist in his own right, brought me back to reality by suggesting that, “In all that we do, first let’s do no harm.” He added, “If you want the client to run, let’s be sure he can walk first. By demanding that he runs first, you may break him in half.”

This experience paralleled something Dr. Margaret Hoops, my mentor at BYU, told me. She essentially warned me that I should be prepared to know that anyone involved in the attempt of changing human behavior considers themselves an expert. She insisted that my first obligation, now that I was a “professional”, was to ensure that I did no harm.

She was right. Over the years I met a wide collection of experts. There was my Uncle Fritz and my Aunt Trudy, my neighbor Mrs. Wirt, countless mothers and fathers, my barber, and numerous sales clerks I met over the years. The last expert I ran into was the flight attendant on the way here. Virtually every person I ever met was an expert.

I later discovered that some of these “experts,” once they had a barn or converted garage and professed to love kids, were expert enough to provide “professional” interventions, for which they charged parents a lot of money. While it would be improper to question their motives, the scary thing about these “experts” is that the probability of knowing that something harmful is being done to the client is lower than if the care is provided by a credentialed professional. This issue (harming the client) typically raises its ugly head in the area of behavior management.

Some years ago, I sat in a time-out room of a program. This time-out room was constructed out of plywood. It was about 4 ft. by 4 ft. and about 7 ft. tall. The top of this box was covered with steel mesh. Beyond the steel mesh was a light bulb. A chair was in this time-out box. It would have been impossible for the client to lie down, or have much movement at all. The client had the option to either stand-up or sit on the chair. This sort of time-out or seclusion procedure had nothing to do with re-establishing the locus of control within the client and keeping the client from harming him/herself or others. This sort of approach was simply punishment.

Over the past 15 years I have noticed that the vast majority of negative press articles are directly related to the so-called behavior modification experts. Under the disguise of distancing themselves from “therapy,” these behavior modification experts get more press exposure, albeit negative, than Paris Hilton. Through the process of generalization by the public at large, we all end up with a black eye.

I recall the initial NATSAP meeting in Albuquerque, New Mexico. A poll was taken among the attendees as to what they saw as the mission or goal of NATSAP. The clear winner of that poll was standardization. It was obvious that the initial members of NATSAP intended to create

distance between themselves and unethical, unprofessional, and non-standardized programming, driven by ignorance or pure profit motives. The “founding fathers and mothers” of NATSAP recognize we have a sacred trust, both to the child and the family, long before we count the dollars.

The “founding fathers and mothers” also recognized that a handful of operators within our industry are primarily responsible for the negative public press; causing everything we do to be called into question. This clatter in the press often provides the fuel for legislative efforts to restrict, regulate, and control our industry. While standardization is welcomed and needed, we do not want untrained and inexperienced bureaucrats (who have rarely worked full-time with troubled youth and families) to tell us what constitutes professional intervention. We need to regulate ourselves. If I have heard it once, I have heard it a thousand times from my colleagues: “If we don’t do it, they will do it for us.” Another interpretation is that if we don’t regulate ourselves, the rogue programs will eventually rob us of the abilities to do what we know to be ethical, professional, and effective in changing the lives our clients and their families.

For this reason and from the very beginning, I have been a very vocal supporter for NATSAP to define and (and if you will,) standardize basic, fundamental practices in operating programs and schools for special needs students. The recent examples in Utah, Montana, and Oregon are shining examples of this process. In all three states, NATSAP program members were instrumental in drafting rules and working cooperatively with state regulatory agencies. The result was the enactment of new standards, enhancements, and the articulation of established standards in an effort to provide optimal care.

It is my firm belief that guidance through self-imposed regulations will bring legitimacy to this emerging professional body. Legislative processes (in terms of regulations) are typically reactionary in nature. They often react to bad policy of a particular program that has not been well thought out and tested against best practice standards.

I believe that NATSAP’s efforts to define Best Practices are important, fundamental, and represent the first step in defining

appropriate care. This much needed drive for standardization begs the question, “What about creativity?” “Is a co-existence of these apparently polar forces possible?”

Before we jump to the answer, let us briefly examine what creativity is and what it is not. I believe the most creative thinking in the arena of behavior sciences comes from the writings of Gregory Bateson, Milton Erikson, Don Jackson, Paul Watzlawick, Janet Beavin, and Collete Carrise. They draw upon a variety of bodies of knowledge such as anthropology, cybernetics, linguistics, communication theory, and mathematics to form a theory of change of human behavior. Their work is truly a synthesis, drawing from theories and bodies of accumulated knowledge that was “outside the box” for behavioral sciences. Their work was truly creative. It was not, however, contrary to established practices as to the definition of causing harm to clients. In other words, their “protocols of change” were such that they did not cause harm to the client.

Conversely, to hide behind the label of creativity and operate exclusively for financial reasons at the peril of ignoring standardized practice is not creativity, it is greed. This new emerging group of ours has attracted people that are inherently creative. Many of you have drawn upon bodies of knowledge from education and from behavioral sciences in all their variety, including psychology, arts, movement, work with animals, music, vocational rehabilitation, neuro-psychology, psychiatry, and medicine.

We stand at the threshold of a new era in treating children and adolescents in residential and outdoor settings where we not only draw upon traditional models of care, but look to a more holistic approach. In doing so, let us walk the high road of combining creativity and standardized best practices. Thank you.

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An Evidence-Based Practice Model for Residential Treatment Programs

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Abstract

This article presents a model for residential treatment based on a contextual approach to evidence-based practice. The model is organized around the metaphor of rock climbing and includes the following components: empirically supported treatments, clinical consensus, client, caregiver, therapeutic relationship, family participation, theoretical orientation, outcome research, admission criteria, multi-disciplinary assessment, and individualized care plans. The model's goal is to identify and integrate effective components of residential care to improve client outcomes. Implications related to each component of the model are suggested.

An Evidence-Based Practice Model for Residential Treatment Programs

Private residential treatment provides clients with a great diversity of services. Today's programs offer services such as music therapy, psychotherapy, adventure therapy, equine therapy, psychiatry services, special education, neurofeedback, and vocational education. These varied services, both within and among programs, have arisen from a need to meet the increasingly complex needs of youth and families. This diversification has created a "tapestry of many therapies" (Fahlberg, 1990) within programs.

Prior to the 1990s, most residential treatment programs were solidly grounded in one of six theories: psychodynamic/milieu, medical, behavioral, peer culture, emotional growth, or psychoeducational (Lyman, Prentice-Dunn, & Gabel, 1989; Zimmerman, 2004). Since the 1990's, most residential treatment programs have become less reliant on theory, moving to the "tapestry" approach. Though the efforts to be responsive to youth and family needs are laudable, leaders in the residential treatment network have issued a call for coherent and up-to-date models of treatment (Abramovitz & Bloom, 2003; Durrant,

1993; Gass, 2006; Lieberman, 2004; O'Malley, 2004; Stednitz, 2004; Whittaker, 2004).

A renewed reliance on formalized models would bring two distinct advantages to residential treatment. The first advantage would be improved outcome research both within and among programs. Formalized models enable researchers to codify residential treatment programs and their services, making the research more valid and generalizable. A second advantage would be improved client care. Formalized models integrate diverse theories and services within programs, reducing the likelihood of “working at cross purposes and sending mixed signals to the youngsters” (Abramovitz & Bloom, 2003, p.127-128). Experts agree that mental health care is optimized when it is integrated across all services and disciplines (Drake et al., 2001; Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002; National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; President's New Freedom Commission on Mental Health, 2003; Rapp & Goscha, 2005).

Evidence-Based Practice

One movement has emerged in mental health in the last decade that has potential to meet the needs of the residential treatment network: evidence-based practice. Evidence-based practice has been promoted by federal policy authorities (National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; President's New Freedom Commission on Mental Health 2003; Schinke, Brounstein, & Gardner, 2002; US. Department of Health and Human Services, 1999) and implemented at the National Institute of Mental Health, the Substance Abuse and Mental Health Service Administration (SAMHSA), Medicare and Medicaid, and most state mental health authorities (Panzano & Herman, 2005). The primary goal of evidence-based practice is to improve quality in mental health care by informing treatment decisions with the best available evidence (Drake, Merrens, & Lynde, 2005).

Experts note the argument for evidence-based practice is “... like

publicly prizing Mother and apple pie. Can anyone seriously advocate the reverse: nonevidence-based practice?” (Norcross, Beutler, & Levant, 2006, p. 7). “Evidence” can truly be a compelling standard. However, attempts to operationalize and implement evidence-based practice have been wrought with controversy (e.g., Essock, Goldman, Van Tosh, Anthony, Appell, Bond et al., 2003; Kazdin, 2006; Norcross, Beutler, & Levant, 2006; Westen, 2001). Two general positions have been at the center of the debate: one empirically-driven and another contextually-driven.

The empirical position contends an evidence-based practice must use treatment interventions that have been validated in multiple randomized controlled trials (RCTs) of manual-based treatments and subsequently recognized by leading policy authorities, such as the Cochrane Library or the American Psychological Association (Chambless et al., 1996; Kihlstrom, 2006). This position was popular at the beginning of the evidence-based practice movement, and continues to be the position preferred by managed care and insurance companies (Norcross, Beutler, & Levant, 2005). However, many clinicians have voiced concern about its narrow focus and potential misuses. An example of such controversy has been the development of empirically-supported, manualized lists of treatments that some state mental health systems and insurance companies have prepared for the purpose of determining reimbursement policies and rates (Reed & Eisman, 2006). Critics voice concern that exclusive reliance on such lists, along with the strict evidentiary criteria of the empirical position, effectively excludes *most* of what is done in therapy (Messer, 2004, Norcross, 2001; Ramchandani, Joughin, & Zwi, 2001; Reed & Eisman, 2006). They note most interventions in clinical practice are not manual-based. Furthermore, the critics of the empirical position argue it ignores potentially valid findings from hundreds of efficacy studies not meeting RCT standards and many other quantitative reviews (e.g., Omer & London, 1988; Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980). These studies show that therapy in general works as well as, if not better than, psychotropic medication for all but the most severe biologically-based disorders (Lambert & Archer, 2006 for a review), and specific treatment interventions account for relatively little variance in treatment outcomes (Lambert & Ogles, 2004). In fact, a variety of factors account for the 40-50% of known variation

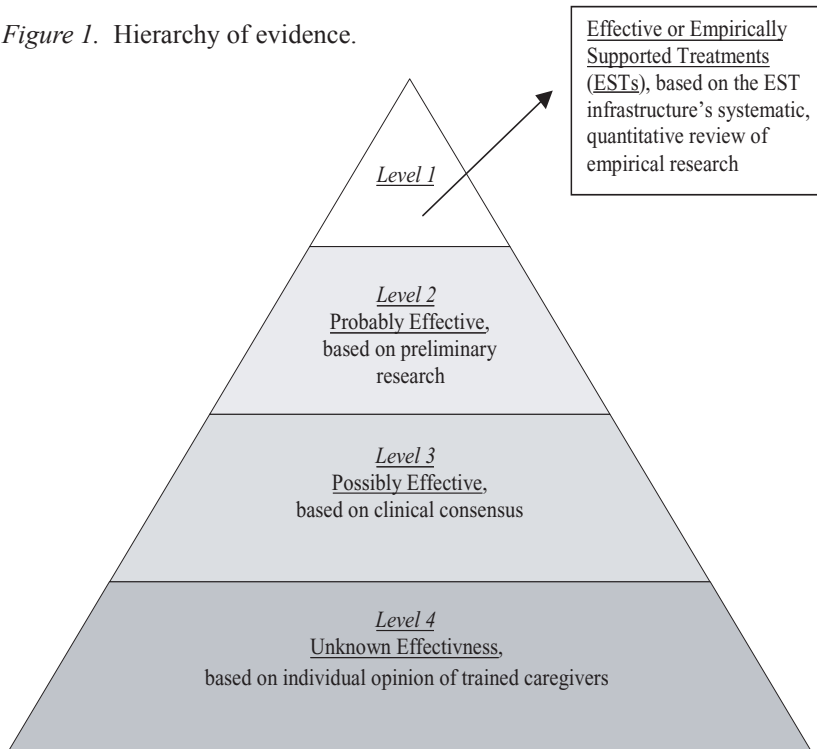
in treatment outcomes (in rank order): client factors (i.e., attitude toward treatment, severity of symptoms), the nature of the treatment relationship, the characteristics of the therapist, and, last, the specific treatment method used (Goodheart, 2006; Norcross & Lambert, 2006; Reed and Eisman, 2006).

The contextual interpretation of evidence-based has recently gained prominence in academic and policy circles (Goodheart, Kazdin, & Sternberg, 2006; Norcross, Beutler, & Levant, 2006). This interpretation purports evidence is best produced by systematic blending of: (a) a variety of research designs and methods, including qualitative research and interventions in natural settings, and (b) nonscientific evidence derived from clinical experience (Drake et al., 2005; Dulcan, 2005; Institute of Medicine, 2001; Kazdin, 2004; Messer, 2004). The American Psychological Association, a proponent of a contextual interpretation, recently issued a definition of evidence-based practice: “the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture, and preferences.” (APA Task Force on Evidence-Based Practice, 2006, p. 1). The Chair of the Task Force, Dr. Carol Goodheart (2006), described this contextual definition of evidence-based practice as a “three legged stool,” with the legs being research, patient characteristics, and clinical expertise. The crux of the position is that the clinician uses judgment to integrate and evaluate relevant research, clinical information, and client characteristics when making treatment decisions (APA Presidential Task Force on Evidence-Based Practice, 2006). The present article adopts the contextual interpretation of evidence-based practice and applies the definition to a model addressing the complexities of the residential treatment setting.

What is the definition of “evidence”?

It is important to define the term “evidence” as used in this article, because it bears on every component of the proposed model. Evidence is most easily understood in terms of a hierarchy (Essock et al., 2003). Figure 1 depicts an evidence hierarchy that is an amalgamation and simplification of other published hierarchies (Chambless, Baker, Baucom, Beutler, Calhoun, Daiuto, et al., 1998; McCabe, 2004; Norcross & Lambert, 2006; Rachandani, Joughin, Zwi, 2001).

Figure 1. Hierarchy of evidence.



The hierarchy diagram illustrates two important ideas. First is that evidence has diverse origins, the least common of which is the research laboratory. Caregivers are vital sources of evidence (Levels 3 and 4). Clinical consensus, opinion essays, anecdotal information, and clinical judgment are legitimate sources of evidence (Drake, Latimer, Leff, McHugo, & Burns, 2004).

According to the hierarchy of evidence, clinical evidence (Levels 3 and 4) is “possibly effective” or of “unknown effectiveness.” This is not to say that treatments supported by clinical evidence alone are less effective than those supported by scientific evidence. Instead, it typically means that treatments at these levels have not been subjected to the rigors of the scientific method.

Note the size of clinical evidence relative to the size of scientific evidence in the hierarchy presented in Table 1. The contextual approach to evidence-based practice recognizes that Levels 3 and

4, though non-scientific, are the levels of evidence most commonly used in clinical settings. Why would a model that seeks to increase a scientific basis recommend frequent use of nonscientific evidence? There may be two main reasons. First, there are an insufficient number and variety of scientifically validated treatments (called empirically supported treatments) to meet the diverse needs of clients in general and youth in particular. In fact, of the 200 mental disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) applicable to youth, only a limited number have treatments for which there is a strong research-base. The dearth of empirically supported treatments is most likely due to the difficulties inherent in conducting rigorous psychological research. A treatment typically achieves the “empirically established” designation only after years of pilot testing and controlled evaluation (Mueser & Drake, 2005). The second reason that the model endorses the use of nonscientific evidence is that it values the ongoing, critical role of caregivers in generating innovative and responsive treatments meriting scientific review. Empirically supported treatments currently at Level 1 in the hierarchy often originated in clinical settings as caregivers found new ways to help their clients.

A second important concept illustrated by the graphic is that clinical treatments should ultimately be validated by evidentiary methods high in the hierarchy. The goal is to raise the body of evidence to increasingly higher levels by systematically submitting the treatments to the full spectrum of the evidentiary process. This is not to suggest that evidence at top levels can substitute for evidence at low levels, as research evidence without a coexisting clinical evidence base is problematic. Imagine a case where a particular treatment was determined to be effective via rigorous research in controlled settings, but ineffective in actual practice according to clinical consensus. Because all levels of evidence are important, it would not be advisable to use the treatment according to the contextual model. In that vein, Goodheart (2006), Chair of the APA Presidential Task Force on Evidence-Based Practice, suggested it may be good to conceptualize evidence as heterarchical (i.e. legitimately derived from a multiple data sources).

A Proposed Evidence-Based Model for Residential Treatment Centers

The story and graphic depicted in Figures 2 and 3 illustrate a contextual approach to evidence-based practice applied to residential treatment settings metaphorically based upon rock climbing. This metaphor seems applicable because of the analogous processes shared by rock climbing and residential treatment. In both experiences, the tasks presented by engaging the process can seem overwhelming, even daunting. However, when approached with an organized set of interrelated people, tools, and events, the work can be rewarding, exhilarating, and creative. The primary goal of both rock climbing and residential treatment is usually safe movement to a desired position by

Figure 2. Rock climbing metaphor for an evidence-based practice model of residential treatment.

Imagine standing on a narrow ledge 50 feet up a 200-foot tall vertical canyon wall. The elements –sun and wind – are intense. Your client is a few feet above, hanging in a precarious location. She has been stuck there, scared and tired, for too long. She needs to get to the top of the wall.

Your first goal is to assure your client that she can succeed and that you will help. She calms and focuses. Then, you encourage her to “rig up” the **harnesses and rope**, which represent the therapeutic relationship. In so doing, your client becomes the **lead climber**. The other end of the rope is held by you, the care provider, now **belayer**. This support system assures her of protection and safety while scaling the sheer wall. You clearly tell her, though, that it’s up to her to do the climb: the belayer does not pull the lead climber up.

Your next step is to **assess** the situation, in a way comparable to a multidisciplinary assessment. You appraise her strengths and limitations. You assess the **climb’s rating level** which is based on the inherent challenges and resources (ledges, cracks, rocks) and is akin to the treatment setting or level of care. The terrain above and immediately surrounding your

Figure 2. Rock climbing metaphor for an evidence-based practice model of residential treatment.

client look like they would be rated “experienced” level. You believe that the climb will be hard for her, but you also believe she can use the terrain and her personal strengths to succeed. You hear her **family** who stands at the bottom, desperately screaming advice. It seems she doesn’t hear. You highly value their advice because of their wider vantage point. At the **top of the canyon wall are past climbers**, who are akin to past clients who participate in an outcome study. They came to the edge to tell you what worked best during their climb. You listen to their feedback because they’ve experienced the climb.

Before she ascends, you devise a **climb plan**—akin to the treatment plan – that incorporates different routes, tools, and holds. The plan assimilates the information you gathered and your recommendations, based on your training and experience. The goal of the plan is to move in the optimal direction, avoiding spots that are unnecessarily dangerous. You explain that there are **different styles of climbing**, such as Traditional or Sport Climbing, which are akin to the classic theoretical orientations in residential treatment (e.g., milieu, behavioral, peer culture). You tell her that you will teach her to use methods that fall within both styles, when each is appropriate. You teach her how to use **specialized tools, handholds, and footholds**, all of which are comparable to Empirically Supported Treatments (ESTs). You tell her that the equipment and holds you are teaching her will work in different situations and are known to promote successful climbs. One tool is critical: the **carabiner**. A carabiner is a reliable clip. Carabiners are akin to clinical consensus – the collective wisdom of experts in the mental

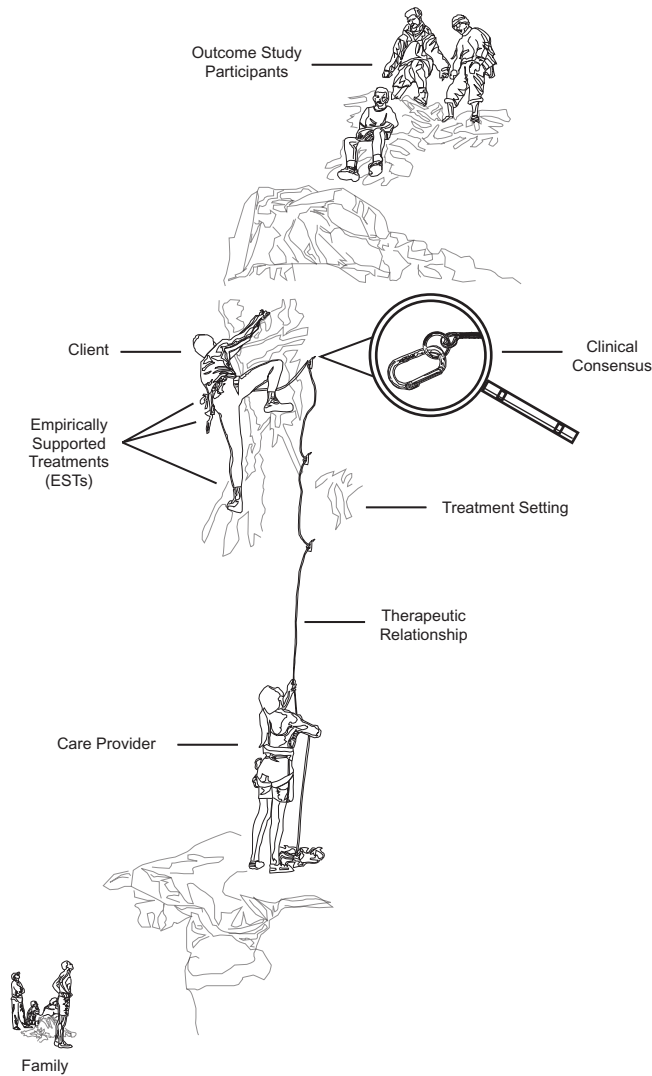
Figure 2. Rock climbing metaphor for an evidence-based practice model of residential treatment.

health field. You tell her that you'll be advising her to attach the rope to the wall with carabineers at regular intervals so that, should she fall during the climb, the rope will catch her after a short drop. When the specialized equipment isn't sufficient or when she loses hold, the carabiners will keep her safe and moving forward.

As the lead climber-client advances, your role as belayer-care giver remains vital. You ensure that the harnesses and rope stay connected. You encourage and support the lead climber. You use your good vantage point to advise her, when she needs. You communicate with everyone, even serving as a relay communicator when needed. You use every part of yourself -- your experience, judgment, values, and style --to integrate information to help the lead climber reach success.

Initially, her progress is slow and difficult. She needs many breaks and plenty of feedback. A few times, you and she revise the climb plan. After a while, she climbs with creativity and confidence and her reliance on you decreases. Those watching become inspired by her climb. When she makes it to the top, she looks down, lets out a loud victory cry, and calls her family up. They are already on the way.

Figure 3. Rock climbing graphic for an evidence-based practice model of residential treatment.



confronting challenges, using resources, and creative problem-solving. The individual components of the model, as well as the relationships between the components, are discussed in the following sections.

Empirically supported treatments (specialized tools, handholds, and footholds). Empirically supported treatments (ESTs) are like the specialized tools, handholds, and footholds of the lead climber - they are known to work well for specific problems. A lead climber is typically presented with a variety of problems while climbing, often

demanding unique and particular solutions. Although the climber carries an array of equipment, only certain tools are the “right fit” for particular problems. Using the right ESTs under appropriate conditions is a key to progress in treatment, just like using the right tools and holds under appropriate conditions is the key to progress in climbing.

Specific treatments account for 5-8% of the known variation in outcomes (Norcross & Lambert, 2006), an amount that is smaller than the variation explained by other known factors (i.e., client attitude toward treatment and symptom severity, therapeutic relationship, caregiver’s personal attributes) but nonetheless important because the selection of specific treatments is arguably how caregivers have the most immediate influence on outcomes. ESTs are often narrow in scope, pertaining exclusively to treatments where there is rigorous scientific evidence (Level 1). ESTs are available for adolescents with internalizing conditions (e.g., anxiety and depression), externalizing conditions (e.g., aggression, defiance, and disruptive behavior), chronic mental illness, and substance use problems (Fonagy, Target, Cottrell, Phillips, Kurtz, 2002; Kazdin & Weisz, 2003). In mental health service delivery, ESTs have become standard practice (Chambers, Ringeisen, & Hickman, 2005). A recent survey by the National Association of State Mental Health Program Directors found that 47 states were involved in implementing ESTs in their systems (Panzano & Herman, 2005).

It is possible private residential treatment is currently too loosely conceptualized and diverse to be evaluated as a single empirically supported treatment. Perhaps in the future after increased reliance on organizing theories facilitating codification of programs, coupled with a rigorous program of outcome research, types of private residential treatment may attain a high level of empirical support. In the meantime, specific treatments used within particular residential programs are likely the best possibilities for implementing empirically supported treatments (e.g., functional family therapy or parent management training).

For a residential treatment program to move toward an evidence-based practice, it should include ESTs that are suited to the common

presenting problems and client/family demographics. Many ESTs are portable, affordable, and applicable to the youth, families, and setting of residential treatment (e.g., parent training, social skills training). The objective is to import ESTs with as much fidelity as possible. However, modifications will often need to be made to ensure a good “fit” for the setting and clientele (Essock et al., 2003; Panzano & Herman, 2005).

Due to clinical time constraints and the complexity of research, it is unrealistic to expect caregivers to locate, evaluate, and integrate complicated research studies for every presenting problem. Fortunately, a new publicly and privately funded infrastructure relieves clinicians of the burden of sifting through rigorous research. This infrastructure uses a standardized process to make the EST designation, typically involving the screening of thousands of research studies according to elaborate criteria. One published research article with positive findings, or even a dozen published research articles, does *not* qualify a treatment as an EST. Instead, a particular treatment has to successfully pass through the evidentiary filters of the EST infrastructure to be designated as an EST.

“Gold standard” organizations in the EST infrastructure, along with their corresponding websites, are listed in Table 1. Three cautions about these websites are noteworthy. First, the websites use different terminology to refer to treatments with Level 1 evidentiary support. Some refer to them as *model programs* (Substance Abuse and Mental Health Service Administration), some refer to them as *evidence-based practices* (NRI Center for Mental Health Quality and Accountability) and, of course, others refer to them as *ESTs* (American Psychological Association). Nonetheless, the treatments listed on the sites can be considered treatments with Level 1 support as defined in this article. Second, the EST website lists do not always overlap because organizations use different slightly criteria to determine ESTs. Therefore, when searching for ESTs to import into a residential program it is a good practice to search multiple websites, giving highest priority to treatments appearing on multiple lists. Third, it is vital to evaluate the appropriateness of particular ESTs for the developmental needs of a youth population (Hoagwood et al., 2001; Kazdin & Weisz, 2003). Though the research on ESTs appropriate for youth is significantly

less developed than that for adults, most of the websites listed in Table 1 have material devoted expressly to youth.

Clinical consensus in residential care (“carabiner”).

Clinical consensus is a level of evidence derived from a widely held standard of care or from professional guidelines, such as those promulgated by the National Association of Therapeutic Schools and Programs (NATSAP). Like a carabiner used in a climb, clinical consensus is reliable and trusted when used correctly. It keeps treatment on course especially when the other tools (e.g., ESTs) are not particularly useful. Good climbers periodically check their carabiners for wear and implement new ones when the old are found to be outdated or unsafe. So too with clinical consensus; it is a dynamic entity, responsive to changing needs and information.

Noted evidence-based practice experts advocate for the priority of clinical consensus evidence because it guides clinicians in the application of ESTs (Drake et al., 2005; Goodheart, 2006; Norcross et al., 2006; Wampold & Bhati, 2004). ESTs should always be evaluated for relevance and utility when applied to a certain level of care. Level 3 evidence (clinical consensus) can be used precisely for that purpose: to determine the conditions under which Level 1 or 2 evidence (scientific) should be used. Clinical consensus can also be used to inform clinical decision-making when scientific evidence is not available. One example is the NATSAP Standards of Good Practice, which are invaluable to caregivers because they address many issues for which there is no research base. In these ways, organizations such as NATSAP help caregivers implement evidence-based practice. They provide collective expertise to help the caregiver make sound clinical decisions that could otherwise seem daunting.

Client in residential treatment (lead climber).

Like the lead climber on the canyon wall, the client possesses the most powerful role in the evidence-based practice model. Psychotherapy outcome research supports this notion. Quantitative reviews indicate that client factors are the most potent predictors of treatment success. When combined together, clients’ expectations, readiness for change, active effort, and problem severity account for 25-30% of the variation in measured outcomes (Norcross & Lambert, 2006). Simply put, clients have the greatest impact on treatment

outcomes. These findings underscore the importance of client motivation and active involvement in treatment. However, newly enrolled residential clients typically have little desire for personal change. Therefore, providers need to be especially well trained in techniques addressing ambivalence and promoting intrinsic motivation (Rollnick & Miller, 1995). Intrinsic motivation can be the most vital issue for clients in treatment.

A common misconception is that evidence-based practice eliminates or reduces the value of client preference and choice in the treatment process. Some believe evidence-based practice involves applying ESTs without regard for the preferences of the client. To the contrary, evidence-based practice has its foundation in the values of client self-determination and shared decision-making (APA Presidential Task Force on Evidence-Based Practice, 2006; Drake, 2005; Institute of Medicine, 2001). Evidence-based practice requires an active client role, with the client serving as a partner in the processes of treatment (Birkel, Hall, Lane, Cohan, & Miller, 2003). Active roles for youth have dramatic implications for residential treatment. For example, youth can have meaningful participation in co-creating a care plan, selecting treatments, making discharge decisions, and evaluating treatment progress. Granted, an active client role assumes youth have resolved issues of low motivation and desire to be active, which is unlikely to occur in the first stage of treatment. However, when motivation issues are resolved, the program policies and procedures should support a legitimate and active client role in treatment.

Caregiver in residential treatments (belayer).

Like the belayer in rock climbing, the caregiver has a critical role in the process of evidence-based practice. The caregiver is responsible for assessing the client and the situation, communicating with people involved in the care of the client, integrating all types of evidence, and co-creating plans for treatment. In addition, the caregiver is responsible to adjust ESTs to match the needs, characteristics, culture, and preferences of the client and family (APA Presidential Task Force on Evidence-Based Practice, 2006). In many situations, caregivers must rely solely on their judgment to make decisions because scientifically and consensus derived evidence is not available (Drake, 2005). Caregivers also have a significant bearing on client

outcomes. Quantitative reviews of the therapy outcome literature indicate that about 10% of the known variation in client outcomes, above and beyond the type of treatment, is attributable to therapist factors (Norcross & Lambert, 2006). Personal attributes of the caregiver (e.g., flexibility, honesty, respectfulness, trustworthiness, confidence, warmth) are correlated with positive client outcomes (Ackerman & Hilsenroth, 2003). In addition, the literature indicates the professional judgment and expertise of the clinician are important components of evidence-based practice (Crits-Christoph et al., 1991; Goodheart, 2006b; Wampold & Brown, 2005). An evidence-based practice relies on the caregiver's competent integration of knowledge, experience, technical and relational skill, critical thinking, decision-making, and self-awareness in a fluid, complex, and ambiguous situation (Goodheart, 2006b).

The finding that client outcomes are related to caregiver qualities provides a strong rationale for maximizing clinical expertise and training in the residential treatment network. Residential treatment falls on the extreme end of the continuum of care, largely due to the severity and complexity of youth and family problems. Clinical expertise and training may be more important at this level of care than at any other level. Clinical staff at this level should be the "best of the best," with maximum training and experience. Therefore, administrative efforts to foster clinical training, mentoring, supervision, and staff retention are not merely "perks," but fundamental to evidence-based practice and positive client outcomes. Perhaps these issues can best be addressed at a high level, such as organizations that guide the profession (e.g., NATSAP). Focus groups or committees may consider implementing clinical staff training programs and staff retention programs.

The therapeutic relationship (rope and harnesses).

The therapeutic relationship is analogous to the rope and harnesses used in rock climbing; the connection between client and caregiver makes the process safer, more manageable, and, because it keeps it "on course" and effective. Decades of efficacy research have led researchers to conclude the relationship between the client and the caregiver is a potent predictor of treatment outcomes (Norcross, 2001). Its importance is second only to the role of the client and is independent of the specific type of treatments used. In

fact, treatments account for significantly less variation in therapy outcomes (5-8%) than the therapeutic relationship (10%) (Norcross & Lambert, 2006). The research indicates there is Level 1 scientific evidence for the following components of the therapeutic relationship: empathy, goal consensus, and collaboration (Norcross, 2001). Within this research, empathy refers to the caregiver's ability to understand the client from the client's point of view, goal consensus refers to the agreement between caregiver and client on the goals for treatment, and collaboration refers to the shared participation of caregiver and client in the work of treatment.

The impact of the therapeutic relationship on treatment outcomes has important implications for care plans and treatment focus at residential schools. "Connecting" or "joining" with youth could arguably be the most powerful act of the caregiver in the residential school. Time spent forming healthy relationships is highly productive, even though it may not be immediately transferred into measurable skills. The expectation is that the therapeutic relationship becomes the foundation for skill building and for change. Like belayers who constantly attend to the integrity of the ropes and harnesses connecting them to lead climbers, caregivers need to be constantly mindful of their connection to clients, as positive outcomes are largely dependent on the quality of that relationship.

Family involvement in residential treatment (people at the base).

The role of the family at the base of the canyon wall of Figure 2 and 3 is comparable to the role of the family in residential treatment. The family is valued by the belayer and caregiver and is actively involved in the process by communicating, informing, observing, and climbing. They are an essential component of the treatment process.

In general, research reviews conducted on psychotherapy outcome literature show treatment programs with family-based interventions are more effective than child-focused programs for youth (Huan et al., 2005; Kumpher, 1999; Sunseri, 2004). More specifically, residential treatment outcome research indicates family involvement in treatment, as well as family functioning after discharge, are among the strongest predictors of youth outcomes after residential treatment discharge (Hair, 2005; Jenson & Whittaker, 1989; Robinson, Kruzich,

Friesen, Jivanjee, & Pullman, 2005). Two studies are particularly informative on this issue (Landsman, Groza, Tyler, & Malone, 2001; Stage, 1999). Landsman et al.'s (2001) study included two groups of clients at one residential program, one group treated with a family-based approach, the other group treated with a standard youth-based approach. The family approach provided skill training for families, extended aftercare, and active family participation in therapy and decision-making. The individual approach used "treatment as usual," including individual and group therapy, behavior management, and educational, medical, and recreation services. Results showed youth receiving the family-based approach had significantly shorter lengths of stay prior to graduation and were more likely to be discharged to home than to another placement. Stage (1999) investigated the role of family dysfunction, disruptive behaviors, family therapy, and victimization on discharge outcomes at a private residential school. The results showed family participation in therapy was the only significant predictor of successful discharge to a less restrictive setting. Using different and rigorous methodologies, studies such as these led expert reviewers to conclude that family-based interventions improve youth outcomes (Hair, 2005; Huang et al., 2005). It bears mentioning that there are no empirical studies supporting the limiting of youth's contact with family as a method for helping children in residential care (Robinson et al., 2005). This body of literature has led experts to recommend a shift from a youth-focused to a family-focused model in residential care (Huang et al, 2005; Nickerson, Salamone, Brooks & Colby, 2004). One researcher concluded, "...the road to better treatment outcomes may be paved with comprehensive, effective family treatment" (Sunseri, 2004, p.50).

Experts recommend "horizontal and vertical integration of families" (Lieberman, 2004, p. 290) in residential treatment. To support horizontal integration of families, Whittaker (2004) recommended broadening the levels of care within residential treatment to include respite care, co-located treatment (home and residential treatment), and partial placement. Regarding the vertical integration of families within residential treatment, Lieberman (2004) wrote, "A family-focused agency is permeable to families, uses parents as advisors in care and wrap-around planning, pays families for participation in key advisory and policy-making functions, and involves families

throughout the life of the agency” (p. 290).

An expanded family role in residential treatment has the potential to trigger dramatic changes in residential treatment. It may require significant restructuring of policies and procedures because the degree of involvement recommended is not satisfied by common practice in residential care (e.g., telephonic therapy once weekly). For example, a family-based program might require parents to “shadow” youth for a week of treatment, monthly on-site therapy visits, and/or multiple family therapy sessions a week.

Theoretical models in residential treatment (style of climbing).

Like different theories, different styles of rock climbing (e.g., traditional, sport) use different equipment, methods, and assumptions. Though often underused or underdeveloped, the underlying theories in residential treatment are psychodynamic/milieu, medical, behavioral, peer culture, emotional growth, and psychoeducational (Lyman et al., 1989; Zimmerman, 2004). Extensive reviews on implementation and evaluation of the theories used in residential treatment are available (Abramovitz & Bloom, 2003; Cohler & Friedman, 2004; Lyman et al., 1989; Rosen, 1998; VanHasselt & Kolko, 1992; Zimmerman, 1990). These reviews suggest there are varying degrees of Level 2 and 3 evidence for interventions stemming from the underlying theories used in residential treatment. Because there is some support for the theories used in residential treatment, it is conceivable that any one or combination of them can be used in an evidence-based practice model.

Evidence-based practice is designed to limit bias. In fact, the mission of evidence-based practice is to identify which theory-based interventions are effective for particular clients under certain specific circumstances. It is important to note that both medical theory and cognitive-behavioral theory have been the focus of evidence-based practice research. This slant is more a function of empirical neglect than a bias inherent in evidence-based practice approach. With creative research methodology, evidence-based practice could readily be applied to theories that have received relatively little scientific attention in the youth outcome literature (e.g., milieu theory, emotional growth theory) (Kazdin, 2006; Kazdin, Bass, Ayers, Rodgers, 1990).

At least two conditions need to be followed when developing underlying theory. First there needs to be sufficient evidence to support their use with the needs of the youth at a particular residential treatment program. A good fit is needed between the client population and the theory or theories. For example, youth with severe conduct disorder may respond better to a program based on behavioral theory than a program based on the theory of positive peer culture (Zimmerman, 1990). Similarly, psychoeducational theory may not be effective for youth with very low IQ scores.

The second condition for increased reliance on theories is meaningful integration. When an eclectic theoretical approach is used, divergent assumptions about etiology and treatment need to be reconciled in a cogent manner. To illustrate, students with a bipolar disorder may be treated with a biopsychosocial approach, which systematically endorses multiple etiologies and multi-modal treatment such as psychotropic medication (medical theory), self-monitoring (cognitive theory), and improved social relationships (milieu theory). Care providers can logically integrate these theories by acknowledging that although bipolar disorder has an organic etiology (and therefore benefits from a medication regime for primary symptom management), self-monitoring promotes early intervention for mood swings and improved social skills and social awareness mitigate the negative social effects of the primary mood symptoms.

It may be worth adding another theory to the repertoire of “theory candidates” in residential treatment. Strength-based theory is gaining momentum in the youth-based literature. It draws from solution-focused therapy and the prevention, resiliency, spirituality, and positive psychology movements (Smith, 2006; Snyder, Berg, & Thompson, 2003). The theory focuses on building strength, resiliency, solving problems, and strategic use of protective factors. Martin Seligman, past president of the APA noted, “Treatment is not just fixing what is broken; it is nurturing what is best within ourselves” (1999, p.1).

Perhaps some meaningful integration of the theoretical orientation(s) underpinning the work of residential programs can improve care by integrating and ordering services, treatments, and priorities. Better developed theories would also help the effort to

codify programs, thereby facilitating outcome research. It is likely that many residential programs have, at some level, already grappled with the complexities of diverse theoretical assumptions and have arrived at some synthesis. Perhaps the challenge will come with articulating theoretical orientation to referral sources, staff, youth, and families.

Outcome research in residential treatments (past climbers atop the canyon wall).

Outcome research data is comparable to the information gained from past climbers. From the top of the wall, past climbers can provide feedback to those traveling over the same route. Their feedback can be valuable because these climbers have traversed the route and have informed perspectives. Outcome research can be like this experience. It is a standardized method of receiving feedback on youth functioning and treatment efficacy after residential care has ended, when the feedback is enhanced by a change of context and the passage of time.

Outcome research has practical benefits. It provides information to care providers, families, youth, referring professionals, and insurance companies about outcomes. For example, outcome study results could enable a residential staff member to say, “Youth enroll in our program with psychosocial problems place them in the 25th percentile of same-aged youth. However, by graduation, the majority of our students are at the 85th percentile of psychosocial functioning.” Outcome research data could enable an administrator to tell a parent, “According to our outcome data, seventy-five percent of students who left treatment against the advice of program staff relapsed within 3 months.”

One of the ultimate benefits and utilities of outcome research is program improvement (Troutman, 2005; Weisz, Donenberg, Han, & Weiss, 1995). Outcome study data can be used to identify specific presenting problems or types of youth where the outcomes are relatively poor. For example, a residential program may decide to redesign the substance abuse treatment approach for females if outcome data indicate female youth with substance abuse problems have less favorable outcomes than male youth.

The residential treatment network has a compelling need for outcome studies. Relative to other sectors in mental health (e.g.,

home-based services, school-based services, community mental health) there is a dearth of published outcome research conducted in residential treatment (Curry, 1991; Epstein, 2004). Furthermore, most of the published research is based on samples drawn either from public residential treatment programs serving youth in the juvenile justice and child welfare systems (Curtis, Alexander, & Langhofer, 2001; Hair 2005) or inpatient psychiatric hospitals (Epstein, 2004, Lyman, Prentice-Dunn, & Gabel, 1989). Those care systems are sufficiently different in terms of clientele, stakeholders, funding, and services to question whether the findings generalize to private residential treatment settings. Furthermore, the residential treatment research corpus is fraught with methodological flaws. Reviewers criticize this research for its reliance on single, small, non-randomized samples, lack of standardized measures, and unsophisticated statistical analyses (Curry, 1991; Curtis et al., 2001; Epstein, 2004, Hair, 2005)

Curry (1991) made suggestions for improving this body of research, particularly regarding the use of “gold standard” empirically validated assessment measures, [e.g., Youth Outcome Questionnaire (Mosier, Burlingame, & Wells, 1998), Child Behavior Checklist (Achenbach, 2001) Child and Adolescent Functional Assessment Scale (Hodges, 1999)] and more powerful research designs using comparison groups. At a larger level, residential school networks may benefit from a cooperative or consortium similar to that of the Outdoor Behavioral Healthcare Research Cooperative, established to facilitate outcome research in outdoor programs (www.obhic.com/membership). Benefits of this type of collaboration can include the availability of pooled resources to conduct rigorous research and the opportunity to create a large-scale database of outcomes in private residential care. Outcome research produced at this level would provide invaluable benchmarks for residential treatment, and ultimately evidence on the effectiveness and viability of private residential treatment as a level of care within mental health continuum of care.

It is understandable that the private residential treatment network has been complacent about outcome research. Unlike treatment programs funded by insurance companies and public monies, private residential programs are not required to do outcome-based contracting. However, the time of amnesty for outcome research in

the private residential treatment network will soon end, or perhaps has ended already. Referring professionals and parents, who are generally well-informed and expect high standards, are likely to require that the residential treatment network pass its programs through scientific evidentiary filters of outcome research, as have other levels-of-care in mental health service delivery system. The heightened demand for accountability is a positive step in the right direction, especially if it fuels a process that improves quality.

Despite the problems with the research on residential treatment, it is worth reviewing because it currently provides the best available information on outcomes. Thorough reviews of residential treatment outcome research have been published. Although these reviews summarize research conducted at both public and private residential programs, the majority of research focused on public residential programs (Connor, Miller, Cunningham, & Melloni, 2002; Curry, 1991; Curtis et al., 2001; Epstein, 2004; Hair, 2005; Whittaker, 2004). Conclusions drawn from these reviews are similar: 60-80% of youth treated in residential treatment show significant improvement by the time of discharge; however youth functioning post-discharge is more closely related to discharge environment than in-treatment functioning. According to the reviews, the following factors are related to post-discharge functioning: family involvement during treatment, stability of the discharge environment, and quality of aftercare services. (Curtis et al., 2001; Epstein, 2004). These results may have implications for program development in the residential network. For example, these findings suggest it would be beneficial to focus on generalizing gains made in the residential environment to the family environment as a routine aspect of residential treatment. In practical terms, this could mean that youth should have multiple “home visits” in order to implement new skills with their family before graduation. The results also point the need for intensive aftercare services or transition care services. At admission, residential staff should inform family and youth that transition care is part of the standard course of treatment and therefore will be recommended.

Mental health care occurs along a continuum. Moving directly from residential care to weekly outpatient therapy entails skipping over at least two levels of care in the continuum (i.e., day treatment

and intensive, home-based treatment). Residential therapists should have a strong rationale for doing this, given that aftercare therapy has been found to be vital to client outcomes.

The outcome research suggests residential programs have good reasons to make transition care planning a major focus of their work. With transition care planning, residential therapists work extensively with youth and families to implement a plan for continued success and adaptation following graduation. The plan should address all contexts of youth and family functioning (e.g., work, school, peers, drugs, treatment) and should be arranged and “practiced” far in advance of graduation. Practically speaking, this likely means that youth meet with after care therapists, school personnel, and possibly even peers before graduation. It also suggests that selected aftercare be extensive enough to meet the intense needs of newly graduated youth and their families. Clearly, transition care tasks are cumbersome, need to begin in the initial stages of residential care, and are likely to be a major focus of treatment throughout residential care.

Assessing the appropriateness of residential treatment setting (climb rating level), multi-disciplinary assessment (assessing the situation and climber), and care plans (climb plan).

The last three components of the evidence-based practice model are related and the culmination of the preceding components. First, evidence-based practice requires programs to assess the appropriateness of the treatment setting for the youth they serve (Hussey & Guo, 2002; Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998). One study of 17 public residential programs found about one-third of youth would have been better served in community settings (Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998). This finding needs to be explored within the private residential network. In an ideal rock climbing situation, a youth would not begin a climb unless those supervising were sure the climber was appropriately matched to the challenge of the terrain. The same is true for clients in residential treatment settings. Programs should define and implement inclusionary and exclusionary criteria for their clients. In an evidence-based practice model, youth are admitted to a program when program-specific outcome research demonstrates that the anticipated outcomes are positive, as well as when clinical consensus and empirical research suggest the residential level of care

is indicated.

Once admission criteria are established and followed, the evidence-based practice model requires a thorough, multidisciplinary assessment for incoming youth. Licensed therapists involved in the care of the youth should have the competence to formulate clear case conceptualizations assessing diagnoses, weaknesses, and strengths (APA Presidential Task Force on Evidence-Based Practice, 2006), which in turn should determine the care plan. Appropriate selection of ESTs and other treatments used in the care plan depend on an accurate assessment (Kazdin, 2004).

The care plan is the primary vehicle for individualizing treatment to the needs of a particular youth and family. There is consensus among evidence-based practice authorities that individualized care plans are a fundamental requirement of evidence-based practice (Drake et al., 2005; Huang et al., 2005; Institute of Medicine, 2001). In fact, the President's New Freedom Commission on Mental Health (2003) calls for providers to ensure that each youth has an individualized, single plan of care addressing youth and family needs in salient domains and integrating services into a meaningful whole. Standardized care plans are *not* evidence-based practice. In treatment as in rock climbing, the plan is co-created with the youth and family, individualized, and repeatedly evaluated and adapted to suit to the situation (APA Presidential Task Force on Evidence-Based Practice, 2006). Lengths of stay are not uniform, and neither are the care plans. For some residential programs, this aspect of evidence-based treatment would require dramatic changes to the content and process of treatment. Individualizing care is complex, inefficient, and difficult. Despite these significant challenges, individualized care is a cornerstone of evidence-based practice and well worth the effort.

Conclusions

The evidence-based practice model has far-reaching implications for residential programs. It calls for empirically supported treatments, systematic outcome research, intensive staff training and retention programs, increased roles for the youth and family, cogent theoretical underpinnings, and individualized care plans that place priority on

the therapeutic relationship, client motivation, family-based services, and transition care planning. The changes suggested by the model are admittedly difficult, perhaps daunting. Given that most program administrators and care providers are already investing exhaustive efforts, it may even seem impossible. However, it is conceivable that evidence-based practice, phased in systematically, may not entail much more work. Perhaps the solution lies not in working more, but in working “smarter” by putting time and energy into treatment components that are most likely to maximize positive outcome. It further seems that regardless of feasibility, evidence-based practice in mental health is here to stay. The viability of programs will ultimately depend on the degree to which evidence-based practice principles are implemented. The hope is that the network of residential programs can pool resources to develop organizing theories, provide staff training and retention programs, explore admission criteria, evaluate the applicability of empirically supported treatments, strengthen clinical consensus, and conduct systematic outcome research. Working collaboratively across programs, is likely to strengthen outcomes for individual programs and ultimately support the common goal of improving quality care for the youth and families served.

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Table 1.

Organizations and Websites with Lists and Descriptions of Empirically Supported Treatments

Organization/Website

Substance Abuse & Mental Health Service Administration (SAMHSA)
www.modelprograms.samhsa.gov/

American Psychological Association
www.apa.org/divisions/div12/rev_est

Cochrane Library
www.update-software.com/publications

NRI Center for Mental Health Quality and Accountability
www.nri-inc.org/cmha.cfm

National Institute of Drug Abuse
www.nida.nih.gov/Prevention

Office of Juvenile Justice & Delinquency Prevention
www.strengtheningfamilies.org

BMJ Publishing Group
www.clinicalevidence.com/ceweb

International Campbell Collaboration
www.campbellcollaboration.org/SWCG

Integrated Risk Management Model for the Therapeutic Schools and Programs: Why the risk is worth taking

John Mercer

Mission Mountain School

Abstract

This article is the first of two written to focus attention on risk and behavior management in therapeutic schools as an ongoing process with key components and steps. The professional literature for public schools contains a large number of articles addressing risk and behavior management, but most possess limited application to therapeutic schools. These papers attempt to bridge this gap by outlining the characteristics of therapeutic schools and comparing risk management principles with other types of therapeutic programs. Demographics of the population served by therapeutic schools are described. The importance of experiential education in the therapeutic school is explored along with the role of risk and challenge in the learning process. Risk management and other useful terms are defined. An integrated risk management model is presented discussing risk assessment and analysis. Examples from the Mission Mountain School's approach to integrated risk and behavior management is presented as an illustration of how the principles identified in the literature can be used to create an applied model of integrated risk and behavior management. Citations are referenced both as a resource and to stimulate thought and discussion. This paper is directed toward school administrators, clinical directors, and program directors seeking to understand the important concepts and theory of risk management. The integrated risk management model and concepts introduced in this paper may also help the referring professional or parents to better evaluate an individual program's risk management approach and its suitability for different student profiles.

Introduction

The National Association of Therapeutic Schools and Programs (NATSAP) is a voluntary professional association founded in 1999, dedicated to improving the quality of care in private pay residential programs for children. Membership is contingent on following established NATSAP ethical principles and best practices. The *2003 Directory* published by NATSAP lists 113 programs. Fifty-eight (58) of these programs opened after 1993 and 26 started since 1998. This represents a 105% increase in new programs in 10 years (NATSAP, 2003). In 2006 NATSAP continues to grow, consisting of 165 current members and serving over 15,000 children nationally (Santa, 2006). Approximately 30% of the programs listed in the current *NATSAP 2006 Directory* are schools, with 10 boarding schools, nine emotional growth boarding schools, and 31 therapeutic boarding schools. NATSAP defines a therapeutic boarding school as providing:

...an integrated educational milieu with an appropriate level of structure and supervision for physical, emotional, behavioral, familial, social, intellectual, and academic development. Therapeutic schools either grant a high school diploma or award credits that lead to admission to a diploma granting secondary school. Therapeutic schools serve students who have a history of failing to function at home or in less structured or traditional schools in terms of academic, social, moral, or emotional development (NATSAP, p. 6, 2006)

For the purposes of this paper, the term therapeutic school includes all the schools found in the NATSAP organization.

Program Type and Continuum of Care

Examining the differences between types of programs can provide a greater understanding of the different categories and types of risk therapeutic schools encounter when compared with other programs. It is helpful to look at where the therapeutic school model falls in a continuum of care to understand not only what these risks might be, but also what families can expect from a therapeutic school. As seen in Figure 1, the continuum begins with the day school and ends with the residential treatment center.

Figure 1. Comparison of program types

<u>Day School</u>	<u>Boarding School</u>	<u>Therapeutic School</u>	<u>Residential Tx Center</u>
<p><u>Daily Living,</u> Hygiene, Self Care, Nutrition, Health, Medication management Personal and Community Chores</p>	<p>Little attention or focus on daily life skills, other than homework</p>	<p>Curriculum focuses on creating school culture, DL skills, hygiene, self care, nutrition, personal and community chores. Students may have Individualized Plan</p>	<p>Some focus on DL skills as adjunct to therapy: hygiene, self-care, and nutrition. May be included in TX plan</p>
<p><u>Recreation,</u> Sports, Health and Fitness and Experiential Education</p>	<p>Indoor sports classes, team sports, health class</p>	<p>Focus on experiential education, milieu building, team sports, health class, gym, outdoor recreation, adventure and wilderness activities, individualized student plans</p>	<p>Recreation therapy, as adjunct to therapy: activities, some sports, may be included in tx plan</p>
<p><u>Education,</u> Classes, Curriculum, Course work</p>	<p>Curriculum sequence based on pedagogical theory, leading to diploma</p>	<p>Curriculum based on pedagogical theory, leads to diploma, co-curricular arts and experiential activities, IEPs, & LD support, high degree of faculty mentoring</p>	<p>Education as adjunct to therapy, often focuses on filling gaps in transcripts, IEP's and LD support available</p>

<u>Therapy</u> Individual Group, Modality, Style	<u>Day School</u>	<u>Boarding School</u>	<u>Therapeutic School</u>	<u>Residential Tx Center</u>
	Some limited in school counseling, referrals available, some mentoring	School counselors, dean of students, dorm parents, high degree of faculty mentoring available	Dean of students, high degree of faculty & staff mentoring, extensive therapy included on site, therapists on staff, individualized tx plans	Highly staffed, clinically based, high ratio of therapists to students, sophisticated tx plans, variety of individual therapy available.
<u>Psychiatric</u> Care/Services	None on site	None on site, some off site referral. Limited medication management.	School facilitates off site visits, or has Psychiatrist come on site, facilitates med. management	Onsite psychiatrist and medical staff, intensive med. management, time out, therapeutic restraints and ICU.
<u>Parent</u> Involvement	High opportunity in PTA type activities	Less opportunities available, founders day etc.	Regular parental involvement typical required onsite	Depends on program
<u>Student Profile</u> Screening Academic Social Hx Intellectual Psychological Psychiatric Willingness Student desire Self modulating Ability to perform	Open/inclusive Important Not usually import Not usually import Not usually import Not usually import Adequate Adequate Adequate Adequate & import	More rigorous Important Important May be considered Not addressed Not addressed Adequate Adequate Adequate Adequate & import	Rigorous Important Important Important Important Considered Usually willing Often lacking Often lacking Often lacking	Rigorous Not important Important Important Important Important Often lacking Often lacking Often lacking

Academic boarding schools typically divide their curriculum into residential elements, program activities, and academic components or programs. Most boarding schools do not integrate the students' experience between these program areas. Only a few possess a well articulated philosophy of adolescent development expressed in a sequential, systematic residential, or experiential curriculum. Much of the literature on risk management for day and boarding schools is directed at disaster mitigation or minimizing risk of physical harm to students. Currently there is an increased focus on prevention of school related violence and assault (Haynie, Alexander & Walters, 1997; Katz, 2000).

As seen in Figure 1, therapeutic schools have a lot in common with regular boarding schools and with residential treatment centers. Many therapeutic schools, however, hold a stronger allegiance to the school part of their mission than the residential treatment center. The result is that education may be a more central component for the therapeutic boarding school. Depending on the school model, therapy may be equal in importance, or may be secondary to the students' learning experience. Some of the early therapeutic school models used an emotional growth curriculum as adjunctive to education. Residential and recreation also form the other two central components of therapeutic schools. Therapeutic schools often have a much higher degree of experiential education as part of the program than regular schools or a residential treatment centers. In addition, therapeutic schools typically have a greater focus on behavior management than regular schools. Psychiatric care has been limited in the past with therapeutic schools, but is becoming more prevalent and quite similar to treatment center models.

Treatment centers possess a primary focus on psychological and psychiatric care and therapy, with residential, recreation, and academics as adjunctive elements to the primary care objectives. They follow more of a medical or behavioral health care model rather than a pedagogical or experiential learning model.

These observations are supported by the work of Balmer (2003), who has delivered several presentations categorizing programs based on the following five components as proportionately represented in

their structure: milieu/community, therapy/counseling, education, activities/recreation, and psychiatry. The relative amount or focus on each of these five components provides another way to conceptualize similarities and differences.

While these categories may not be based on research, they are generally consistent with available research. No current research classifies the different programs by constituent components. In recent years, the distinctions between these models have become blurred. Models where treatment centers are being designed as schools, as well as schools integrating more of a treatment center modality, are becoming more prevalent (Amtzis, 2003; Gaffney, 1999; Horwitz, 1999; U.S. Department of Health and Human Services, 1999).

Best practice standards can vary for day schools, therapeutic boarding schools, and residential treatment centers. Parent and student perceptions and expectations also influence what constitutes an acceptable level of risk. The ability of students to self-modulate and self-manage is a key factor in looking at different risk management practices between boarding schools, therapeutic boarding schools, and residential treatment centers. Programs should be designed to manage and mitigate risks to a reasonable level for a typical student profile. Programs can encounter difficulties when they accept students who do not fit the profile and find their risk management plans are inadequate to protect students.

Population Served by Therapeutic Boarding Schools

While many children successfully navigate their teen years, adolescence can be a difficult time of turmoil and adjustment for some individuals. Popular and scientific literature express concern about the problems and difficulties faced by these troubled adolescents in the United States. Suicide, violence, alcohol abuse, and other drug abuse all negatively affect adolescents, as well as their families, schools, and communities. Along with behavioral disorders such as attention deficit hyperactivity disorder, these problems create difficulties in learning opportunities, adjustment processes, and raise questions about how to effectively educate and care for these children (Erikson, 1968; Goldstein, 1997; Pagliaro & Pagliaro, 1996; Roeser, Eccles, & Sameroff, 2000; Steinberg, 2001).

The median age for the first manifestation of symptoms of mental disorders in the United States is 16 (Robins, & Price, 1991). The risk for unipolar depression and chemical dependency is highest at ages 15 – 19 (Burke, Burke, Rae, & Regier, 1991). Longitudinal studies link adolescent dysfunction, behavioral, and emotional disorders to the development of persistent personality and affective disorders in adulthood. These conditions have a detrimental effect on adult competency, success, and ability to function in society (Ge & Conger, 1999).

One 14-year longitudinal study of 386 adolescents from a working class community found that at age 18, a large number of these adolescents met diagnostic criterion for lifetime psychiatric disorders as defined by the DSM-III-R. This includes 32.4% as alcohol dependent, 9.8% drug dependent, 9.4% depressed, (half of those were suicidal), 22.8% phobic, 2.1 % OCD, and 6% PTSD. This study further identified significant impairments for chemically dependent youth with school failure rates, poor grades, and greater emotional and behavioral problems (Reinhertz, Giaconia, Lefkowitz, Pakis & Frost, 1993).

Studies link attention deficit disorder and hyperactivity with poor academic achievement in adolescent children (Taylor, Chadwick, Heptinstall, & Danckaerts, 1996). Other studies link externalizing disorders such as oppositional defiant disorder and conduct disorder with poor school performance, maladjustment, and criminality (Mannuzza, Klein, Abikoff & Moulton III, 2004). Drug and alcohol abuse have been linked with these and other serious problems (e.g., mood disorders, anxiety and stress disorders, personality and cognitive learning disorders) (Tapert, Baratta, Abrantes, & Brown, 2002; Belcher & Shinitzky, 1998; Pagliaro & Pagliaro, 1996).

Emotional and psychological disturbances occurring in adolescents are growing. In 2003, it is estimated that 20.6 % or 5.1 million of the children in the United States between the ages of 12 and 17 received counseling or treatment for emotional or mental health problems as compared to the 2002 estimate of 19.3% or 4.8 million. About nine percent of those receiving treatment in 2003 required hospitalization. Fifty-one percent of 12th graders in 2003 used some illicit substance

during their lifetime. Twenty-four percent used an illicit substance within 30 days of the survey. Twenty-eight percent of the youth between 12 and 17 years of age using illicit drugs in 2003 received treatment for mental health problems (National Institute on Drug Abuse, 2004; Substance Abuse and Mental Health Services Administration, 2004).

The number of children visiting pediatricians' offices "with recognized psychosocial problems more than doubled between 1979 and 1996" (American Academy of Pediatrics, 2003 p. 34). At the same time, the pool of parents is decreasing. Only 26% of households in the U.S include children under 18 and less than half of those are intact families with both biological parents present. Numerically this implies that while adolescent dysfunction is increasing, the number of households with children is decreasing, amplifying the effect on total population of households with adolescents (American Academy of Pediatrics, 2003).

In 1997, 11% of all public school children received services under the Individuals with Disabilities Education Act, and emotionally disturbed children comprised eight percent of that population. A 1999 study of 18,623 children served by community mental health services reported 55% percent had individual education plans, and 62% of those plans related to the emotional disturbance designation (Center for Mental Health Services, 1999).

Educational professionals identify most of these students as severely emotionally disturbed. Many of these children may need and qualify for special education services under PL 94-142 and PL 101-476. The Substance Abuse and Mental Health Services Administration estimates there may be as many as 4.5 to 6.3 million under-served adolescents that fall into this category. The number of resident days severely emotional disturbed children spent in residential care nearly doubled from 4.5 to 8.3 million from 1970 to 1986 (USDOE 1994, 1997, 2002; Frank & Dewa, 1992).

These children pose problems from both an educational perspective and a mental health perspective. Achenbach, Dumenci, and Rescorla (2003) describe how 12.8% of the 1,641 adolescents in a longitudinal study received mental health services in 1999. They note that only

30.5% of those having a need for mental health services (as indicated by the problem scores on the child behavior checklist) actually received those mental health services.

Twelve percent of the 63 million adolescents in the United States suffer from serious emotional disturbance and over 2.5 million children lived in some kind of residential treatment or care annually in the early 1990's. The estimated annual cost for this care is over 1.5 billion dollars (Weisz, Weis, & Donenberg, 1992). Providing for the residential care and education of these children is a major expense and can consume a disproportionately high amount of the special education budgets in many states (MacMillan & Grimes, 1996).

Clearly this population poses challenges for therapeutic schools in that they are likely to have experienced delayed progress in some aspect of their development. In addition, there is a high degree of substance abuse, incipient mood disturbances, impulse control, and related problems with focus, attention, and executive functions. This means responsible programs need to have well-developed systems in place to help these children, protect them from harm, and foster their growth and development. Integrated risk management processes play an important role for schools because they are data driven and self-correcting. This provides for institutional learning and improved quality of care.

Why Not Try to Eliminate All Risk

Risk is a fact of life and students need to learn how to manage and mitigate risk in order to have a full life. Adolescents naturally seek out risk as part of their learning experience. Learning how to successfully identify and manage risk is an important component in the process of adolescent development that helps facilitate self-esteem, concept, confidence, and competency (Dougherty, 2002).

Experiential Education and Risk

Experiential education is one of the important programmatic elements often differentiating a therapeutic school from more traditional schools and residential treatment centers. John Dewey saw risk and problem solving as an essential ingredient to a good education (Dewey, 1937). Risk, and how the individual responds to it,

is a fundamental factor in experiential education. Risk and challenge, which is an enjoyable form of risk, are found as central components of almost all outdoor adventure programming (Berman & Davis-Berman, 1995; Meier, Morash & Welton, 1980; Neill & Dias, 2001; Priest & Gass, 1997). This can be illustrated by examining the following paradigm used at Mission Mountain School.

Experiential education processes

- The process starts with the identification and introduction of task, goal, and the challenge associated with the desired outcome.
- The participant is briefed about the activity/event, which generates anticipation with excitement about benefits, and/or anxiety and a heightened awareness of challenges and risks associated with the activity.
- This excitement/anxiety is channeled into planning for the activity.
- Implementation of the activity begins with the student actively following the plan and preparing to face the challenge.
- The experiential or doing part of the task or challenge is divided into three distinct phases of experience:
 - The beginning is where the participant is still anxious, still thinking about the upcoming challenge and may attempt to manage anxiety through reorganizing or rearranging equipment.
 - The mid-point of the journey or task occurs with the student actively engaged in problem solving and experiencing the resolution of challenge as “flow.”
 - The return phase interrupts the flow, and the student begins to think about going back to the everyday realities of life. The return involves an initial processing or “quick debrief,” to help to instill the experience into memory.
- After the return, the learning processing continues and evolves through the articulation of stories, artwork, photos, etc. inspired by the experience. The articulation helps the student understand the experience and how to apply it to a broader context in her life. The learning then becomes part of the individual’s sense of self as expressed in her personal mythology.

Risk plays a key role throughout this experiential education (EE) paradigm, as it tends to be a motivator in the beginning of the process, and serves as a continuing catalyst to create flow experiences in the middle of the EE curriculum. Risk is typically the centerpiece of the stories told when students return from the EE experience. Perceived risk or challenge is effective in enhancing learning and development (McKenzie, 2000, 2003; Walsh & Golins, 1976). Programs can seek to manage perceived risk or challenge to increase engagement and learning on the part of the student (Priest & Gass, 1997). In this model, students experience gains in self-confidence and self-esteem by facing the challenges or risks found in the experience. Seeking ways to articulate their experiences and express what they have learned leads students to the development of a “personal mythology” about their experiences. This further reinforces their learning, through the process of telling and re-telling the stories of their challenging experiences and the associated risk they faced. This process serves to embed the learning deep into the fabric of their personality.

The difference between perceived risk or challenge and actual risk is critical in risk management planning. Programs can use student perceptions as a risk management tool to keep actual risks low while enjoying the benefits of perceived risk in facilitating student-learning processes. Choosing to brief or not brief students about an activity is one way program staff can increase perceived risk or challenge. This dynamic can be used to increase engagement on the part of the student, while maintaining the activity risk at a lower level.

Conversely program staff need to think about times when they want to lower anxiety and reassure students by having them accurately perceive risks rather than overestimate them. Excessive fears or anxiety about an activity can adversely impact students’ satisfaction and learning from the experience (McKenzie, 2003). In such circumstances, risks are managed, and opportunities to learn enhanced, by helping students accurately assess, prepare, and develop appropriate coping strategies to increase their confidence and decrease their fears.

The Mission Mountain School describes an actual example of institutional learning through their risk management process. A recent survey of student and alumni conducted by the Mission Mountain

School discovered while many students expressed great satisfaction, sense of accomplishment, and an increase in self-esteem from outdoor recreation activities, some students felt overwhelmed by the challenge of the activities. The following risk management analysis process used by the Mission Mountain School illustrates an example where staff set goals with students to bike to the top of a nearby mountain summit, emphasizing the difficulty of the task. This increased the challenge from the student's perspective.

However, the risk analysis process further established the actual activity risks were low when compared to other kinds of mountain biking. It was a relatively short distance for the activity (seven miles one way). The grade was mild (less than 1,000 foot elevation gain) with a wide unobstructed roadway with minimal and infrequent vehicle traffic. The staff were in constant radio contact with the school, and could readily evacuate a student by motorized vehicle within a 20-minute drive if there was a need. While some students may have still perceived the task as incredibly risky or difficult, the actual level of difficulty and activity risk was relatively low.

As a result of the risk management analysis and planning processes like this, the Mission Mountain School discovered an opportunity to manage the perceived risk and challenge of outdoor activities at different levels to meet differing student needs. For the student that is afraid, inept, or in early phases of the program, staff now brief them on the short distance, easy grade, opportunities for numerous stops, the wide roadway, and the easy vehicle access for evacuation and support on this route. This approach reduces these students' anxieties, building confidence and competency in the activity. At the same time, for the more assured students comfortable in the latter phases of the program, staff continue to gradually emphasize increasing activity challenges and perceived risks. For instance, staff may challenge more competent and adept students to race to reach the summit, or make the complete roundtrip without stopping, or to carry gear for other less proficient students.

McKenzie (2000) describes the importance of matching the challenge of an activity to the capabilities of the participant. As the skill and accomplishments of the participant grow, the challenge

and perceived risk must also grow to maintain a “...constructive level of anxiety,” (p. 20) to facilitating learning. The critical point of this approach to remember is that risk can serve as an incredibly beneficial element of programming if managed to promote learning. The application of risk management analysis and planning processes at the Mission Mountain School actually helped staff identify indicators of perceived risk and understand how and when it is useful to lower perceived risks or the challenge experienced by certain students. The Mission Mountain School identifies the next step in the risk management process is establishing indicators of stability and resilience, determining when it is useful to actively increase the challenge experienced by students.

What Risks Are Not Acceptable to the School Program?

Implementing risk in therapeutic school programming needs to be determined within the context of the mission, philosophy, goals, and policies of the program. This will vary from program to program. It is also constrained by law, regulation, and the concept of industry standard. Risk management plans will ultimately define for the school what risks are and are not acceptable for the school program.

What is Risk Management?

Risk management is pertinent to all residential programs caring for children. At the center of this statement is a belief that risk management, coupled with best practices, results in improved quality of care and outcomes for children in these programs.

School management literature describes risk management as an ongoing component of an open systems approach to school administration. Risk management is further conceptualized with its incorporation into the contingency theory of school management. Contingency theory posits there are multiple potential outcomes to any one situation and best management practice is to be prepared to address the most likely outcomes, positive or negative. Contingency theory is a useful framework for looking at risk management from a broader organizational perspective (Hanson, 2003).

Risk management in therapeutic schools will vary from program to program. However, to be effective and relevant, risks must be evaluated

within the context of the mission, philosophy, goals, and policies of the program. Acceptable risk is constrained by law, regulation, and the concept of industry standard or best practice. Risk management is very closely tied to the concept of “best practice” since practices are evaluated and selected to reduce risk as well as increase program effectiveness. Risk management processes can be used as instruments for institutional research, identifying practices that are acceptable or not acceptable to have in the school program. Some large schools and programs may have a designated “risk manager” with various levels of formal training in risk assessment and management. Most schools, however, will rely on the principle administrator to take the lead in risk management. The best approach to achieving the most utility out of a risk management program may come through an integrated risk management approach (Chordas, 2001; Fort, 2000; Pistell, 2001 and Trump, 2002).

Definition of Terms

It is useful to develop a clear set of terms to use in the description of risk and risk management efforts. Each organization needs to look at and define risk, as well as determine what risk management means for their organization. It is important for programs to define these terms within the context of their mission, program, population served, and other stakeholders. The following definitions are used by the Mission Mountain School.

Risk is the probability of an adverse outcome occurring.

Risk analysis is the systematic examination of all aspects of the program to identify potential and real adverse outcomes.

Risk management is not about elimination of all risk. Risk management occurs when risks are identified through risk analysis and strategies for mitigating and managing them are developed. Management also means implementation of the strategies to bring risk down to acceptable levels as appropriate for the school.

Acceptable levels of risk occur when the likelihood of an adverse outcome is either so small that it is deemed to no longer be of concern or the mitigation of the risk is in place to offset adverse outcomes. Acceptable risk must be evaluated within the context of the school mission, philosophy, goals, and policies. What makes risk acceptable is strongly influenced by and may have

to stand the legal test of the concept of a comparable current industry standard or principles of best practices.

Standard of care is an important legal concept. Standards of care are defined first through laws and regulations, then by professional organization's "principles of best practice" and then by the literature found in professional journals. "Regardless of the profession, a standard of care is the degree of skill and knowledge that can be reasonably expected of a normal, prudent practitioner of the same experience and standing" (Shoop, 2002, p. 2).

Integrated risk management is the inclusion of risk management functions into school programs by implementing data driven evaluative processes designed to assess, manage and mitigate risk in all aspects of the school's operations.

It is important to understand the concept of negligence and how it often influences the responsibilities of the school head, program directors, clinical directors, and other professionals. Permut (1998) identifies four primary components related to the management of risk associated with negligence. He suggests that principle staff and administrators examine and pay attention to the following:

Proper duty to care through adequate supervision must be present to avoid negligence, which includes the following duties:

- To use competent and efficient personnel,
- To adequately instruct staff and students,
- To furnish and maintain safe equipment and safe premises,
- To make and enforce adequate rules.

Breach of duty has to be present to prove negligence. This occurs when the school administrators fail in their responsibility to protect the student. This is evaluated in the context of the "reasonable man" doctrine. Did the administrator act in a reasonable and prudent fashion to protect the student from harm?

Proximate cause has to be present to prove negligence. This means that the primary cause of the injury to the student is

failure to perform in a reasonable and prudent manner through omission or commission.

Injury has occurred has to be present to prove negligence. This means that an actual injury or damage of some kind has to have occurred to the student.

Permuth further states prevention is the best course of action to manage negligence and suggests schools establish goals for risk management, positive interventions, and curricular focus. The best approach to achieving those goals can come through an integrated risk management approach.

Integrated Risk Management

Integrated risk management means the process of risk assessment and institutional research is imbedded in all aspects of the program (see Figure 2). The basic components of a integrated risk management system include the following:

- There is an ongoing risk assessment and analysis of all aspects of the school including the physical plant and programs.
- Integrated risk management plans are developed for any potential crisis scenarios and all major risks as identified in the assessment. Integrated means that they are inclusive and unite programmatic and administrative efforts.
- There is an incident reporting and documentation system for the collection and analysis of data about both accidents and near misses.
- A safety committee, risk management committee, or an equivalent meets regularly to review the incident/accident reports, analyze the data, determine patterns and trends, develop key indicators of impending risk, review risk management plans, safety policies and procedures, and make appropriate recommendations or changes as needed.
- There is participation by all of the constituencies and stakeholders in the process and active support, if not involvement by, the school administration.
- Acceptable and unacceptable risks need to interface with the student profile. Both acceptable and unacceptable risk

must be identified and a student profile constructed that screens the student out or in based on qualities, strengths, weaknesses, and characteristics that are within the context of the risk management plan. In addition, there must be a continuous feedback loop with consistent evaluation of risk management policies and activities and the environment to ensure that outcomes are kept within acceptable parameters (Cheney, 1998, Stowitschek, 1998).

Risk Assessment and Analysis

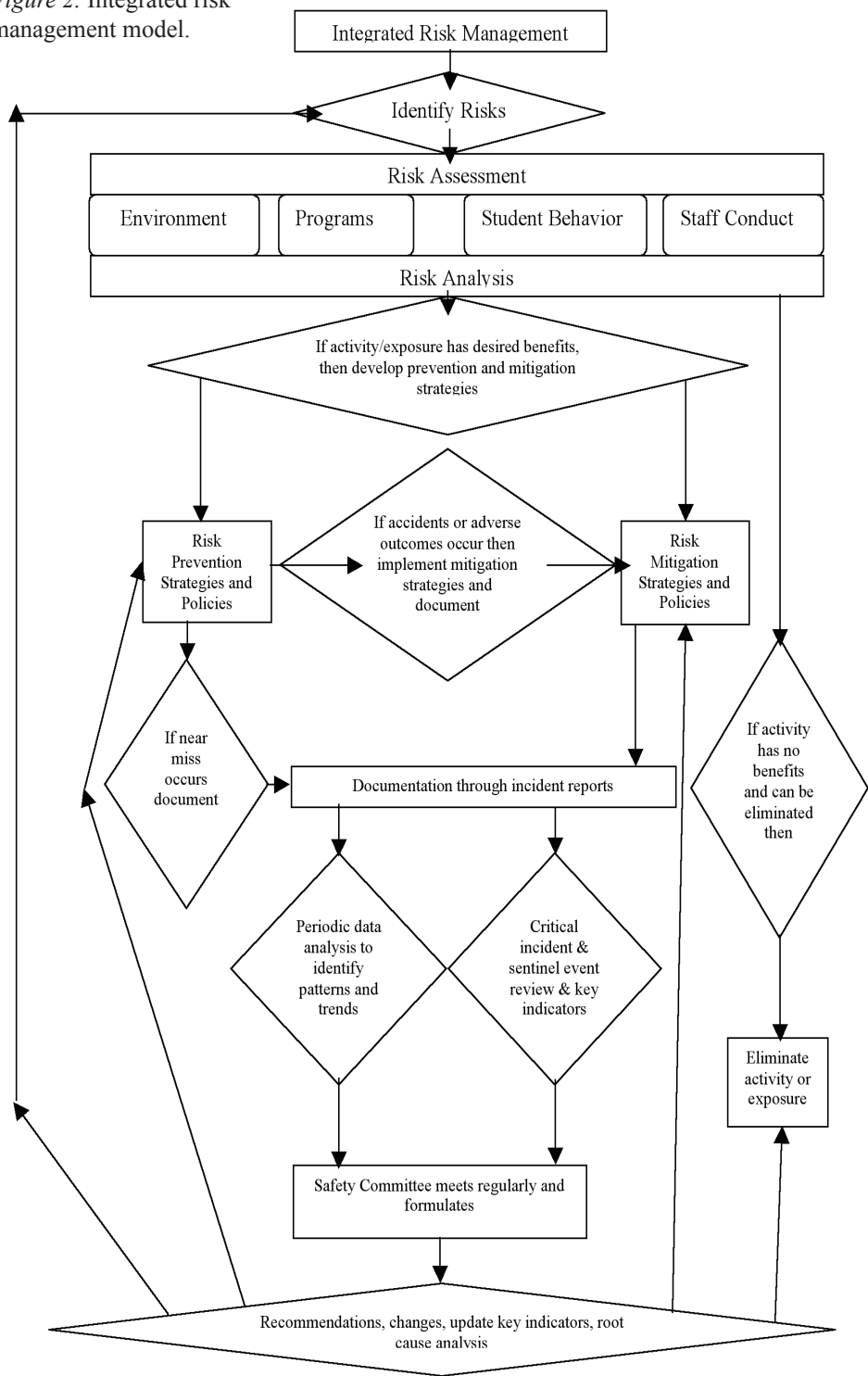
Risk assessment and analysis is the first step in the integrated risk management process. This is where programs systematically examine all aspects of their operations to determine risks and exposures. In the following example from the Mission Mountain School, this part of the process is coordinated by examining risks related to the: (1) environment, (2) programs, (3) student behavior, and (4) staff conduct.

Risks Related to the Environment

Risk related to environment entails looking at all aspects of the site, setting, and geographic area. Examples of environmental hazards schools may have to prepare for include storms, floods, earthquakes, and fires, etc. Schools in rural settings may have to deal with frequent power outages. Wildfire in the west is often a significant issue of concern. Schools may need to work with the state agencies to ensure the school and the surrounding lands are as wildfire safe as they can possibly make them. Schools may also want to invest in their own fire suppression and fire fighting equipment. Schools in the rural northwest may have risks/hazards with wildlife. For instance, the Mission Mountain School has both a wildfire and wildlife risk management plan.

Other risks related to the site are more specific to facility issues. This includes looking at common concerns in school management such as building and facility safety, fire safety, health inspection issues, food service inspection issues, water quality issues, and hazardous materials (including asbestos). Properly prepared schools possess detailed and explicit disaster management plans addressing both environmental and site related risks in the event of a problem or

Figure 2. Integrated risk management model.



crisis (Chordas, 2001).

Risk Related to Program

When examining risks related to programs at the Mission Mountain School, one key factor that emerged was the high degree of experiential and outdoor activities provided to students. Many of these activities often require transportation to access program sites. Our risk analysis and the experience of other outdoor programs suggest that the one of the greatest potential risks in experiential activities is transporting students. This is likely to hold true for many therapeutic schools. In response to this risk, prudent schools will have a vehicle maintenance plan, regular safety checks, and a driver qualification process.

Some programs may have risks particularly unique to their setting or their program. In these situations, there may not be an industry standard available. When this occurs, good risk management assessment and analysis may have additional benefits as these policies may serve to establish the industry standard. It is useful to examine different program areas to determine the potential risks associated with the individual components of a typical therapeutic boarding school. The Mission Mountain School approaches this issue by examining the functional model of program service delivery (i.e., residential, outdoor recreation, therapy, and educational programming).

Residential. An examination of the residential component of the therapeutic school reveals the same potential risks of chemical burns and exposures related to the use of household and industrial chemicals and cleansers one would find in any home. Many residential programs also include student chores and work components and there are potential risks arising from work or chore practices.

Health care and medical management often falls under the purview of the school nurse. There are risks associated with medication management along with risks associated with contagious illness and blood borne pathogens. Food borne illness can also be a significant risk that must be addressed by food service risk management. Again, risks associated with travel and vehicle use in the residential part of the program is perhaps all programs' greatest concern. Hotchkiss and Kowalchick (2002) provide good direction and suggestions for the

residential component of schools.

The following example is the list of potential risks identified as part of the assessment process. These risks are likely to be found in the residential component of any boarding school. Each of the potential risks that are identified should be addressed in the school's risk management plan to prevent their occurrence or reduce and mitigate the risk.

- Chemical and cleanser burns, exposures, etc.
- Burns.
- Falls.
- Unsafe work or chore practices, using tools inappropriately etc.
- Food borne illness.
- Contagious illness.
- Blood borne pathogens.
- Health care needs.
- Medication management:
 - Storage.
 - Administration.
 - Contraindications/side effects/allergies, etc.
 - Documentation.
 - Health care issues.
- Travel and vehicle related accidents.
- Fire.

Recreation/Activities. The Mission Mountain School operates an extensive outdoor and experiential education component in their programming. The Mission Mountain School accesses valuable information about risk management processes for outdoor recreation through the annual Wilderness Risk Management Conference, the annual Association for Experiential Education (AEE) Conference, and AEE's resources available to outdoor and experiential programs (Gass, 1998). Russell and Harper (2006) also provide useful information on the frequency of illness and injuries for participants in wilderness outdoor programs.

It is helpful to itemize the list of outdoor and experiential activities and then brainstorm the potential risks that could conceivably come

out of those activities. The following is an example of the potential risks that might be found in a typical outdoor education program. Again, each of the potential risks should be addressed in the school's risk management plan.

- Horses – injuries to humans: collisions, kicks, bites, getting stepped on, head and spine injuries, fractures, strains, & sprains, allergies; injuries to horses: kicks, bites, cuts, colic, and founder.
- Winter mountaineering -- avalanche, cold related injuries, falls, fractures, strains, & sprains, getting lost.
- Mountain biking -- crashes, head and spine injuries, fractures, strains, & sprains, heat and hydration related illness, road rash, abrasions, and contusions.
- Cross-country & telemark skiing -- falls, cold related injuries, fractures, strains, sprains, ACL injuries & avalanche.
- Wild land backcountry mountaineering, /hiking/camping --falls, fractures, strains, & sprains, heat and hydration related illness, cold related injuries, bugs, animals, hygiene, gastro-intestinal problems, and allergies.
- Rock climbing -- falls, head and spine injuries, fractures, strains, & sprains, abrasions, and contusions.
- Team sports injuries -- collisions, fractures, strains, sprains, heat related and hydration related illness, contusions:
 - Soccer -- ankles and knees.
 - Volleyball -- shoulders and wrists.
 - Baseball -- ankles, knees, shoulders, elbow and wrists.
 - Basketball -- ankles and knees.
- Triathlons -- crashes, head and spine injuries, fractures, strains, & sprains, heat, cold and hydration related illness, road rash, abrasions, and contusions, over training, ankles, knees, drowning, and cramps.
- Transportation – risks of auto accidents while driving to and from activities.

Education/Academics. The risks associated with academics possess many of the same potential risk management concerns one might find in any school facility. They include potential risk associated with fire, stairs, mechanical rooms, and facility maintenance. There are specific

risks associated with lab sciences, especially chemistry, physics, and biology because of the potentially reactive chemicals, glassware, and the use of an open flame powered by gas to heat chemicals. The list below is an example of potential risks that might be found in an academic program. Once again, vehicle use and risk of auto accidents emerge as primary concerns. Each risk needs a corresponding risk management plan (Chordas, 2001).

- Lab sciences including chemistry, physics, and biology may include risks related to:
 - Dangerous, toxic, reactive chemicals.
 - Burns.
 - Explosions.
 - Gas.
 - Electricity.
- Field trips and experiential education opportunities include earth and physical science, ecology and environmental science among others.
- Some wildlife observation excursions involve potential encounters with dangerous wildlife.
- If vehicle transportation is involved, that is generally greatest risk.

Therapy. In its manual *Standards for Behavioral Health Care* (2004), the Joint Commission on Accreditation of Health Care provides an excellent resource for risk assessment of the mental health care components of a therapeutic school. There are two kinds of risk related to therapy. One is primarily in the emotional and psychological realm and the other is in the physical realm. The risks in the emotional and psychological realm that might occur are related to misdiagnosis and ineffective treatment planning and service delivery (Cheney, 1998). However most risks related to the logistics of providing therapy (individual and group therapy, etc.) are quite low as long as the consideration of student behavior is deferred to its own program operations section. Some potential physical risks could arise from some experiential or metaphorical therapy assignments. The following is an example of the potential risks that might be found in any therapy program. Again, each should be addressed in the school's risk management plan to prevent or mitigate their occurrence.

- All therapies – incorrect diagnosis, ineffective treatment plans, lack of progress.
- Traditional individual & group therapy – physical risks are low.
- Experiential therapies:
 - Injuries related to impaired coordination due to emotion/mental stress.
 - Equine therapy -- collisions, falls, kicks, bites, stepped on, head and spine injuries, fractures, strains, sprains, and allergies.
 - Metaphoric work assignments -- overexertion, strains, sprains, heat, cold, and hydration related illness, working with tools, blisters, abrasions, and contusions.

One word of caution worth noting is that the above assessment is based on a therapeutic school model eschewing the use of therapeutic holds, or any form of physical restraint or force to manage students. Any program using therapeutic holds, restraints, seclusion, or other forms of physical behavior management must have an additional set of significant risks to evaluate and manage (NATSAP, 2004). This holds true for risks to students as well as staff.

Risks Related to Student Behavior

Student behavior is an area where there can be significant potential risks. Most therapeutic boarding schools invest a lot of time and energy in developing and implementing behavior management strategies to both engender positive pro-social change in behavior as well as to minimize and manage “risky” student behaviors. These potential risks may occur in any therapeutic school. Prudence requires each of these behaviors and potential risks have a corresponding risk management plan to prevent their occurrence or reduce the risk. Clearly there is direct relationship here between good admission screening and risk management. In addition, it is very useful to develop key indicators for each unacceptable risky behavior. These key indicators serve as an early warning system that helps predict if a student may be moving toward unacceptable behavior. A key indicator can trigger an immediate response through the integrated risk and behavior management system. The following is an example of unacceptable “risky” student behaviors:

Harm to others:

- Homicide.
- Physical or sexual abuse or assault.
- Hazing/teasing/abuse.
- Theft.
- Destruction of property.

Harm to self:

- Suicide.
- Self-mutilation.
- Risk taking or thrill seeking.

Other problem issues or student behaviors that may cause harm:

- Runaway.
- Impulsiveness.
- Preoccupation/stress.
- Clumsy/accident prone.
- Inattentive.
- Inflated sense of abilities or accomplishments.

Addictive Illness:

- Substances.
- Food/eating disorders.

Risks Associated with Staff Conduct

Most boarding schools invest a lot of energy into staff development and training to reduce the possibility of potential problems. However, prudence still requires schools examine and identify the potential risks that might arise through inappropriate staff conduct. The following is an inventory of potential risks associated with staff that might be found in a typical therapeutic boarding school. Each of these potential risks need a corresponding risk management plan to prevent their occurrence or reduce and mitigate the risk.

- Boundary issues.
- Assault/abuse/harassment – physical, sexual, or emotional.
- Inappropriate, exclusive, enmeshed, or enabling relationships.
- Substance abuse:
 - Under the influence at work.
 - Condoning substances.

- Providing substances.
- Incompetence – below standard skills, capability, and or performance.
- Negligence – neglect:
 - Not following company policies.
 - Not fulfilling responsibilities.

Conclusion

Therapeutic schools enroll a population of students with a variety of mental health issues and developmental needs often associated with increased risk. Program directors, school administrators, and clinical directors may be reluctant to expose these children to any additional risk of any kind. Yet therapeutic schools tend to have a high degree of experiential learning activities to serve the needs of these students. The professional literature documents and describes the importance and need for appropriate levels of risk to facilitate and enhance learning through experiential and outdoor recreation and adventure therapy. The integrated risk management model presented in this paper provides a system wide process potentially assisting therapeutic schools and programs in addressing risks associated with serving these students.

Integrating this model with student behavior management processes provides an effective operational research tool for program directors and school managers by pinpointing areas for improvement, while at the same time identifying and enhancing beneficial risks promoting student development. The second article in this series discusses this integration and the operational implementation of risk and behavior management processes incorporating student behavior management with school improvement and provides opportunities for institutional learning and continued program development.

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Strategies for Risk Management of Therapeutic Schools and Programs: How to Take Appropriate Programmatic Risks

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Mission Mountain School

Abstract

The previous article focused on the rationale of intentional risk management; not avoiding risk, but managing it appropriately for positive benefit for NATSAP programs. This article assumes programs have made the decision to invest in risk processes, detailing key strategies for integrated risk and behavior management. This includes a practical discussion of processes for preventing and mitigating risk. A sample of the literature describing behavior management theories and practices and case management is examined. A model of integrated risk and student behavior management is presented, describing how behavior management plans incorporate and support risk management efforts. This paper is directed toward school administrators, clinical, and program directors seeking the important questions to ask in order to review or develop a program's risk management efforts. The integrated risk and behavior management practices introduced in this paper may also help the referring professional or parents to better evaluate an individual program's risk management approach and its suitability for different student profiles. Policies and administrative practices used at the Mission Mountain School are used as examples of these concepts.

Introduction

The previous article described the importance of risk and risk management in the therapeutic school setting. A model for integrated risk management was introduced and processes for identifying and analyzing risk discussed. In an integrated risk management model, risk is assessed and analyzed by the systematic examination of four kinds of risk. This includes (a) risk related to the environment; (b) risk associated with the programmatic components of residential life, recreation, therapy and education; (c) risk from student behavior, and

(d) risk arising from staff conduct.

Strategies for Risk Management

Once a school has accepted the positive benefits of risk and identified potential risks, the second step in the risk management process is to develop risk reduction strategies for prevention and mitigation of inappropriate program risks. If the risk exposure or activity has a positive benefit for the student, then appropriate plans and strategies are developed for managing the risk within optimum levels. If the risk has no positive value to the student of program, then the risk exposure or activity is eliminated. If the risk with no positive value cannot be eliminated then strategies for prevention and mitigation of the risk are developed (See Figure 1).

Figure 2 Integrated risk management model

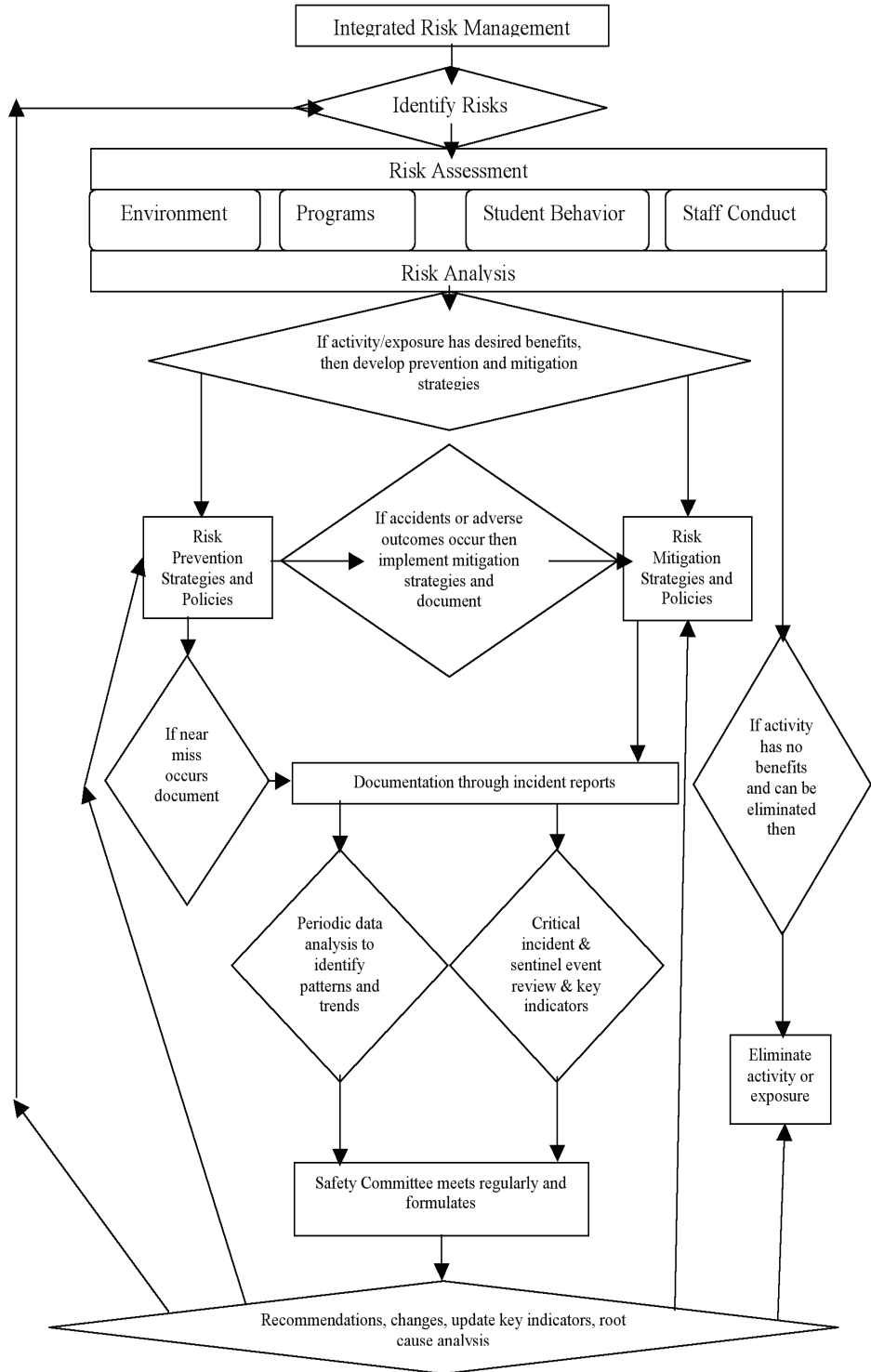
Preventive Strategies

The major preference to address inappropriate program risks is to successfully implement effective preventive strategies (identified by some programs through the analogy of “closing the barn door before the horse gets out”). In this strategy, schools attempt to find ways to minimize harmful risks through proactive planning and preventive measures. The following is a functional outline of several key components of the preventive processes applying to each of the areas that have identified potential risks.

Environment

- Risk management audits.
- Safety hazard policies, procedures, and prevention planning.
- Regular inspections.
- Incident reporting and evaluation with recommendations.

Figure 1. Integrated risk management model.



Programs Includes Residential, Outdoor Recreation, Therapy and Education

- Risk management audit.
- Safety policies and procedures.
- Hazard reduction and accident prevention planning.
- Incident reporting and evaluation with recommendations.

Student Behavior

- Student profile.
- Admission policies and screening.
- Orientation and training.
- Regular assessment and evaluation.
- Pro-active inter-professional case management planning.
- Pro-active behavior management planning.
- Incident reporting and evaluation with recommendations.
- Develop “key indicators” to help identify students at risk.

Staff Conduct

- Job descriptions.
- Qualifications and credentials.
- Recruitment policies and screening.
- Personnel policies.
- Orientation and training.
- Regular supervision, assessment, and evaluation.
- Proactive coaching, progressive discipline, and developmental problem solving.
- Incident reporting and evaluation with recommendations.

Mitigation Strategies

Even with effective prevention strategies in place, prudence requires schools still plan and prepare for events that cannot be prevented. These reactive processes are often referred to as crisis planning, crisis mitigation, and emergency planning, or risk mitigation. This subject has been extensively addressed in the private school world and examples of available resources can be obtained through the National Association of Independent Schools (nais.org) and Independent School Management (ISM). The JCAHO (2004) manual is also a very good

resource. The following is an outline of several key components of mitigation plans and processes for each risk assessment area:

Environment

- Regular drills and practices.
- Disaster and crisis management plan with specifics as needed to mitigate and manage adverse outcomes.
- Immediate notification of appropriate individuals, authorities as indicated in crisis management plan.
- Delineated areas of functional and programmatic responsibility:
 - Crisis coordinator.
 - Communication coordinator.
 - Media coordinator.
 - Student management coordinator.
- Critical incident review.
- Periodic review and revision of plans in response to new risk assessment.

Program

- Specific and general crisis management plan:
 - Delineated areas of functional and programmatic responsibility.
 - Crisis coordinator.
 - Communication coordinator.
 - Media coordinator.
 - Student management coordinator.
 - Immediate notification of appropriate individuals and authorities as indicated in crisis management plan.
- Critical incident review.
- Periodic review and revision of plans in response to new risk assessment.

Student Behavior

- Student behavior management plans:
 - Addresses “key indicators” when present.

- Problem description.
- Problem analysis.
- Plan goals, measurable objectives and target behaviors.
- Risk assessment.
- Evaluative process.
- Appropriate notifications including integration with student treatment plan.
- Specific and general crisis response plans:
- Quick response based on the presence of “key indicators.”
- Notification of appropriate individuals, parents etc.
- Crisis coordinator.
- Communication coordinator.
- Media coordinator.
- Student management coordinator.
- Individual student management.
- Management of the milieu.
- Critical incident review.
- Periodic review and revision of plans in response to new risk assessment.
- Periodic review and revision of “key indicators” in response to new data and risk analysis.

Staff Conduct

- Regular coaching and evaluation.
- Establish policies and procedures to handle incidents.
- Progressive discipline policy.
- Reporting process.
- Critical Incident plan:
 - Interim responsibilities and duties of staff.
 - Discipline actions.
 - Notification of parents, authorities as appropriate etc.
 - Management of students:
 - Students involved.
 - Other students in the milieu.
- Critical incident review.

Documentation, Analysis, Review, and Feedback

Both prevention (i.e., proactive) and mitigation (i.e., reactive) strategies have some common elements, but the most important elements of both may be the documentation, reporting, analysis, and feedback functions. These critical processes create a system that is responsive to changes in the program's internal and external environments. Documentation can take a variety of forms, but it is important that it be ongoing and continuous. It is critical that information about each incident or accident is recorded. This holds true for near misses as well. Programs may also want to provide a channel for students, families, and alumni to submit information and input into risk management efforts. The Mission Mountain School's risk management process incorporates information from therapists through therapist's group reports, from supervisors through the daily supervisor report, from program staff through incident reports, from students and families through quality of life reports, and from alumni through surveys.

Once the data is collected, it is important to conduct periodic regular analyses of the data to identify trends, patterns, emerging problems, and successes. A critical incident review needs to occur quickly after a significant accident, incident, or near miss. JCAHO (2004) has an excellent definition of what they call a "sentinel event" that may be useful as an example of what constitutes a significant accident, incident, or near miss. Analysis and review of the data can occur through a risk management committee or some other similar process. The following must occur if risk management plans are to be effective:

Components of Incident Reporting and Review Process

- Written accident – incident reports.
- Incident review and analysis.
- Critical incident review and analysis.
- Identification of "key indicators" that can be used to predict the increased likelihood of a significant incident and trigger prevention strategies.
- Regular safety/risk management committee meeting to make

recommendations based on above.

- Revision and adjustment of policy and plans to incorporate key indicators and result of learning from review.

The report, review, analysis, and revision part of this process also serves to motivate organizational learning and increase the sophistication of the school's risk management plan. It can lead to a self-regulating system that increases effectiveness and efficiency using concepts of action research (Cheney, 1998; Sagor, 2000).

It is important to note that integrating the risk management functions of prevention, mitigation, documentation, and analysis of incidents with the behavior management planning process lead to the development of key indicators to predict and prevent the likelihood of risky student behavior. At a minimum, programs should have a set of key indicators developed for all critical incident types of problem behaviors (e.g., suicide, runaway, self-harm, assault). Programs should also have prevention and mitigation responses for those behaviors.

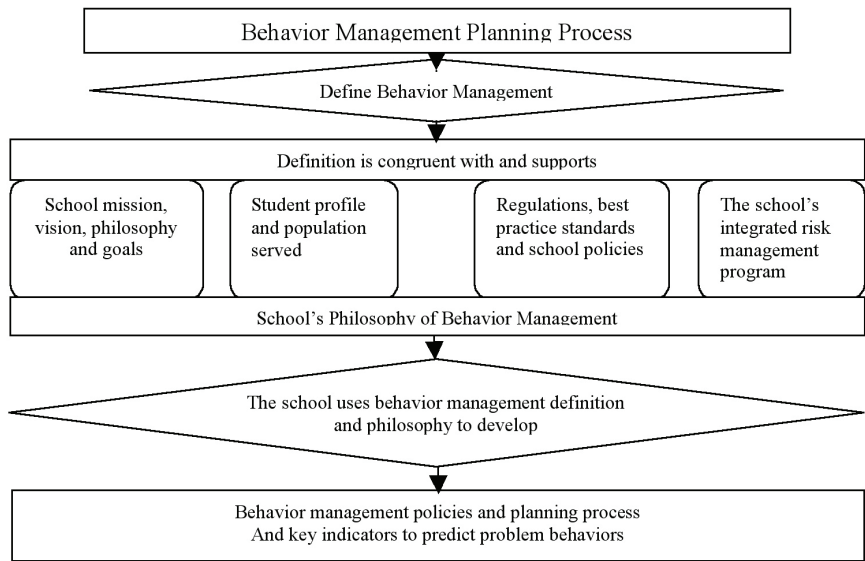
Planned program indicators should also serve to trigger appropriate behavior and risk management responses to reduce the likelihood of critical incidents from occurring and the resulting potential harm. For example, a student that has: (a) conflict with peers, (b) not bonded with a therapist or staff, (c) a history of running away, (d) substance abuse issues, (e) recently experienced an extremely difficult parent visit, and (f) has significant emotional turmoil would be seen as being at increased risk of running away. One appropriate proactive risk and behavior management response may include increased staff time, additional one-on-one therapy, assigning a student partner, providing a community support group, as well as other appropriate elements. If the risk indicators do not subside, then the response may also lead to implementing 24 hour staffing, necessary hospitalization, or referral to a secure psychiatric facility.

Integrating Risk and Behavioral Management

The development of behavioral management strategies as part of a risk management plan is very important to most therapeutic boarding schools. This integrated process starts with the definition of behavioral

management. The school develops its definition to support its mission, vision, and educational philosophy, as well as be appropriate for the population served and reflective of best practices and its risk management program (See Figure 2).

Figure 2. Behavior management policy development.



It is important for schools to articulate both a definition and philosophy of behavior management. There are numerous articles about this topic and a wide variety of approaches. Bucher & Manning (2001) provide an overview of the principal theories of behavior management and their application in a school setting. Dougherty (2002) discusses a developmental approach placing value on developing pro-social behavior. Walker (1998) addresses the need for teaching and developing pro-social behavior in early childhood. His discussion has great utility for programs dealing with young students or immature students. Van Acker and Talbot (1999) explore the context and risk of aggression and prevention strategies. Kohn (1993) writes about the use of rewards and the negative consequences of that approach. Maag (2001) rebuts Kohn, suggesting that rewards are a positive behavior management tool. Mitchem, Young, and West (2001) argue that peer-assisted self-management promotes learning and pro-social

development. Haynie, Alexander and Walters (1997) examine the decision making process of youth at risk. Lawson (1998) describes processes used in milieu management of traumatized children. Fletcher & Hinkle (2002) discuss adventure based counseling. Roeser, Eccles, & Sameroff (2000) examine instructional, interpersonal, and organizational aspects of school life and adolescent behavior. Yowell & Smylie (1999) describe how student self-regulation develops and is supported by program components, interpersonal relationships, and the school environment.

This is a small sampling of the literature addressing different approaches to risk and behavior management. It is critical for schools to do their homework and articulate appropriate definitions and philosophies of behavior management congruent with their mission, vision, and goals. One example of a definition of behavior management is the 2005 definition of the Mission Mountain School:

Definition: Behavior management refers to general strategies and processes designed to promote positive personal growth of the student or enhance self-regulation and positive behaviors within programs, activities, and classes and in the general milieu. Behavioral management also refers to general strategies and processes designed to address, manage and change student behavioral issues that are identified as having the potential to place the child "at risk." Behavioral management also includes all efforts to manage other general behavioral issues that occur in the different program activities, classes and/or in the general milieu that have been identified as unproductive or disruptive and which create "problems" (Mission Mountain School, 2005.)

Behavior Management Philosophy

The philosophy of behavior management drives a school's approach to the design and implementation of behavior management, planning, and interventions. The philosophy is developed to be congruent with the school mission and is informed by the risk management process. For example, all behavior management processes at the Mission Mountain School must incorporate the following general philosophical

guidelines:

- Do no harm.
- Minimize or manage risk for all individuals.
- Be consistent with and support the mission, vision, philosophy, and goals of the school.
- Be designed to promote self-regulation.
- Be thoughtful, insightful, deliberate, pro-active, positive, and timely – not reactive or rushed.
- Use the least restrictive and least intrusive approaches.
- Use intervention tools designed to de-escalate stress and crisis and reduce the incidence of key indicators.
- Manage therapeutic stress to keep it within levels that it can be reasonably expected that the student can handle without precipitating crisis.
- Incorporate a systematic planning process with regular evaluation and feedback.
- Keep all of the key players informed of the plan and status of the student (Mission Mountain School, 2005).

Behavior Management Policy Example

The definition and philosophy are used to establish behavior management policies, serving to provide direction and guidance for the integration of the risk and behavior management functions at schools. The following is an example of a behavior management policy linked to the previous philosophy and definition of behavior management at the Mission Mountain School:

An important aspect of risk management at Mission Mountain School is how we approach behavior management with our students. Our students may have issues with impulse control, self harm behaviors, or may be distracted and inattentive. These issues may be a result of, or exacerbated by, concomitant organic or psychosocial problems. Our policy of behavior management at Mission Mountain School is designed to protect the dignity of the student, encourage self-regulation and positive pro-social behavior, and compassionately recognize their developmental stage, psychological and

emotional issues, and any other stressors that may affect their behavior.

The following consequences are not acceptable at Mission Mountain School: corporal punishment, verbally abusive language, physical restraint except in the case of potential harm to self or others, and denial of a nutritionally adequate diet.

Mission Mountain School has written behavior management plans for all of its program areas. These are delineated in detail in each of the program area handbooks and in the risk management handbook. It is the responsibility of the program directors to maintain and review the behavior management plans annually and to submit them to the school head and governing body for approval. The clinical director is responsible for the oversight of the behavior management plans to reasonably ensure that the implementation of behavior management plans and strategies are consistent with our behavioral management philosophy, planning, and implementation process. (Mission Mountain School, 2005).

Behavior Management Planning

Once behavior management is defined and the philosophy and policies are articulated, a school is able to identify how it is going to approach the planning process. There is considerable material in the literature about case management as an implementation tool related to managing behavior. Tobin and Colvin (2000) discuss the use of incident reports in an integrated case management approach to make decisions about appropriate interventions. Stowitschek (1998) discusses the concepts of interprofessional case management and introduces a series of articles by Stowitschek, Smith, and Armijo (1998), Armijo, McKee and Stowitschek (1998), and Phillips (1998). All these articles address various aspects of integrated case management designed to prevent, identify, modulate, or mitigate problem student behavior. The concept of regular review and evaluation of the effectiveness of the management plan is critical to risk and behavior management.

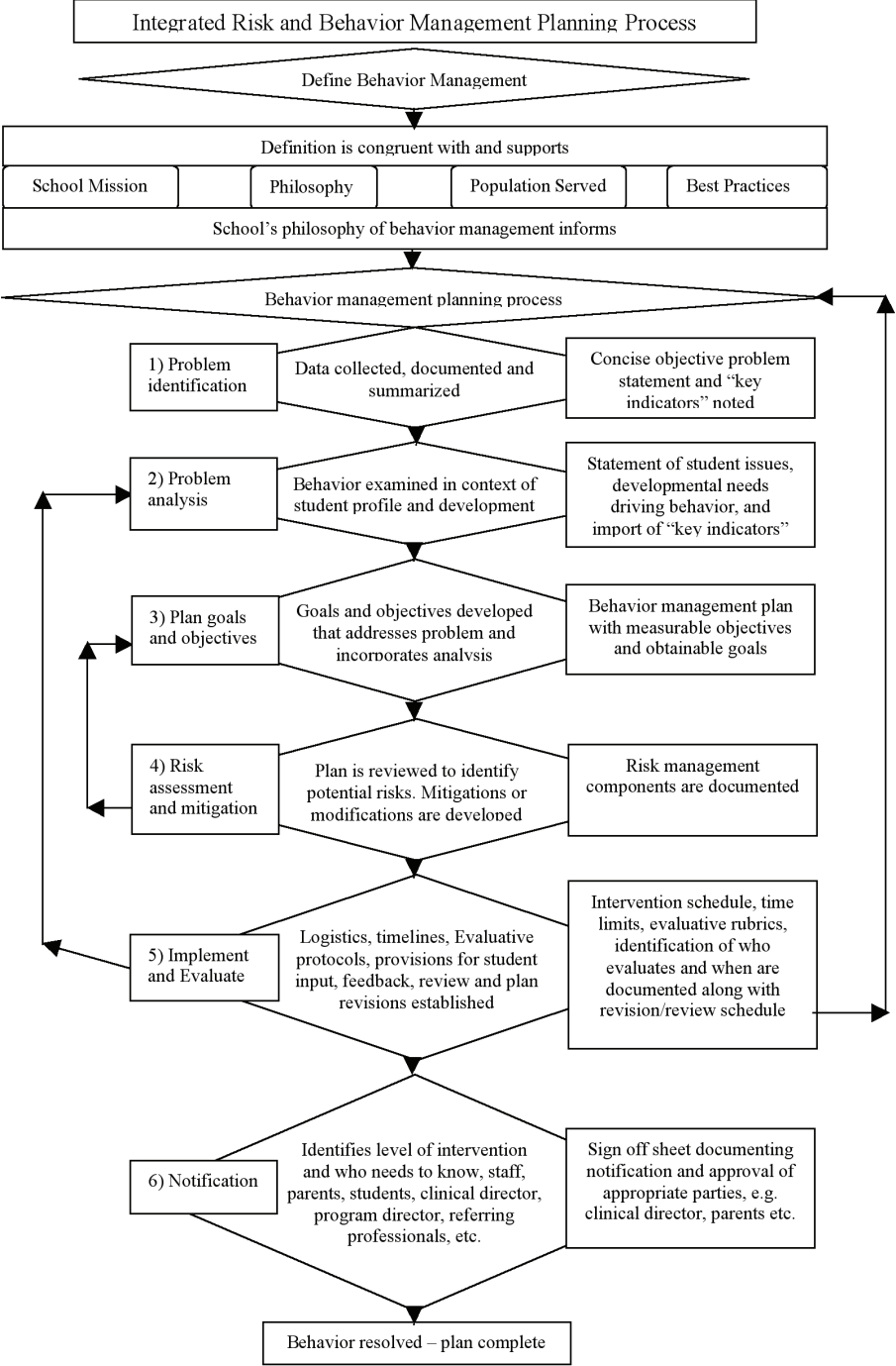
Integrated Risk and Behavior Management Planning and Implementation Process

Using the Mission Mountain School as a continuing example of integrated risk and behavior management, their mission statement and educational philosophy embrace experiential, developmental, and sequential learning. Their planning steps for behavior management reflect the same approach. Each of the steps in the behavior management planning process described below are congruent with the logic in their other planning processes for students, including treatment plans and individual student developmental curriculum plans. This provides a congruent experience for students and the behavior management system supported by the risk management system. In turn, these systems support and reinforce experiential educational and therapeutic processes.

This integrated approach provides the staff and students with a seamless way to address behavioral issues without significant disruption to process (see Figure 3). The integrated model of behavioral management requires completion of the following steps in each planning effort:

- Problem description starting with objective observable data.
- Problem analysis including assessment of the student's internal and external resources, influences, and current state.
- Plan with clear goals, measurable objectives, and clearly defined target behaviors.
- Risk assessment including evaluation by the school nurse if applicable and implementation of risk management through safety instruction, or other measures as needed.
- Evaluative process with backup plans in case the student is unable to achieve targeted behavior.
- Appropriate notifications and sign offs, including integration with student treatment plan.

Figure 3. Integrated risk and behavior management planning process.



Behavior Management Planning Process Steps

1. Problem description.

- The problem description needs to start with objective data and reference date and times of observations and sources of data. Potential data sources may include direct observation, admission notes, testing and psychological evaluation and reports, quality of life reports, supervisor's reports, therapist's reports, group notes, progress notes, conversations or letters from parents, etc.
- Intuitive deductions, analysis, or explanations for behavior are not presented in the problem description.

2. Problem analysis.

- Once the problem behavior has been described, then conduct an analysis of the contributing factors and the etiology of the behavior. Begin that analysis by asking specific questions as part of the problem solving process.
- This means that at a minimum any special intervention designed to address behavioral or emotional issues requires an analysis of:
 - Key indicators that predict “risky” behavior.
 - The student's "ego strength" and capacity of the student to achieve the desired outcomes.
 - The student's developmental stage and emotional maturity.
 - What the student's needs are and to what degree they are being met or unmet.
 - The student's place in the therapeutic process and how that impacts both behavior and intervention design.
 - How or if the student's issues are manifesting or influencing behavior.
 - The general or specific state of the milieu and impacts on student behavior.
 - The general or specific state of current family dynamics and impacts on student behavior.

3. Goals and objectives.

The development of goals and objectives takes into account the analysis and strengthens the behavioral management plan. It does this by following these concepts:

- Honors the student's rights and accords her respect and dignity.
- De-escalates crisis, addresses key indicators and keeps stress within a manageable level leading ultimately to student success.
- Engages the student in the process of developing the behavioral intervention and gains her willingness to accept and participate in the plan, intervention, or consequence.
- Is congruent with and supports the individual goals and objectives of the student's individual care plans (treatment plan, education plan, etc.).
- Lead to learn! Create knowledge acquisition or personal growth that will help improve or enhance quality of life for the student or help her resolve or learn how to manage some aspect of her issues/problems.
- Helps the student successfully address, or accomplish some aspect or task that supports her progress through either the developmental curriculum or an individual pathway as appropriate to her needs.
- Is multifaceted in that the intervention addresses not only behavioral issues but also promotes emotional growth and intellectual learning through metaphors.
- Helps the student link cause and effect.
- Is something that the student has a reasonable likelihood of being able to accomplish.

4. Risk assessment and mitigation.

Risk assessment and mitigation assist the plan in being thoughtfully crafted to minimize and mitigate risks. This section:

- Documents that a risk assessment and mitigation plan was developed prior to implementation and modified as needed to address any emerging risks or safety concerns.
- Documents that a supervisor has reviewed the risk

management assessment and mitigation plan.

- Documents that preventive or mitigating specifications have been implemented and periodically checked.
- Documents that if the intervention involves physical activity, metaphors, work, or unusual physical stress, the school nurse or other qualified staff will initially and periodically check on the student's health and capacity to accomplish the task.
- Documents that if the intervention involves physical activity, metaphors, work or unusual physical stress, and/or the use of hand tools or other equipment, that the student is initially instructed in proper ergonomic use and safe handling protocols and periodically checked.

5. Evaluation and feedback.

The evaluation and feedback section of the plan:

- Documents and articulates clear strategies, time lines, and contains a sunset provision.
- Documents and establishes achievable goals with a clear definition of what constitutes completion.
- Includes and documents the process for student comments, staff evaluation, and redirection as needed.
- Identifies and documents who is responsible for implementation, supervision, and evaluation.
- Includes and documents a systematic review and evaluation component and is regularly updated as needed.
- Documents any evaluation or data that shows that the student is failing or unable to accomplish the goal within a reasonable time frame, or the activity is causing an unforeseen hazard. If this occurs, then the plan will be reviewed and modified or discontinued as needed to address the risk concerns.

6. Notification and documentation.

This section of the plan is critical and is composed of the actual documentation of the planning process, along with a distribution list with signatures indicating acceptance of notification. It is important the plan:

- Be communicated clearly, and distributed to the student, staff, therapists, clinical director, management team, school head, family, consulting and referring professionals as appropriate.

Levels of Staff Involvement, Decision-Making, and Implementation

The behavioral management plan identifies appropriate levels of decision-making and staff involvement in developing and implementing behavioral management interventions. In general, the therapists, teachers, and advisors are charged with monitoring, documenting, and managing the individual student's needs through the developmental curriculum. The program supervisors and directors are charged with monitoring, documenting, and managing the needs of the milieu. The concept is that as a behavior management plan becomes more individualized or innovative it moves outside of the normal program, requiring greater levels of participation, assessment, and evaluation by all parties to ensure it is a useful and effective endeavor with acceptable levels of risk (see Figure 4).

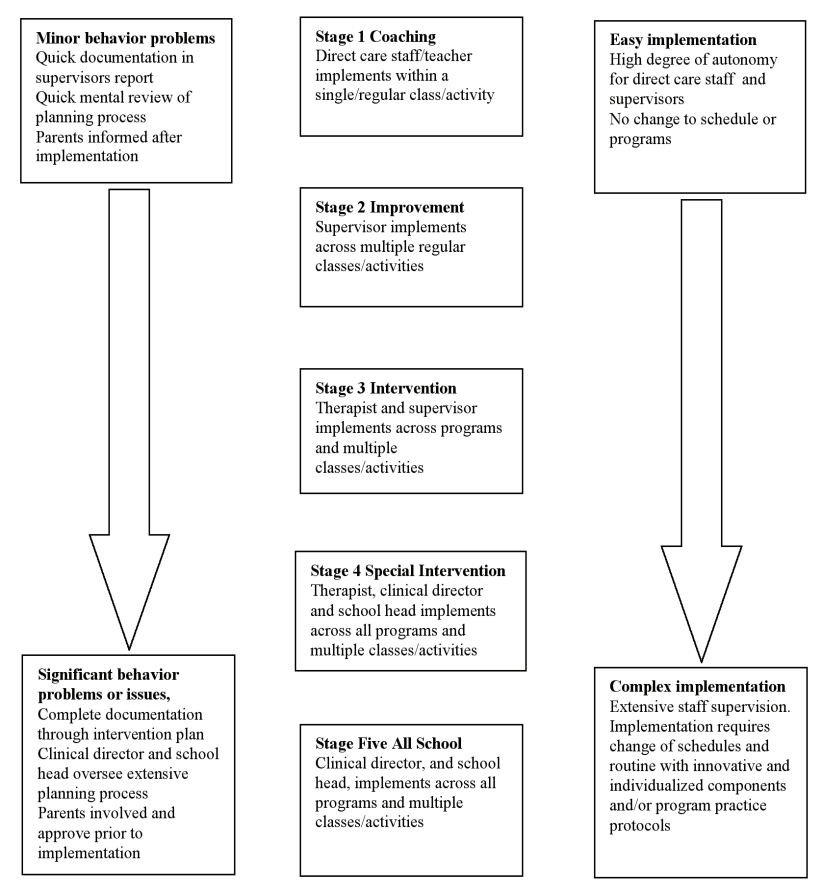
These stages of intervention are designed so there is a continuum of appropriate choices, ranging from imbedded interventions occurring contextually throughout the program's ongoing daily schedule and activities to highly specialized innovative individual interventions occurring almost entirely outside of the normal day to day activities and schedule. The former can be implemented immediately and "in the moment" by direct care staff, while the latter can be only developed and implemented through a planning process incorporating the participation, review, and approval of the clinical director, the school head, the student, and parents.

In general, Stage One and Two interventions are contained and implemented within the normal practices of the program. The student's schedule and responsibilities are not significantly impacted. Planning for interventions at this level requires a quick mental review of the planning process and the selection of appropriate strategies by the staff and/or supervisor as outlined in appropriate program handbooks.

Stage Three interventions incorporate elements specifically tailored to the student. This requires more planning and review. The student’s therapist takes the lead and collaborates with a supervisor to develop the intervention. The planning process is followed and documented and the clinical director is notified.

Stage Four and Five require an interdisciplinary team approach with direct involvement of the student’s therapist, program supervisors, the clinical director, school head, and parents. Interventions at this level are integrated as part of the student’s treatment plan and all of

Figure 4. The behavior management continuum.



the behavior management planning steps are carefully followed and rigorously documented.

Stages of Intervention

The following describes the levels of staff decision-making and involvement in behavioral interventions from the specific and situational to the most global and inclusive.

- Stage One – Coaching, teaching, counseling
 - Individual staff in the moment.
 - Supports existing plan and protocols.
- Stage Two – Improvement plan
 - Staff and supervisor.
 - Supports existing plans and protocols.
- Stage Three – Intervention plan
 - Therapist and supervisor within multiple programs.
 - Requires notification of the clinical director.
 - Requires modification of existing plans through plan update or review.
 - Documented, student and staff sign off.
- Stage Four – Special intervention plan
 - Selected therapists, and clinical director within multiple programs.
 - Requires modification of existing plans and ongoing documentation through special intervention plan.
 - Requires approval of the clinical director and notification of the school head
 - Requires an interdisciplinary team review.
 - Documented, student, therapist, clinical director, and parents sign off.
- Stage Five – All-school interventions
 - All programs, staff, and students.
 - Requires ongoing documentation through all school special intervention plan.

- Requires an interdisciplinary team review and management meeting.
- Requires approval of the clinical director and the school head.
- Documented, student/community letter to parents requesting intervention, parents telephone notification via therapists, followed by regular individual updates. Community progress letters from the head.

A better understanding of the progressive nature of the different stages of intervention can be developed by examining a more detailed description of Stages One, Four, and Five. This comparison illustrates the continuum of increased planning, oversight, and supervision from Stage One to Five as well as the increasing severity of behavior that is addressed.

Details of a Stage One coaching plan.

Who: This stage involves one or several students

What: This stage addresses situational problems arising in the moment. For example, there is excessive noise and talking during class.

Indicator: Staff observing inappropriate student behavior requiring immediate redirection to meet programmatic and group normative standards is the trigger for this stage.

Plan: The plan is drawn from the behavioral management section of the program handbooks, professional training, and/or experience. The planning process includes a quick mental review of the six steps of the behavior management planning process as described earlier.

1. Problem description starting with objective observable data.
2. Problem analysis including assessment of the student's internal and external resources, influences and current state.
3. Plan with clear goals, measurable objectives and clearly defined target behaviors.
4. Risk assessment - will this escalate or deescalate risky behavior?

5. Evaluative process – timeframe.
6. Documentation and notification as needed.

Implementation: The direct care staff implements this stage. For example: a teacher addresses a student's disorganization during an activity through immediate coaching in the moment following existing and regular protocols.

Scope: This stage is implemented within the scope of the normally scheduled program activity.

Evaluation: The staff involved evaluates the student response as meeting or moving towards target, no change or as increasing in frequency, amount, or severity. Based on this evaluation and the principles of our risk and behavioral management plan, the staff makes a decision to end the intervention, continue, modify it, or seek consultation.

Notification/Documentation: Documentation of this stage occurs through one or more of the following: quality of life reports, incident reports, daily supervisor's report, progress notes, and daily therapist's report.

Detailed discussion of key aspects of a Stage Four special intervention plan.

Who: This stage involves one or several students.

What: This stage addresses significant and serious problem behaviors. This includes problem behaviors continuing to manifest, expand, and disrupt either classes or program areas, or problem behaviors that create unacceptable risks to the student, milieu, staff, or facility. This stage could also be used to address problem behaviors that are predicted by our risk management indicators, but have not yet manifested.

Indicators: This stage may be initiated by:

- Key indicators suggesting that serious problem behavior is imminent.

- A single serious incident such as an attempted runaway.
- A significant pattern of multiple observed inappropriate behaviors over time and across settings.
- Unsatisfactory responses to improvement plans and behaviors that result in significant or prolonged disruption of programming.
- Behaviors that offend the basic rules of the school.
- Failure to respond and/or meet redirection toward programmatic and group normative standards.
- Failure to meet individual or development plan goals within required time frame.
- Failure to respond to stage three behavior intervention plans.

Plan: The process begins with a review of all aspects of a student's progress and situation. This review is conducted by the treatment team and discussed with the program head in a meeting. At that meeting, a planned course of action is determined. The clinical director supervises the development, articulation, and implementation of the plan. This includes following the six steps outlined in the behavior management plan process. The written plan follows the written philosophy and guidelines for behavioral management and draws from the behavioral management section of the various program handbooks, the general and individual developmental curriculum, and is influenced by professional training, experience, and cross team collaboration. It includes a description of the problem, a review of the student files and progress notes, a formulation of the problem, desired outcomes, intervention design, evaluation /redesign process, and expected completion or sunset date. Prior to implementation, the plan addresses risk assessment, mitigation, and management, including an assessment of impacts to process or schedule as well as an appropriate notification process. In general, the intervention at this level is highly individualized to address the needs or issues of the student under consideration. It may incorporate elements identified in the program handbooks, or adaptations or innovations of a previously successful or effectively implemented intervention.

Implementation: The clinical director, therapists, and program supervisors are involved in the implementation. The clinical director signs off on the plan and the school head is notified and must approve

the plan before it can be implemented. Staff, supervisors, and therapists discuss problems and implement the plan. For example, if the intervention may impact staffing patterns or timing of phone calls, then the supervisor is notified, along with therapists and parents involved in phone calls. Generally this information is forwarded to the program area team, as well as possibly discussed at a program meeting delineating the plan and delegating responsibility.

Scope: Intervention at this level often occurs outside of, or partially outside of, the context of the existing programs. It may result in major modifications or rearrangement of typical schedule, and may require the addition or implementation of new or unusual program elements, resources, or staffing patterns. It may require daily supervision and review, and usually does not extend beyond one week in duration without review. It may also impact the student's scheduled communication with parents, parent or home visits, or other events. If the student's parental visit, retreat, off campus or home visit is impacted, an invitation is extended to the parents to come to campus and support their daughter in accomplishing the tasks of the special intervention plan.

Evaluation: The therapists, supervisors, and clinical director directly evaluate the student's progress using the rubrics established in the plan and keep the school head informed. Based on this evaluation and the school's principles of risk and behavioral management, the decision is made to end the intervention, to continue, or modify, or seek consultation and additional support. If the intervention is not successful, the next step may be a referral to another facility or program.

Documentation: If the plan addresses a specific child, then documentation is ongoing through the special intervention plan as described below and in the child's progress notes or developmental plan/file as appropriate. Group interventions are documented through one or more of the following as appropriate: quality of life reports, daily supervisors' report, and daily therapists' report.

Program area team meeting: The implementation of specific behavioral management strategy to address a student's problem

behavior within all aspects of the program area requires a program/team meeting to inform staff of the requirements of the intervention.

Discussion of a Stage Five school intervention.

Who: This stage involves all students.

What: This stage addresses a significant and serious incident or problem behaviors continuing to manifest and expand to disrupt multiple program areas. It would be used to address persistent “underground” or dishonest behavior on the part of numerous students, key indicators, behavior placing students at risk for runaway, self-harm or relapse, or other problem behaviors creating unacceptable risks to the students, milieu, staff, or facility.

Indicators: This stage can be initiated by one or more key indicators suggesting imminent serious risk, a single very serious incident, or a significant pattern of multiple observed inappropriate behaviors over time or across settings. Associated with these indicators are unsatisfactory responses to improvement and intervention plans. It could also be triggered by behaviors resulting in significant or prolonged disruption of programming or behaviors offending the basic rules of the school.

Plan: The therapists, supervisors, clinical director, and school head develop a plan for working with staff and students. This plan follows the school’s philosophy and guidelines for behavioral management and draws from the behavioral management section of the various program handbooks, the general and individual developmental curriculum, and is influenced by professional training, experience, and cross team collaboration. It includes a description of the problem, a review of student files and progress notes, a formulation of the problem, desired outcomes, intervention design, evaluation /redesign process, and the expected completion or sunset date. The plan addresses risk assessment, mitigation, and management of risks, and includes an assessment of impacts to process or schedule prior to implementation and appropriate notification process. In general, the intervention at this level is highly targeted toward a specific problem in the milieu. It often involves an innovative approach engaging positive members of the student body in developing an experiential group process that

resolves the problem. The plan may incorporate elements identified in program handbooks, or adaptations or innovations of a previously implemented successful or effective special intervention.

Implementation: The therapists, the clinical director, and the school head are the primary architects of implementing this plan. This includes following the six steps outlined in the behavior management plan process. Staff and supervisors discuss the plan and develop an implementation schedule. In all school interventions, phone calls and conference calls may be delayed or rescheduled. Parents need to be notified and engaged to support the intervention. The planning for the intervention is extensive and requires information delineating the plan. Delegating responsibility is forwarded to program area teams and/or discussed at an all-school staff meeting.

Scope: All-school interventions may occur outside of, or partially outside of, the context of the daily schedule. They are usually process driven and require some modification or rearrangement of the schedule, possibly requiring the addition or implementation of new or unusual program elements, resources, or staffing patterns. It requires daily ongoing supervision and review and may not extend beyond one week in duration without review. With review, the all-school intervention may extend past two weeks in duration, but no longer than three weeks. The all-school intervention may impact the student's scheduled communication with parents, parent or home visits, as well as other non-essential scheduled events. If parent visits, retreats, or other interactions are impacted, an invitation is extended to the parents to come and support the community in their intervention efforts. It should be emphasized that such visit is not the same as a parent visit weekend or retreat, and that the parents may come only if they are willing to focus on the needs of the community. They will need to reschedule another time to fulfill the parent visit requirements. Parents will continue to receive regular updates about the status of the community through the therapists and will receive at least one phone call weekly from their child.

Evaluation: Staff, supervisors, therapists, the clinical director, and the school head evaluate the students' response as either meeting or moving toward target, no change, or as increasing in frequency,

amount, or severity. Based on this evaluation and reflecting on the school's philosophy and principles of risk and behavioral management, a decision is made to end intervention, continue intervention, create necessary modifications, or try a different approach. In some cases, one or more students that are consistently sabotaging the community may be referred to a wilderness program or more structured psychiatric care facility.

Notification and documentation: The staff are notified through the planning process described above. The students and the parents are also involved in the planning process. If possible, the parents are notified prior to the implementation of the plan. This notification often occurs through a conference call with the student, their therapist, and their parents. The all-school intervention is documented through an all-school intervention plan. Specific student's progress is documented through the child's progress notes or developmental plan as appropriate. Overall progress is documented through one or more of the following (as appropriate): quality of life reports, daily supervisor's report, and daily therapist's report.

Program area team meeting: Once a Stage Four or Five special intervention plan is articulated, then the appropriate individuals must be notified. At a minimum, the student, student's parents or legal guardian, student's therapist, program directors, clinical director, and school head need to be notified. However, it is important that any staff expected to supervise, monitor, or support the plan are also notified. If the plan calls for a significant intervention and requires that the student's daily schedule be altered or that the student operates outside of normally programmed activities, then all staff should be notified of the special intervention in a timely fashion if possible. Implementation of an all-school intervention requires significant program coordination through an all school staff meeting and all community meeting with staff and students. Specific strategies need to be developed to address likely problems that may arise.

Conclusion

Schools using the approaches outlined in this and the previous article will most likely be consistent with or exceed the current

principles and practices that NATSAP has established for risk and behavior management (NATSAP 2004a, 2004b, 2004c, 2004d). But perhaps more importantly as a result of doing this work, the school will have confidence in their risk management process and approach to behavior management. Both will reflect the philosophy of operating the school and support experiential learning processes. This will allow such schools to focus its attention and energy where it should be, which is on providing high quality care to its students.

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Prescription Medication and Street Drug Considerations in Outdoor Behavioral Healthcare Programs

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Abstract

In the 1980's, the mental health and medical community tried to solve many adolescent behaviors through medication. Some of these medications created inappropriate risks for clients in outdoor-based substance abuse or behavioral healthcare programs. This dynamic requires programs to increase their knowledge and awareness of how both prescribed medications and new street drugs pose risks to adolescents entering outdoor challenging environments. This paper argues that all program staff need to be aware of the risks and side effects associated with prescription medications and street drugs when considering outdoor behavioral healthcare programs. These considerations need to be carefully written and understood in program policy and procedures, serving as a critical component of risk management.

Introduction

In 1971, very few clients participating in outdoor behavioral healthcare (OBH) programs for young offenders were on medication. By the mid to late 1980's, more and more clients who participated in OBH program were on prescription medications. Many of these clients were instructed they needed to go off the medication because of established drug-free substance abuse treatment policies. However, with the increased number of clients with Attention Deficit Disorder (ADD) and the associated Ritalin rush by the mid-to-late 1990's, the majority of clients entering OBH programs were on some type of medication. Coupled with this phenomenon is a resistance on the part of medical doctors to remove clients from the medication, creating an inevitable discussion and debate as to when it is appropriate and inappropriate to take medications in wilderness environments in expedition settings.

Growing Client Drug Prescription Use

Over half of the clients currently entering OBH programs are diagnosed with ADD, ADHD, Depression, Anxiety, and Bipolar disorders according to the Diagnostic and Statistical Manual of Mental Disorders: DSM-IV (1994). Many of these clients' prescribing psychiatrists and doctors will not remove the clients from prescribed medications due to liability, malpractice, or philosophical issues. Coupled with this phenomenon is an increasing number of clients with DSM-IV Bipolar diagnoses, with accompanying medications that can potentially kill the client under certain environmental conditions. Because of this, it is now common OBH practice to tell parents and clients they cannot be accepted into wilderness treatment if they are on medications that effect: (a) the body's ability to stay hydrated, (b) the body's ability to maintain appropriate core temperature, (c) the body's ability to perform appropriate sweating and cooling, and/or (d) the body's propensity to develop a fever.

The following medications listed in Table 1 can create one of these four problems when clients are in outdoor physical treatment experiences (e.g., hiking with a pack, extended exposure to warm or hot environments). The drugs listed below all have the potential to produce hyperthermia, which can be deadly in an outdoor environment. Drug-induced hyperthermia can come on very fast without usual warning signs or symptoms. Because this condition is created by a drug within the body's system, it is more difficult to treat under field conditions. This type of hyperthermia is a true medical emergency and is extremely dangerous in wilderness environments.

Table 1. Prescription drugs that can produce hyperthermia in an outdoor environment.

Drug Name	Purpose	Manufacturer
Haldol	Used to treat psychotic disorders and symptoms such as hallucinations, delusions, and hostility, and to control muscular tics of the face, neck, hands, and shoulders. It is also used to treat severe behavioral problems in children and in hyperactive children (short-term use).	Ortho-McNeil
Topamax	Used with other medications to treat certain types of seizures in patients with epilepsy or Lennox-Gastaut syndrome (a disorder that causes seizures and developmental delays). Topiramate is used to treat patients who continue to have seizures even when they take other anti-seizure medications.	Ortho-McNeil
Navane	Used to treat schizophrenia and symptoms such as hallucinations, delusions, and hostility.	Pfizer
Prolixin	Antipsychotic medication used to treat schizophrenia and psychotic symptoms such as hallucinations, delusions, and hostility.	Bristol-Myers Squibb
Risperidone	Used to treat the symptoms of schizophrenia. It is also used to treat episodes of mania or mixed episodes in patients with bipolar I disorder.	Janssen
Seroquel	Used to treat the symptoms of schizophrenia. It is also used to treat episodes of mania or mixed episodes in patients with bipolar I disorder.	AstraZeneca
Stelazine	Used to treat schizophrenia and symptoms such as hallucinations, delusions, and hostility. It is also used short-term to treat anxiety in some patients.	Goldshield

Table 1. Prescription drugs that can produce hyperthermia in an outdoor environment.

Drug Name	Purpose	Manufacturer
Eskalith	Used to treat and prevent episodes of mania in people with bipolar disorder.	GlaxoSmithKline
Lithobid	Used to treat and prevent episodes of mania in people with bipolar disorder.	Solvay
Geodon	Used to treat the symptoms of schizophrenia. It is also used to treat episodes of mania or mixed episodes in patients with bipolar I disorder.	Pfizer
Abilify	Used to treat the symptoms of schizophrenia. It is also used to treat episodes of mania or mixed episodes in patients with bipolar I disorder.	Bristol-Myers Squibb
Moban	Used to treat schizophrenia and symptoms such as hallucinations, delusions, and hostility.	Endo Labs
Thiothixene	Used in the treatment of nervous, mental, and emotional conditions.	Pfizer
Symbyax	Used to treat the symptoms of schizophrenia. It is also used to treat episodes of mania or mixed episodes in patients with bipolar I disorder.	Eli Lilly
Zyprexa	Used to treat the symptoms of schizophrenia. It is also used to treat episodes of mania or mixed episodes in patients with bipolar I disorder.	Eli Lilly
Thorazine	Used to treat psychotic disorders and symptoms such as hallucinations, delusions, and hostility. It also is used to prevent and treat nausea and vomiting, to treat behavior problems in children, and to relieve severe hiccups.	SmithKline Beecham

Common effects of nonprescribed drugs in OBH experiences

When clients arrive to OBH treatment programs, many of them still have street drugs in their system. This can cause serious issues in the field if not carefully monitored. Ecstasy, methamphetamine (meth), and crystal meth can cause extreme dehydration and create heat regulation problems if they are still present in a client's system. This is especially important because clients often enter programs extremely dehydrated from the previous and recent use of these substances.

Clients coming into programs following an extended use of meth, crystal meth, cocaine, or crack cocaine can also be at-risk for heart problems. In one example, a 17 year-old male experienced a heart attack in the first 36 hours of admittance to a program. At about 2:00 a.m., staff were notified and began to monitor the client because of feelings of nausea, severe chest pain, sweating, and pain in the left shoulder. The symptoms continued off and on throughout the night. Although it seemed illogical that a 17 year-old would be having a heart attack, the symptoms were clear and he appeared very ill. At 7:00 a.m. support staff extracted him from the field and took him to a local medical clinic. The clinic personnel ran five EKGs because the medical staff (including the doctor) could not believe that a healthy 17 year-old could have a heart attack. Doctors monitored his progress in the local hospital for 24 hours, with a cardiologist at the LDS Hospital in Salt Lake City, UT also monitoring his status. The next morning, a decision was made to life-flight him to the LDS Hospital in Salt Lake City. He returned to the program six weeks later and completed the program.

In another case, two clients were removed from a program as a result of heart damage problems due to cocaine, meth, and crystal meth use. Both clients were experiencing problems with tachycardia (i.e., an abnormally rapid beating of the heart). When the clients began even routine hiking, each would develop extreme tachycardia. Staff notified base camp and support personnel that the clients appeared very tired and could not hike. When basic assessment of their medical condition was taken, tachycardia was discovered. OBH program clientele often experience high blood pressure (BP) and pulse rates if they are in poor physical condition or if they are not accustomed to altitudes routinely experienced in many programs (e.g., most clients

will make an approximately 6000-7000 foot gain in elevation upon arrival to the program). These clients' extreme pulse rates were above and beyond any normal increases. The program supervisor went on the trail with them and monitored both BP and pulse rate for 24 hours. This was done every two minutes when they: (a) woke up, (b) stood up, (c) after standing for an extended period, (d) began hiking, (e) hiked for longer than two to three minutes, and (f) stated they could not continue hiking. Data from these medical assessments showed that when these clients hiked approximately 100-200 yards their pulse would skyrocket to 170 to 240 beats/minute. They obviously were exhausted and their pulse rate would not slow down in a normal time period after they stopped hiking. The program medical director was contacted and he recommended that the clients be referred to a nearby cardiologist. Neither of the clients were able to return to the program. It is important to note that in all three of these examples, the clients *had passed their pre-program physical* conducted by a medical doctor.

Any client entering the program with a history of "speed" use must be carefully observed. One key issue to monitor is the heart rate when hiking and resting during the first 72 hours to one week into the program. Any heart irregularities, (e.g., symptoms of heart attack, tachycardia, extreme palpitation, exhaustion beyond the normal physical conditioning expectations) should be intensely monitored and if discovered, immediately evacuated and taken to a medical clinic and/or cardiologist for an intensive exam.

There are new medications constantly coming on the market, and most that are currently prescribed for a Bipolar diagnosis are considered dangerous in outdoor environments. Monitoring new medications and associated side effects should be standard operating procedures for all OBH programs. One continuing issue to heed is that when new medications are introduced, many times they do not contain any warning of environmental or heat problems. For example, when Topomax was introduced, it was unknown that its interaction with heat problems would be so dangerous. Most antipsychotic medications can also compound issues of drowsiness or alertness. These include nonprescription medications for allergies, colds, hay fever, asthma, cough, sinus problems, antihistamines, and prescription pain and sleep medication (e.g., CNS depressants). Drugs excluded from this

consideration include: Lithobid, Lithium Carbonate, Geodon, and Eskalith (note in the precautions of some of these drugs it states that CNS depressants may add to the effects of the drug).

Another drug to remain cautious about is Depakote. If taken in the current level of high dosages prescribed today (e.g., 1500 mg per day), Depakote creates an unsafe situation in outdoor environments because of the inability of the client to remain alert. The client often appears in a drugged mental and emotional state, having difficulties accessing emotions and doing any real therapeutic work. They appear as though they have been smoking marijuana and simply cannot remain alert with a clear thought process required to participate in OBH programming. As a general rule, we have found, clients cannot take more than 500 mg per day of Depakote and be able to actively participate and do the necessary therapeutic work to realize their individual treatment strategies.

Medications and Exposure to the Sun

Currently there are also more medications that increase sensitivity to the sun than in the past. It appears that Doxycycline creates the most risk, but several others also increase sunburn risk. These include: Trilafon, Tetracycline, Helidac, Sumycin, Risperidone, Thiothixene, Vibramycin, Monodox, Dynacin, Declomycin, Achromycin, Demeclocycline, Minocycline, Oxytetracycline, Terramycin, Doryx, and Minocin. These medications may also cause the skin to be more sensitive to sunlight than normal. Signs and symptoms from even brief exposure to sunlight may cause a skin rash, itching, redness or other discoloration of the skin, and severe sunburn. In addition, clients may still be more sensitive to sunlight for two weeks to several months or more after stopping the medicine.

There have been at least two occasions with sunburned fingernails as a result of antibiotic use in the field caused by Doxycycline. One case was a female with vaginitis, while the other was a male with an infection in his testicle. Both were given Doxycycline by the course physician. Symptoms did not appear until two to three weeks after taking the medication. Symptoms included: tender, sore fingernails, additional pain when cold, trouble using the fingers in the morning to pack up, and discoloration of the fingernails. Both cases were not easily

identified by doctors (including a dermatologist), but it was generally felt that these problems were caused by some reaction to sunlight as a result of the antibiotics. Both cases were during cooler periods of the year, one during the late fall and one in early spring. Both clients were issued sun block because of the sun sensitive medication. The female used the sun block but her nails still burned. The male refused to use the sun block and received second degree sunburn on his hands and face along with sunburned finger nails. Staff should carefully monitor the proper application of sunscreen if any antibiotics are being taken.

Drug Detoxification in the Field

An important screening procedure for clients in outdoor settings is their drug use history before they enter the program. Drug screenings may uncover what they are currently using, but it does not indicate how much they have taken, for how long, or the last time they used. As a result, OBH programs often require a medical facility detoxification for anyone arriving obviously “drunk” or individuals testing positive for benzodiazepine and barbiturate drugs. Note if clients come from a medical detoxification unit or psychiatric hospital, they may test positive for benzodiazepines or barbiturates, which are often used in detoxification treatment (e.g., Xanax,, Valium) . If this is the case, it must be determined how much and for how long they have been taking the medication. These instances usually require a statement from the physician of the facility to clear the client for an OBH medical detoxification requirement.

Each client must be closely observed for drug withdrawal symptoms in the first 72 hours. Opiate withdrawal (e.g., heroin, morphine, codeine, demerol) will generally manifest with yawning, runny eyes and nose, nausea, muscle cramps, (abdominal and leg muscles most common) malaise, sweating, sleeping/fatigue anxiety, sexual anxiety, loss of appetite, and diarrhea. The worst day is generally the third and the worst symptoms generally subside in five days, although these symptoms can continue for up to 10 days. If clients experience longer and more severe withdrawal symptoms, this usually indicates they have been physically dependent on the drug for longer periods of time and their bodies have become accustomed to larger doses. Also, the more times clients experience detoxification, the stronger the detoxification symptoms will be and the longer they may last.

Amphetamine, methamphetamine, cocaine, and crack cocaine withdrawal will generally manifest with sweating, emotional swings (e.g., severe anger to sadness in short periods of time), anxiety, restlessness, extreme fatigue and sleepiness, and sometimes fever. Depression and suicidal idealization are common during cocaine and amphetamine withdrawal and must be watched carefully, with clients removed to a structured and safe environment when appropriate. These clients will typically go through the emotional aspects of withdrawal approximately three weeks after their first withdrawal period has terminated.

Barbiturates and benzodiazepine's withdrawal can be life threatening and should be approached with extreme care and caution. Within the first 12 to 20 hours, clients exhibit symptoms of nervousness, restlessness, and weakness. They often show tremors of the hands and legs, but by the second day these tremors may become worse and clients may become weaker. Clients who were using at least eight or more times the standard dose can have severe seizures that can be fatal. These seizures can also occur one to three weeks after the initial withdrawal period. Other withdrawal symptoms include dehydration, delirium, insomnia, confusion, and audio and visual hallucinations. Clients displaying such symptoms should be removed from the outdoor program for a medical detoxification, cleared by the physician, and placed back in the program. Clients displaying barbiturate, benzodiazepine, or alcohol withdrawal symptoms, or clients that do not respond to treatment of nausea, vomiting, and diarrhea should be removed to a medical detoxification setting. Clients experiencing delirium or audio and visual hallucinations to the extent they are a danger to themselves or others should also be taken to a medical detoxification environment. Except in alcohol withdrawal, clients have not been observed with delirium, audio, or visual hallucinations severe or extended enough to warrant removing them from OBH programming. Some speed users may have paranoia episodes and threaten staff, but when properly trained staff are available these can be managed in the field until the paranoia passes.

Alcohol withdrawal symptoms usually begin 12 to 48 hours after a person stops drinking. These include body shakes, sweating, weakness, and nausea. Some clients will have seizures and others will

have hallucinations and hear voices, which are generally threatening and cause fear. If alcohol withdrawal of a heavy long-term drinker is left untreated, it will develop into Delirium Tremens (DTs) in two to 10 days. If not treated, this condition can be fatal. These people should be removed from the outdoor program for medical detoxification.

Conclusions and Recommendations

In wilderness-based primary substance abuse treatment or OBH programs, staff should be assigned and trained in the responsibility of researching and approving client medications before clients are accepted into the program. Medications causing heat disease, dehydration, or any conditions that are dangerous to handle in the field should be discontinued prior to coming in the field. Such clients should not be accepted into these programs. All medications with risk should be reviewed with the program's medical director for final approval or disapproval.

In wilderness-based primary substance abuse treatment or OBH programs, staff must be trained and aware of withdrawal symptoms and associated risks of withdrawal. They must be aware of the symptoms and risks of street drugs that clients may have been taking immediately prior to entering the program. A system of assigning a staff to monitor new clients for a minimum of 72 hours upon arrival in the field should be established. Wilderness-based primary substance abuse treatment or OBH programs should have policies and procedures concerning the potential need for evacuation. This includes appropriate training for staff, the necessary contacts, and appropriate communication channels in place to complete the evacuation in a safe and efficient manner.

In summary, specific dangers for all program staff to be aware of include:

- Staff should be aware and notify support personnel of any dangerous signs and symptoms resulting from drug withdrawal;
- Layover days may be necessary to keep clients safe and to more accurately treat high risk symptoms;
- Nausea-associated withdrawal can prevent appropriate water and food intake;

- Weakness and fatigue always affect groups' abilities to make it to the next water source and routes and re-supplies may need to be changed;
- Amphetamine class drugs can cause drug induced heat disease, dehydration, heart problems, and high blood pressure;
- Vomiting and diarrhea of opiate withdrawal can cause dehydration; and
- Sweating associated with withdrawal can cause dehydration.

Additional Resources

A variety of drug informational websites are available:

<http://www.medlineplus.gov>

<http://www.nlm.nih.gov/medlineplus/druginformation.html>

<http://www.rxlist.com/>

<http://www.drugs.com/>

<http://www.health.org/>

<http://www.druginfonet.com/>

<http://www.fda.gov/cder/drug/default.htm>

<http://www.diahome.org/en/>

http://www.healthtouch.com/level1/p_dri.htm

*DISCLAIMER** All medical statements and observations in this article are a result of the author's 34 years of field experience working with clients in wilderness-based environments. The recommendations in this article should not be treated as medical fact. It is important for every organization to refer to medical doctors in each individual case to ensure that the proper diagnosis and treatment is administered.*

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Solution-Focused Therapy with Adolescents in Residential Treatment

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Abstract

This article provides a solution-focused approach for working with adolescents in residential treatment. The content areas include: (1) a discussion of why solution-focused therapy is a salient treatment modality, (2) a review of the philosophical underpinnings of solution-focused therapy, (3) casting a vision for the therapist's disposition toward the client, (4) a solution-focused understanding of mental illness and medications, (5) a discussion of solution-focused therapy techniques, and (6) a brief discussion regarding how to talk about setbacks.

Seven days of residential treatment has been authorized by your new client's insurance company. The client is presenting severe symptoms, and has a family system of strained relationships that are all too familiar. Your new adolescent client is refusing to talk with his or her parents, aside from demands to be removed from residential treatment. You're scrambling to formulate a diagnosis, develop a treatment plan, and get a handle on the client's treatment history. To top things off your supervisor wants to know the discharge plan!

Sound familiar? If it does, then no doubt you have experienced the pressure and time constraints common in residential treatment. Given these conditions, the question is not why solution-focused therapy is needed in residential treatment centers; rather, the question is how could any therapist effectively treat an adolescent without adherence to a brief therapy approach? The culture of managed care almost universally demands residential treatment be "short-term" (Leichtman, Leichtman, Barber, & Neese, 2000). The increasingly strict criterion used by insurance companies to substantiate the need for a "higher level of care" has led to substantial decreases for the average length of treatment within the residential context. The speed at which clients pass through residential programs places additional responsibility

upon residential therapists to maximize the opportunities they have when interacting with clients and their families. In order to be good stewards of the clients' resources and time, residential therapists need to consider adopting a solution-focused or brief therapy orientation.

“Failures” of Treatment

The myriad of messages adolescent clients receive from parents and from previous treatment providers are often permeated with defeat, deficit, and blame. Most adolescents in residential treatment possess multiple experiences with inpatient hospitalizations, partial hospital programs (PHP), intensive outpatient services (IOP), and traditional outpatient services (Leichtman et al., 2000). These past treatment experiences are frequently labeled as “failures.” The memories and messages associated with these “failures” are carried with the adolescent into residential treatment. It is easy to understand why an adolescent client's self-esteem may be shattered. Solution-focused therapists must orient themselves away from this negativity and strive to disrupt the “stories of impossibility” that are self-perpetuated by clients and their families (O'Hanlon & Bertolino, 1998).

Focusing on Solution Possibilities

A fundamental concept of solution-focused therapy is shifting the client's frame of reference from problems to possibilities (De Jong & Berg, 1998; Miller, 1997). This is best accomplished by engaging clients in solution-focused language instead of the familiar problem-focused language (Miller & de Shazer, 1998; de Shazer & Berg, 1992). Clients and families utilizing problem-focused language often cling to the idea (consciously or unconsciously) that in order for change to occur, the problem must be completely resolved. This faulty assumption can be particularly difficult to overcome because with each treatment “failure” the adolescent's identity may become increasingly fused with the problem, sometimes to the point where the problem and the client are virtually synonymous (Schott & Conyers, 2003). The problem is difficult to resolve if this equation (problem = adolescent) persists. This is a reason why many families and clients feel so stuck by the time residential services are activated.

Therapists who engage clients and their families in solution-focused language seek to reshape and reconstruct their rigid and

dichotomist thinking. Solution-focused therapy purposefully utilizes “solution-talk” and avoids “problem-talk” (de Shazer, 1994). Through “solution-talk,” therapists assist clients and their families in seeing that a positive treatment outcome does not necessitate the complete resolution of the problem. Instead, success is measured in terms of improvement in the adolescent’s and the family’s functioning. *The goal becomes life improvement, not problem resolution.* De Shazer (1994) points out that “Of course not all talk about problems is problematic. Sometimes, in fact, it is useful, for instance, if the client has never talked to anyone about the problem, then talking about the problem is doing something different” (p. 80). There are positive ways to talk about problems and there are problematic ways of talking about problems. The path chosen is jointly determined by the quality and types of interactions occurring between the therapist and the client (i.e. use of “solution-talk” vs. use of “problem-talk”).

While many therapists agree with this notion (i.e. a need to focus upon solutions), it can be very difficult in practice for therapists to maintain a positive outlook when working with clients who have severe mental disorders. If the therapist slips into a problem-focused mode of thinking, this may negatively impact clients, their families, and the culture of the residential treatment center. Solution-focused therapists typically strive from the onset of treatment to steer the orientation of clients and their families toward realistic solution possibilities. The language used by the solution-focused therapist is the primary vehicle for constructing a social reality that possesses these new possibilities (G. Miller, & de Shazer, 2000). Accordingly, solution-focused therapists should advocate and intercede for their clients whenever this new reality is jeopardized or challenged. Attacks to this new reality sometimes emanate from the residential treatment center itself. Staff may slip into problem-focused modes of thinking about and relating to the adolescent in care, and clients and families may revert to old habits of blaming.

Constant Change

Another fundamental principle of solution-focused therapy is the belief that change is constant and that only small changes are needed in order to generate positive movement in the lives of clients (de Shazer, 1985, 1988). The principle of constant change is one that is often hard

for clients, families, and even therapists to grasp. While the genetic traits of clients are fixed, clients and their families possess the ability to alter how they interact with and perceive the social, environmental, emotional, and spiritual aspects of their lives. If change is constant, then it is wise for solution-focused therapists to ask clients and their families about any pretreatment changes occurring prior to admission. In Lawson's (1994) study on pretreatment change with a sample of 82 clients, 51 clients (62.2%) were able to identify positive pretreatment changes. An earlier study conducted by Weiner-Davis (1987) found that out of 30 cases consisting of adolescent clients and their parents, 20 cases (66%) reported the existence of positive pretreatment changes. Change is constant, yet if this reality is not pointed out to clients and families they often remain stuck in a distorted reality where problems are static.

Another fundamental principle of solution-oriented therapy is that only small changes are needed in order to usher in greater changes for clients. While society and the therapy community often talk about "random acts of kindness," "the butterfly effect," and Dr. Leo Marvin's philosophy of "Baby Steps" from the movie *What About Bob?*, more "power" resides in these clichés than people may believe. Within the context of residential programs, solution-focused therapists ask their clients to observe what happens in their lives when they do something different that is seemingly small or appears insignificant (e.g. daily hygiene, risk disclosing to staff, remaining in the social milieu instead of isolating, talking to their parents without making accusations, simply identifying positive aspects about the self). These are examples of small steps clients can take that open up new experiences and new pathways to solution possibilities. One key concept to remember during this entire process is that change is constant and clients are capable of discovering new ways of relating and behaving.

Doing What Works

The guidelines of "do more of what works" and "if it works, don't fix it" are cornerstones of solution-focused therapy (de Shazer, 1985). Astute residential therapists are able to quickly assess the client's past attempts to resolve the problem by classifying these attempts into "useful" and "not useful" means of handling the problem. Many times it becomes clear that attempted solutions are often the source of

problems or responsible for their reoccurrence (Watzlawick, Weakland, & Fisch, 1974; Fisch, Weakland, & Segal, 1982). In these situations, solution-focused therapists encourage clients to explore new ways of coping with the problem, as well as seeking to eliminate old coping habits that have proven to be ineffective. During the process of identifying what works for clients, solution-focused therapists are also directing attention toward the unique strengths and characteristics of clients, specifically asking them to share about their talents, interests, and personal strengths. These areas of strength are then used by the therapist to amplify the client's movement toward solutions. This process of highlighting the positive elements and events of the client's life is particularly needed for adolescents in residential care, who as mentioned earlier, frequently view themselves through negative lenses.

Therapist's Disposition toward the Client

Client as Expert

The attitude and disposition of the therapist toward the client is paramount. Will residential therapists assume the attitude of judge and jury, or will they choose a different stance? There is little doubt about the preparedness of the adolescent to receive criticisms and judgments from the therapist. But is the adolescent client prepared for a solution-focused therapist, someone who will place him or her in the role of expert? Many clients who are admitted to residential treatment centers feel as though they have been wronged and/or tricked into treatment, similar to the feelings common among mandated clients. It is also common for adolescent clients to claim they have no voice, or that no one has listened to them in the past. It is recommended that solution-focused therapists take the stance of "not knowing" and invite their clients to educate them about what they know works best for them (De Jong & Berg, 2001). By taking this stance with clients, solution-focused therapists can improve their ability to cooperatively build and construct solutions with clients. When allowed to be the expert on their lives, adolescent clients usually take more responsibility for their own treatment and work with their parents and therapist in a more productive and mutually agreeable manner.

Building Healthy Expectations

Once adolescents see the therapist is genuinely interested in cooperating with them and the therapist values their stories, then the seeds of hope are planted. Adolescents may begin to wonder to themselves, “Will this treatment experience actually be different?” Through use of a solution-focused stance, a healthy sense of expectancy for the realization of solution possibilities begins to become tangible to clients. In order for this to occur the therapist must be genuine and present, fully listening to and acknowledging the stories, emotions, and competencies of clients (S. D. Miller, Duncan, & Hubble, 1997). If this is neglected, then adolescents (who are adept at “sniffing-out” falsehood) will throw-up their defenses and disengage from the therapeutic process.

A Solution-Focused Understanding of Mental Illness & Medications

Mental Illness as “The Problem”

The amount of exposure adolescent clients have experienced with diagnostic labels, combined with the different stories about these labels from various professional and non-professional sources, often makes mental illness “the problem.” Mental illness becomes a significant problem when clients disavow personal responsibility for their poor choices and acting-out behaviors. Frustrated with their child’s behavior, exhausted parents sometimes blindly accept diagnostic labels that describe their child’s misbehavior and emotional instability, framing it as stemming from mental illness. This can lead them away from considering the multiple contributing factors responsible for the adolescent’s current psychological state. This is a potentially combustible issue, one solution-focused therapists will likely have to navigate with each child and family. DSM-IV-TR labels are not the problem; the problem is the tendency of clients, parents, and even treatment providers to view diagnostic labels as the final formulation about an adolescent’s current state and about his or her ability to change. The linear thinking characteristic of western societies, particularly in regard to cause and effect, makes it difficult for individuals to not believe in narrow definitions of mental illness. While this article does not allow for a full discussion of this intriguing subject, solution-focused therapists need to be prepared to have such

discussions with their clients and families. While most parents and adolescent clients admit to the presence of mental illness, there may be some rare situations where such a formulation is not accepted. In either case, solution-focused therapists strive to cast a vision for life enhancement, challenging clients to have the courage to be healthy and to move in a socially useful manner whatever their diagnosis may be (Ansbacher & Ansbacher, 1956; Mosak & Maniacci, 1999; LaFountain, 1996).

It is common for clients and parents to want to know the cause or reasons for the adolescent's problems. In these cases, the solution-focused therapist may answer that such investigations and interpretations could be endless, and the focus of therapy should be concerned about the present and the future (de Shazer, 1994; Watzlawick, Bavelas, & Jackson, 1967). While it might be intriguing to identify a cause for a problem, there is no guarantee that the cause being investigated is still operating upon the problem. In other words, the problem may have "functional autonomy," meaning that it is self-perpetuating in-and-of-itself and the original "trigger" or "cause" is no longer a factor. The solution-focused therapist should empathize with clients who desire to know the "truth" about causes, while redirecting their energies to the here-and-now.

Medications as "Helpers"

It can be very difficult to help adolescent clients understand the benefit they may receive from taking medications for an extended period of time, and that this reality can coexist with a positive outlook on life. Just as people with diabetes learn to acknowledge the presence of specific limitations and the need for specific safeguards in order to remain healthy, it may also be important for clients to acknowledge the presence of emotional and behavioral limitations, some temporary and some enduring. The solution-focused therapist strives to help clients be as practical and pragmatic as possible. Adhering to malignant optimism usually only serves to disadvantage clients and their families, whereas honest dialogue and hope based upon reality can be more constructive and edifying. Solution-focused therapists must embrace the paradox of acknowledging limitations, while also maintaining that there are several unknown solution possibilities available to the client. While it may not be possible to rid some clients from diagnostic labels

of the DSM-IV-TR or their need for medications, it is possible to amplify client strengths and abilities.

Clients who are admitted to residential treatment centers are typically on medications. While there are significant reasons and indications for the use of medications, clients need not be mindless recipients. Solution-focused therapists need to be willing to have conversations about medications and should encourage their clients to talk with their psychiatrist or physician about each medication and its potential benefits and possible side effects. It is very useful to frame medications as “helpers.” This is practically a universal euphemism among mental health professionals that is very positive and strength-based in orientation. Framing medications as “helpers” keeps clients responsible for their own behaviors and minimizes their ability to complain about the influence or lack of influence of a medication.

Solution-Focused Techniques in Residential Treatment

The Miracle Question with a Twist

The miracle question is a useful technique for assisting adolescent clients to identify and clarify goals for life improvement. While the miracle question can be helpful in its “traditional” form, therapists may need to modify it to the specific needs of their clients. The traditional” miracle question is formulated as:

Suppose that tonight after you go to sleep a miracle happens and *the problems that brought you to therapy are solved immediately*. But since you were sleeping at the time you cannot know that the miracle has happened. Once you wake up tomorrow morning, how will you discover that a miracle has happened? Without your telling them, how will other people know that a miracle has happened? (emphasis added, de Shazer, 1994, p. 95).

Instead of offering the “traditional” version of the miracle question (implying the complete resolution of client problems and complaints), it may be more respectful when working with adolescent clients with severe DSM-IV-TR diagnoses (e.g., schizophrenia, bipolar disorder, major depression) to ask the miracle question differently. The solution-

focused therapist who is working in a residential setting is advised to replace the italicized portion of the “traditional” formulation with one of the following phrases: “The miracle is that life is improving” or “The miracle is that your life is on-track to getting better.” The difference with this version of the miracle question is that it subtly communicates respect for the realities of the client’s emotional and behavioral limitations while still maintaining a solution-focused perspective regarding the client’s ability to improve. The power of the miracle question is that it serves as a bridge to connect clients and therapists as well as orienting each to the future (de Shazer, 1994, p. 95). While the “traditional” version of the miracle question is very useful and helpful for many clients, it may not be the best choice for clients who have experienced and are experiencing severe psychological and behavioral disturbances.

Positive Coping

Adolescent clients in residential treatment centers are often well versed in the therapeutic jargon of mental health. A common part of this verbiage is the concept of coping. It is often humorous to witness the reactions of adolescents in residential treatment when a conversation moves into a discussion about coping, especially when in a group setting. Adolescent clients often moan and groan about coping skills and anger management techniques because in most cases they have been able to identify coping strategies, yet have failed to consistently utilize them. The dark side of coping is the valley of shame clients can fall into after they fail to adequately cope with stressors in their life. Adolescents are sometimes reluctant to talk about coping because of this strong association with failure.

The solution-focused therapist’s positive stance on coping is a way to counteract this pattern. Instead of asking how a client failed to cope in a particular situation, solution-focused therapists emphasize the possibility of improved coping in the future. In situations where the adolescent partially coped or coped well for a period of time before making a poor choice, the solution-focused therapist highlights the fact that the adolescent was able to successfully cope as long as he or she did. Questions such as “How did you do that?” and “What were you telling yourself when you noticed you were coping well?” are appropriate for accomplishing this goal (De Jong & Berg, 1998).

Clients are often surprised when the therapist celebrates partial successes instead of examining how they “messed up.” Of course, it is unavoidable that family members and clients will identify and want to talk about what went wrong, and possibly who did what to make the situation worse. Solution-focused therapists accept this reality, yet encourage the family to identify what went well and how things can improve.

Case Example

A female adolescent client was praised by her therapist in a recent session. Why? Prone to physically attacking her parents and throwing household items when upset and angry, in her most recent outburst she only kicked over a small trash can. While the hostility and anger still existed between the girl and her parents, something had changed. The girl’s mother recalled at one point in the episode her daughter had a chair in her hands, and the mother was fearful that she was going to throw it down the stairs. The daughter quickly chimed in by stating that she had considered throwing the chair, but she had changed her mind because she didn’t want to accidentally hurt someone in the family. This revelation helped to alter the girl’s distorted perception of herself from the negative problem-talk, “I am someone who hurts my parents” to the positive solution-talk, “I am someone who cares about my parents.” The disclosure also helped the parents to see their daughter in a positive light (i.e. “she cares about our safety”). This solution-focused perspective on coping helped to open up new possibilities for this client and her family. It is not uncommon that even in the midst of considerable negativity, adolescents and their families are able to identify positives and solution possibilities when they are guided by a solution minded therapist. Families are frequently able to discover these realities even on their own.

Scales

A common challenge faced by many adolescent clients in residential treatment is a limited vocabulary, or a reduced ability to translate their subjective experiences into a language that is understandable by others. A shrug of the shoulders, a blank stare, and the common statements “I don’t know,” and “I’m fine,” are indicators this phenomenon may be occurring. Solution-focused therapists accept these responses and may state “It’s difficult to know how to describe your thoughts/feelings,”

or “It makes sense that it might be challenging to share about your experiences.” Therapists need to be aware that some of their clients might have developmental delays in cognition, attention, auditory reception, and memory, and clients may be several academic grade levels behind in school. The presence of learning disabilities may restrict the client’s ability to participate in treatment when compared to a “normal” adolescent. In light of these challenges, the utilization of concrete tactics to assist clients with sharing about their experiences is very helpful. One tactic that consistently helps is the use of scaling questions.

Scaling questions are particularly helpful because they provide a vehicle for talking about subjective experiences. Consider which mode of inquiry is easier for the adolescent client who is depressed: (a) responding to an open ended question that demands a vocabulary to describe the feelings, thoughts, and behaviors of his or her depression, or (b) responding to a scale from 0 to 10 upon which he or she may identify thoughts, feelings, and behaviors? For example, an adolescent may be asked to identify where he or she is at on a scale; 0 equals where the client was at during the time of admission (e.g. severely depressed) and 10 equals where the client will be at the time of discharge (e.g. little or no depression). If a client states that she is at a 5, then the therapist inquires about how she knows this (i.e. what are the signs or behavioral clues at a 5). Then the solution-focused therapist asks the adolescent to describe how her thoughts, feelings, and behaviors will be different when she is at a 6 or 7. The use of scales helps clients to describe and understand where they currently see themselves in terms of what is being assessed (in this case depression). Scaling questions can also build healthy expectations for future improvement.

“On-Track” Assessments

Once a good working relationship has been established between client and therapist and when the goals for therapy begin to solidify, it is important for the solution-focused therapist to “check-in” with clients about their progress. Life improvement and the solution movements of the client are assessed through “on-track” assessments (Walter & Peller, 1992). The “on-track” assessment asks clients to identify if they are moving toward their treatment goals. Adolescent clients are asked to identify clues or signs telling them they are “on-

track” toward reaching their goals. Once these are identified by the client, the solution-focused therapist asks a variety of questions assessing how difficult or easy it was to stay “on-track” in a particular situation. The therapist may inquire about what adolescent clients actively do to keep themselves “on-track,” and the therapist may also ask about how mindful or aware clients are when they are purposefully moving forward. Clients who are close to discharge and who have demonstrated consistent solution movement are asked to keep noticing what helps them to stay “on-track” (Campbell, Elder, Gallagher, Simon, & Taylor, 1999). If adolescents assess that they are “off-track” or even “derailed,” questions about what it will take to get them back “on-track” are asked.

Finding the Funny Bone

There is a significant amount of literature about the health benefits of humor, and therapists are wise to harness its power. In Martin’s (2001) review of the existing psychological studies on humor from 1960 to 2001, he discerned three explanations or reasons for the efficacy of humor: (1) positive physiological changes, (2) positive emotional states, and (3) improved coping with stress. While it is difficult to identify exactly how humor provides health benefits to individuals, it has been commonly agreed that life is more enjoyable with humor and laughter. As mentioned earlier in this article, many adolescent clients who enter residential treatment have a negative self-concept and outlook on life. Solution-focused therapists are encouraged to consider the power of humor and how it may benefit clients and families. The “silly” and “sarcastic” forms of humor are not indicated; instead therapists should utilize and foster a “relaxing” or “light-hearted” humor that stems from their positive regard for clients. The first step toward establishing the good humor connection with clients comes from the attitude of the therapist. Light-heartedness and the ability to smile and rejoice about client successes can be intoxicating to adolescents who feel stuck in a pessimistic frame of reference. Solution-focused therapists who are able to discern and then skillfully tickle a client’s funny bone will no doubt aid the client with changing his or her outlook on self, others, and the world.

Solution-Focused Perspective on Setbacks

Bumps in the Road

How do solution-focused therapists talk about setbacks with adolescents in residential treatment? The answer is usually through metaphor. Much of therapy is metaphorical, sometimes purposefully and sometimes unintentionally. When it comes to talking about setbacks, describing these events as “bumps in the road” instead of relapses removes much of the stigma and negative connotations tightly wound around this concept. When an adolescent client is informed that bumps in the road are common and that they are expected to occur due to the complexities of life, this helps remove much of the destructive power of setbacks when they happen. The imagery of a road can be very useful because the adolescent client is able to identify that life is a journey. The road of life can be long and unpredictable, and it can be hilly, curvy, smooth, bumpy, narrow, and wide. Adolescent clients can be asked to describe how they see the roads in their lives. Is the road with their peer group smooth or bumpy? What about the road with one’s parents? How is the road of education? The permeations and versatility of this technique is limited only to the imagination of the therapist and the client. A road may be bumpy but if there are several rest stops along that road then the journey is more bearable. If bumps in the road are predicted then life can become a bit more predictable. If life is more predictable then the ability of clients to positively respond to setbacks can be enhanced. If adolescent clients learn how to respond positively to the bumps in their roads then they will likely be able to more fully enjoy life when the ride is smooth.

Implications for Therapists

Residential therapists should consider adopting a solution-focused approach because it is an effective treatment model given the constraints of managed care. Solution-focused therapy effectively addresses the negativity often engrained in the lives of clients. This approach provides a refreshing alternative for talking about the problems and challenges that adolescents are confronted with and provides realistic hope for change. As clients begin to view themselves in a more positive light and as they experience small changes, the solution movement of the client becomes easier to generate.

While the allure of being solution-focused is appealing, it is often very difficult for residential therapists to adhere to this approach given the attitudes of clients, parents, and the treatment culture of the mental health field (which often dwells upon problems and primarily uses “problem-talk”). Being solution-focused in the office with clients is only one manifestation or outlet for this perspective. Therapists should be solution-minded when interacting with direct care workers who provide daily support and structure for clients. Solution-focused therapists are encouraged to be intentional about influencing the treatment culture of residential programs and should challenge coworkers to consider the possibilities that “solution-talk” reveal. Through adherence to a solution-focused perspective, residential therapists can positively impact clients, families, and the environment of care.

Solution-focused checklist

As mentioned earlier, it can be challenging for therapists who work in residential treatment centers to maintain a solution-focused perspective. Having a simple checklist as a reminder of what to look for in therapy can prove helpful. Most solution-focused therapists want to assess their client’s beliefs and attitudes. Gaining a general idea about where the client is in each of the categories listed below will likely assist in the formulation of treatment goals. The following checklist is not intended to replace other psychological instruments used to formulate diagnostic labels or determine personality functioning. Instead, this checklist serves as a guide for solution-focused therapists who want to gain a baseline of a client’s level of solution focus and problem focus orientations. This checklist can also be used by therapists to assist in conceptualizing parental belief systems. It also may prove useful to implement this checklist for the purpose of self-evaluation (even therapists need to take stock of how they are doing).

- Client’s Stories about Self (Tales of Impossibility vs. Tales of Possibility)
- Client’s Relationships with Others (Draining vs. Fulfilling)
- Client’s Words (Problem-Talk vs. Solution-Talk)
- Client’s View of Future-Self (Negative Future-Self vs. Positive Future-Self)
- Client’s View of Responsibility (Other-Determined vs. Self-

Determined)

- Client's Ability to Forgive Self (Self-Deprecating vs. Self-Forgiving)
- Client's Movement (Problem-Generating vs. Solution-Generating)
- Client's Humor (Degrading Humor vs. Up-Building Humor)
- Client's View of the World (Hopeless-Hostile vs. Hopeful-Cooperative)
- Client's Exception Finding Ability (Limited vs. Numerous)

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Family Therapy Assessment and Treatment Planning: Two Case Studies

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Abstract

Family therapy has become a common and important part of residential treatment. The Beavers System Model (Beavers & Hampson, 1990) was developed to provide a means to understand the systemic functioning of families. Two dimensions are used in the Model: (a) Family competence, ranging from severely dysfunctional to competent and (b) Family style, ranging from open (centripetal) to closed (centrifugal). The combination of these two dimensions creates nine different categories of family functioning. To illustrate its use in residential treatment, the families of two adolescent students were analyzed using the Beavers Systems Model. Information for these analyses were obtained from case reviews and qualitative interviews. Implications for using the Beavers System Model to assist in residential treatment are discussed.

Family Therapy Assessment and Treatment Planning: Two Case Studies

The practice of involving the family during the course of adolescent treatment has become increasingly common. Some residential treatment centers and therapeutic boarding schools currently include a family therapy component. This can consist of over-the-phone sessions, visitation programs where families meet with their children and engage in therapy, or a combination of both.

There is considerable evidence that family therapy is an extremely effective treatment modality for children and adolescents. Liddle and Dakof (1995) reviewed the body of research examining the efficacy

of family therapy for adolescent drug abusers. They stated that of all the studies reviewed “not one study found that family therapy was inefficacious.” (p. 515). They also noted that several studies compared family based treatments of drug offenders with non-family based treatments, with family based treatments consistently resulting in better outcomes. Family therapy has also been shown to be effective in treating conduct disorders. In a meta-analysis examining the effects of family therapy in the treatment of conduct disorders, a significant effect size was found ($d=.53$, $n=18$) (Shadish, et al. 1993). A number of other published reports confirm these findings, once again with no studies suggesting that family therapy is inefficacious in treating adolescents with conduct disorders (Chamberlain and Rosicky, 1995). In an additional review of the literature about family therapy treatment for adolescents, Cottrell and Boston (2002) stated there is strong evidence of the effectiveness of systemic family therapy for treating children and adolescents with conduct disorders, substance abuse, and eating disorders, with some evidence that family therapy can also help children and adolescents with depression and chronic illness.

However, little research has been completed evaluating the effectiveness of family therapy in residential settings. In one study, Springer and Stahmann (1998) surveyed 47 parents of adolescents in residential treatment about the quality of family communication and their satisfaction with the residential program, and correlated their responses with frequency of parent-child, parent-therapist, and parent-child-therapist (or family therapy) phone communications. They found a positive correlation between the number of telephone family therapy sessions over a five week period and ratings of functional family communication, while no correlation was found between number of phone calls with just the child or the therapist and functional family communication. An additional positive correlation existed between the number of family therapy sessions and parent satisfaction with the residential program, while no such correlation was found between the number of phone calls with just the child or the therapist and parent satisfaction. One weakness of this study was there was no post-treatment evaluation of family therapy effectiveness.

At the New Haven Residential Treatment Center (NHRTC) in Spanish Fork, Utah in 2004, interviews with students were conducted

to identify the elements contributing to the most beneficial aspects of treatment. These interviews were tape recorded and transcribed, with the transcriptions subsequently reviewed. Students provided a wide variety of responses, with many mentioning beneficial events occurring during the course of family therapy.

As the students' responses about family therapy were analyzed, an overarching model was sought to understand family dynamics and families' progress in NHRTC treatment. Understanding the processes of therapy within a schema is an important part of treatment planning. This can be especially true when engaging in family therapy because of the complexity of the family system and the propensity of the system to distract the therapist from important therapeutic goals. Developed by W. Robert Beavers and Robert B. Hampson (1990), the Beavers Systems Model seems to address these issues in an accurate and productive manner.

The purpose of this paper is to provide an example of how The Beavers Systems Model can be used to conceptualize the experiences of adolescents and their families in treatment. Analysis from two actual NHRTC cases is used to outline the Model's use. While identifying information has been changed to protect client confidentiality, the presentation of pertinent information from students' files and transcriptions of client interviews will also be used.

The Beavers Systems Model

The Beavers Systems Model was derived from clinical practice and associated research and observation. Beavers and Hampson wrote "when consistent patterns emerge from repeated phenomena under observation, as in clinical observation of families, they form the basis for theoretical hypotheses." (1990, p. 3). Using observation to generate their hypotheses and research comparing clinical versus non-labeled or normal families, they delineated the characteristics of competent, well-functioning families. They concluded that family competence does not fall into discrete categories, but instead ranges on a continuum of functional behaviors. And while families with similar competence levels may have different styles of relating with one another, competent families are able to shift their style as developmental changes occur whereas dysfunctional families tend to be rigid in their styles. They

also confirmed the systemic notion that problems within the family system supersede individual psychopathology (Beavers & Hampson, 2003).

Dimensions

The Beaver's System Model plots these concepts on two dimensions: (1) family competence and (2) family style. Family competence is defined as:

“how well a family as an interactional unit performs the necessary and nurturing tasks of organizing and managing itself. The major theme of this dimension is the structure of the family unit: the ability of the adults to negotiate and share leadership, and of the family to establish strong, clear generational boundaries is indicative of competence. Conversely, weak adult coalitions, which may induce a parent-child coalition and ineffective leadership are indicators of lower levels of system competence.” (Beavers & Hampson, 2003, p. 551.)

Competent families are able to resolve conflict and communicate in a functional manner. They show spontaneity, a wide range of feelings, optimism, and facilitate the self-esteem of family members (Beavers & Hampson, 2003).

Family style refers to the degree of centripetal (CP) or centrifugal (CF) qualities in the family. CP families are systems that are more closed. They rely on family members rather than on the outside world for support and satisfaction. CF families are open systems relying on the outside world for support and satisfaction. Relationships with friends are seen as more important than those with family members, and children leave the home earlier than their peers in families with a high degree of CF qualities (Beavers & Hampson, 1990, 2003).

As noted, the Family Competence and Family Style dimensions are plotted onto a model as shown in Figure 1. The horizontal axis represents Family Competence and the vertical axis represents Family Style. The arrow-shaped white space in the figure illustrates how more competent families possess a greater flexibility in style depending on

current demands (therefore not drifting toward stylistic extremes). The shaded notch on the severely dysfunction end shows how the least competent families lack flexibility, and instead implement extreme and inflexible CP or CF styles that do not change in response to different demands or circumstances. When families are rated in terms of style and competence, they can be plotted on the figure, providing an instant visual representation of their current level of functioning (Beavers & Hampson, 2003).

Family Types

In the Beavers Model family competence is divided into five categories: Optimal, Adequate, Midrange, Borderline, and Severely Dysfunctional. As illustrated by the model in Figure 1, families in the Midrange, Borderline, and Severely Dysfunctional categories are more apt to have strong stylistic components (in either the CP or CF directions), while Optimal and Adequate families tend to apply both CP and CF styles in a flexible manner without progressing toward extremes. This creates nine family types, as described in Table 1 (Beavers, 1981; Beavers & Hampson, 1990, 2003).

Methods

Subjects

Case study data for this article comes from semi-structured qualitative interviews conducted as part of a larger research effort. Case studies are in-depth views of an important event or time period in the life of a single individual, and are commonly used to illustrate specific phenomena for the benefit of the audience (Bromley, 1986). "The value of the case-study approach is that it deals directly with the individual case in its actual context." (Bromley, 1986, p. xi). Case studies and qualitative interviewing compliment each other, as qualitative interviewing is a non-directive, unstructured, nonstandardized and open-ended technique used to elicit information from individuals. (Taylor and Bogdan, 1998). For this study, 34 NHRTC students volunteered to participate in qualitative interviews about their therapy experiences.

The analysis of qualitative interviews begins with an initial reading of the transcripts to gain a holistic view of their content, and then during further readings statements made in the interviews are coded for thematic content (Giorgi and Giorgi, 2003). In this case, during

Figure 1. The Beavers Model of Family Functioning. (Figure provided by Robert B. Hampson, reprinted with permission.)

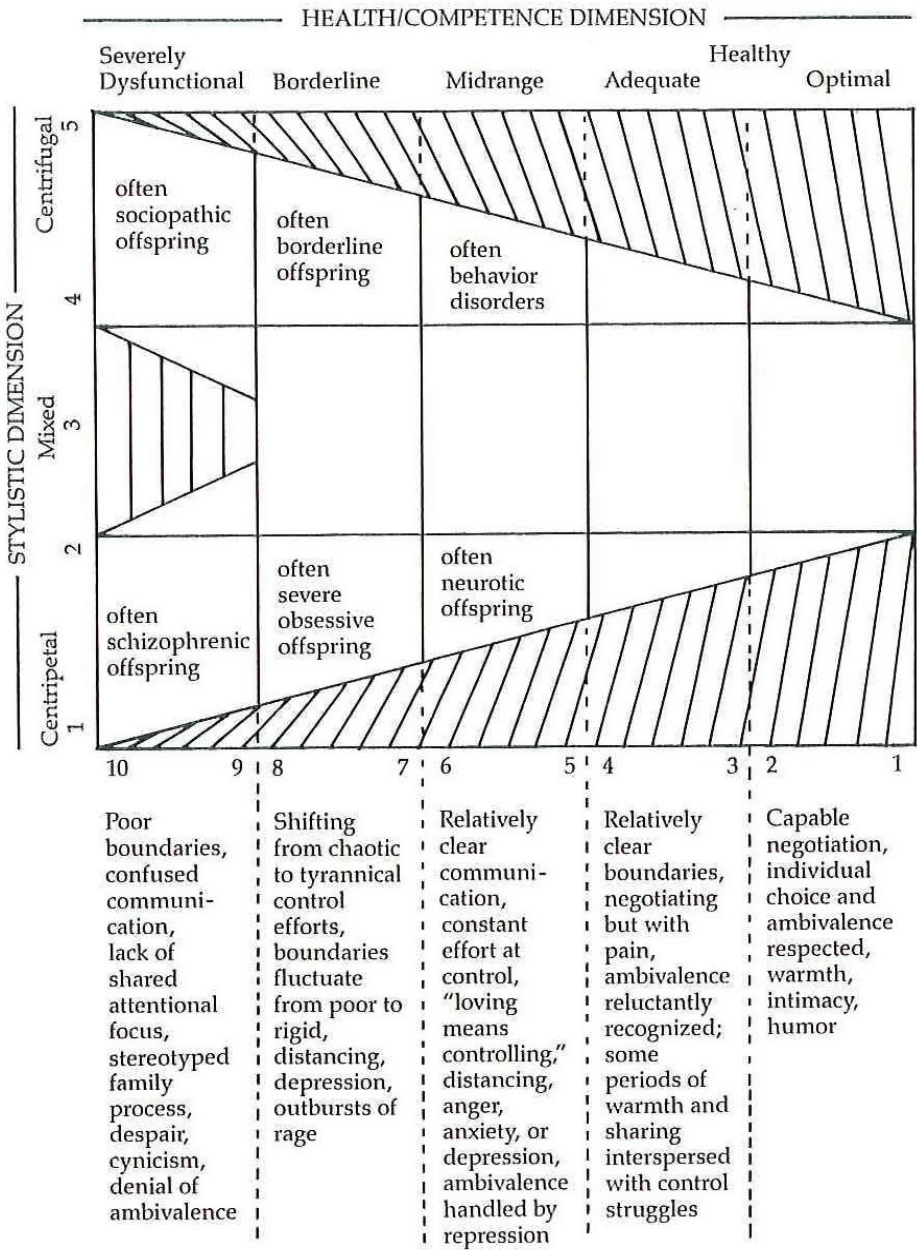


Table 1 . Beavers Systems Model Family Types

Family Type	Characteristics
Optimal	Flexible, intimate, parents share power, boundaries respected, effective communication/negotiation, respect for individuality.
Adequate	Clear boundaries, intimacy, individual responsibility, more control. Parental coalition less effective but cooperative. Warm.
Midrange	Control, power differences, power struggles, unilateral decisions. Repressed or projected feelings, boundaries generally respected.
Midrange CP	Rules, propriety, image, and authority. Feelings repressed. Dependent, emotional women and strong, silent men.
Midrange CF	Control attempted using authority, manipulation, and intimidation, but doesn't work. Open hostility, and blame. Early independence.
Midrange mixed	Parents alternate between fighting and stereotyped roles, children between respect and disobedience.
Borderline	Control prevails. Power struggles, little emotional support. Poorly defined boundaries, compromised separation and individualization.
Borderline CP	Covert attempts to control others' thoughts and feelings. Unequal parental coalition, parent-child coalitions often occur.
Borderline CF	Stormy battles with direct assaults. Loose parental coalition. Little or no nurturance or support. Anger and rebelliousness.
Severely Dysfunctional	Extreme boundary problems, poor communication, chronic emotional distress. Cyclical dysfunctional patterns.
Sev. Dysfunctional CP	Closed, rigid system. Children don't leave home. No individual identity. Unclear boundaries, relatedness is impossible.
Sev. Dysfunctional CF	Diffuse boundaries with outside world. Parents move in and out, children run away. Constant hostility and open conflicts.

the initial review of transcripts, it was noted that many of the students commented about the impact of their family therapy experiences. Some students' remarks provided considerable detail, aptly illustrating characteristics of their families which can be conceptualized using the Beavers Model. While comments made during qualitative interviews are not usually used to contribute to case studies, those who conduct case studies often interview their participants as a way to provide further depth to the illustration of phenomena, so using the students' narratives was appropriate. Therefore, five individuals whose comments were especially illustrative were selected for analysis. These students' charts were reviewed for historical detail about how the family responded in family therapy. Based on that chart review, the two students for whom the family therapy process was clearly and completely described were selected to present as case-study illustrations.

Instrument

Undergraduate university students who volunteered as research assistants conducted semi-structured interviews with each subject. The research assistants received six hours of training covering interviewing methods, rapport building, listening techniques, and using follow-up questions for clarification and elaboration. The interviews were conducted each time a participant advanced in the program's five-level system. Each semi-structured interview began by asking students to identify the issues or problems they addressed since achieving their last level (or entering the program). Next the interviewer encouraged the student to elaborate about their progress with each problem, asking about specific efforts they made to address the issue, how the student changed, and which program elements were the most helpful. The interviews were tape recorded and transcribed, and portions of the transcripts are presented in the following case studies.

Case Studies

Case Study 1

Heather (not her real name) was 16 years old at the time of her admission. Heather had been in two other programs before her admission, running away from one and engaging in sexual activity with another student in the other.

Before entering treatment, Heather acted out in many different ways. She abused drugs, claimed that she had been in many physical fights using weapons such as chains, brass knuckles, and a knife, and said that she vandalized, helped steal a car, and broke into other peoples' homes. She reported many symptoms such as depression, anorexia, anxiety, suicide attempts, mood swings, cutting, apathy, obsession with past boyfriends, and sleep disturbance. She also reported experiencing sexual trauma twice and having flashbacks, hyperarousal, recurring dreams, and other post-traumatic symptoms relating to that trauma. Interestingly she made the claims of aggressive and conduct disordered behaviors to a psychologist while completing an evaluation about a month after her admission, but not to her therapist nor to the facility's psychiatrist, casting doubt on their veracity. Not surprisingly, her parents complained of Heather's frequently lying and other dishonest acts.

Heather's father stated his relationship with his daughter was warm and loving until she turned 11 or 12. On two occasions when she was 12 he reacted poorly to her temper tantrums, and thereafter chose to let his wife do all of the disciplining. After that time, he was not close to Heather, and Heather said that she had hateful feelings toward him and she did not care they weren't close. She reportedly used his reactions to her temper tantrums to punish him when he tried to become involved with her. Heather's mother described her relationship with Heather as strong, loving, and close, with excellent communication. She said the only conflict in their relationship occurred when she had to leave town on business. Heather told the evaluating psychologist she slept with her parents until she was 11 years old, and occasionally her mother still asked her to sleep with her.

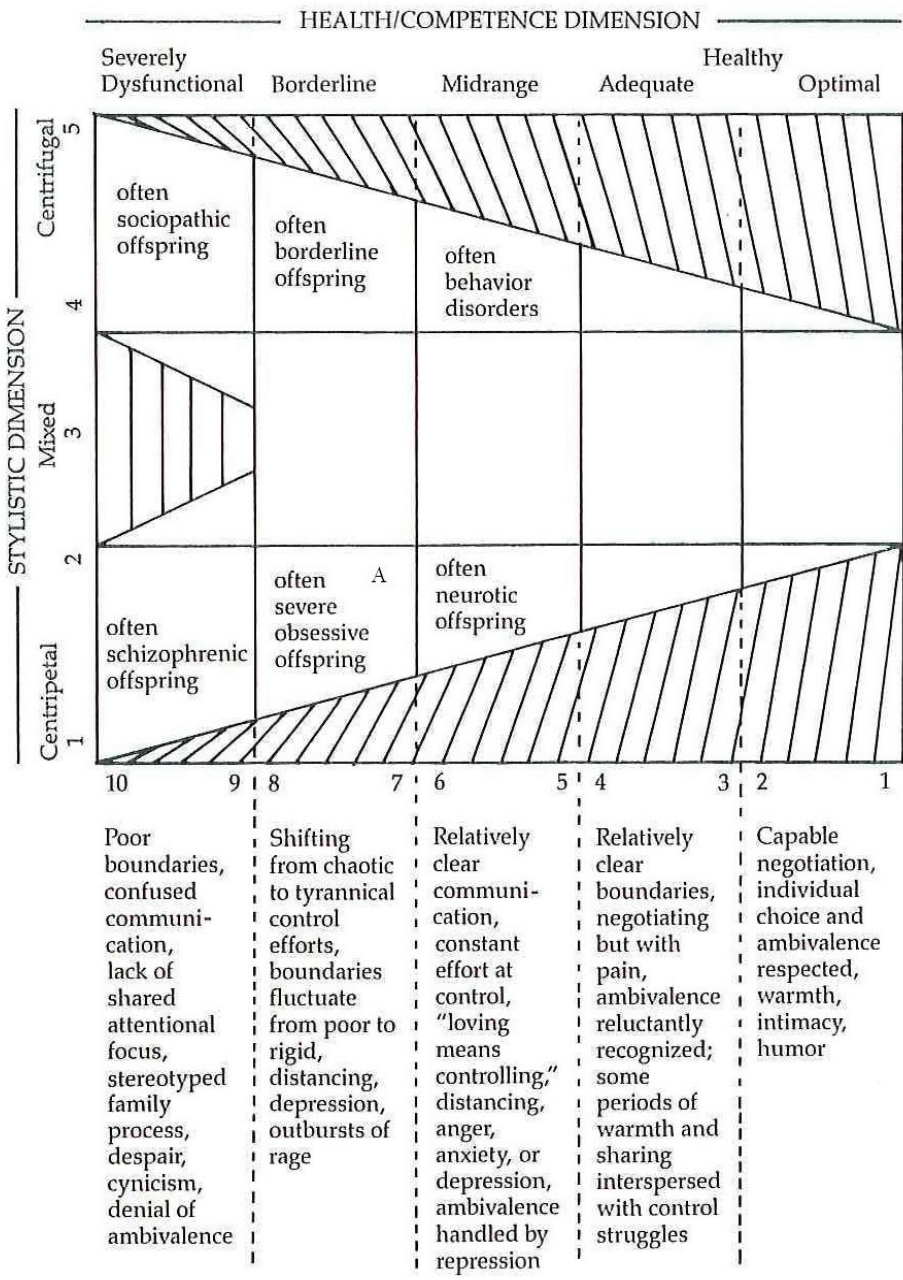
Heather's mother struggled with setting and maintaining appropriate boundaries. Heather was manipulative and her mother was frightened of losing the closeness she valued so much. On one occasion when her parents grounded her for drug use, Heather overdosed on a prescription medication from the medicine cabinet in retaliation. Whenever her mother or father insisted on appropriate behavior, Heather reacted with intense resentment and rage, and her parents quickly backed down.

On the family competence dimension of the Beavers Systems Models, this family scored in the Borderline range. In terms of specific competencies, power was held by the child in the family, and a strong parent-child coalition between Heather and her mother existed. Boundaries between family members were vague, illustrated by difficulty in setting and maintaining limits. The family's conception of itself was incongruent with reality. For example, Heather's mom described her relationship with Heather as close and connected, with good communication. However Heather constantly engaged in lying, manipulation, disobedience and disrespect, hallmarks of poor communication, and a lack of mutual trust. They also did not negotiate effectively, and did not take appropriate responsibility for their actions. They had considerable difficulty expressing painful emotions openly and effectively. Heather used intense emotions to manipulate her parents and her parents panicked when presented with genuine sadness or hurt.

Stylistically the family fit into the centripetal category. Conflict was covert and hidden, and Heather's mother consistently emphasized the closeness of her relationship with Heather. Dependency needs were encouraged, and negative feelings were actively discouraged and avoided. This family fell in the Borderline Centripetal category (shown in Figure 2).

The family's patterns clearly manifested themselves during the first few minutes of the first family therapy session and were the focus of therapy for the next few months. The therapist noted the presence of many power struggles and "depth charges" (i.e., incendiary comments designed to elicit a reaction). Heather's mother quickly began to protect Heather's feelings and to blur parental-child boundaries while her father immediately pulled away from his wife and daughter. As the family exhibited these patterns during the next couple of months, they were identified and explored. Toward the end of this period, the focus of therapy came to rest on the relationship between Heather and her father. This shift in focus was most visible during a session when the family was discussing Heather's obsession over a particular boyfriend. As Heather's mother began engaging in her typical pattern of "fixing" Heather's problem, Heather's father interrupted with a provocative comment about Heather's behavior. The resulting focus

Figure 2. Heather's family's position on the Beavers Model indicated by the letter A. (Figure provided by Robert B. Hampson, adapted and reprinted with permission.)



shifted to the pattern of interaction between Heather and her father, and this pattern recurred over and over again during the next few months. Heather's father was confused by strong emotions and became the primary force that shut down emotional expression in the family. As a result, Heather worried that her intense emotional experiences meant that she was "crazy." This issue became an important part of the work between Heather and her father. Her father focused on listening more effectively, balancing his reactions to his daughter, and responding to her emotions without trying to quell them. As time progressed the family managed emotional interactions more adeptly and at the end of therapy the family's ability to effectively process emotions had improved. Heather developed better emotional regulation skills and her family learned to support her effectively as she experienced intense emotions. In Heather's interview, she made several comments about changes in her father, such as "he always got left out of stuff, so we let him be included and say what he needed to," and she gave an example of a time when she confided in him and he responded well. Heather also said regarding her mother "I feel like me and my mom's relationship isn't negative anymore."

Heather illustrated the family's increase in emotional competency by saying:

"I used to not cry for like a year, and then I would explode one day and I would just bawl, so I started crying a lot, just crying a lot, when I had those kind of explosions, I started having them more frequently, and then it wasn't as big, it was less and less and less and it was more normal and okay for me to cry. And at first I kind of had to force myself to cry because I couldn't do it, and then after I did it, it felt good so I would do it over and over. And it helped a lot."

In terms of boundaries and family structure, the family moved from very unstructured and excessively flexible to modestly structured with substantial flexibility. As Heather's relationship with her father strengthened, he naturally became somewhat more participative in the process of negotiating and maintaining boundaries, thereby contributing to her mother's authority and creating a little more stability. Yet the parents still struggled with unity in their position, with

a desire to include Heather as an equal partner and with consistency in setting and maintaining appropriate boundaries. One comment from her interview illustrates this:

“We made rules about . . . [drugs], what I can and can’t do, and it’s basically no drugs or alcohol, which I’m perfectly fine with. And my parents have the same rule now, for at least the first 30 days that I am home, they can’t drink or do anything like that, and then we’re going to reevaluate it every 30 days for them, but not for me. And we made positive consequences, too, so that I would be okay with the rules and not want to break them. I get a car if I test negative for drugs for a while.”

She added, “It’s hard for me I guess, so we had to kind of negotiate.”

Heather’s account indicates a small degree of improvement in the family, although difficulty with boundaries persisted as illustrated by the equality to which Heather alluded (“And my parents have the same rules now”), and by the oversized reward of getting a car for compliance to what should be basic standards in the family. Before these issues could be addressed (and as an apt illustration of the structural work the family needed to do), Heather’s parents removed her from treatment long before she was considered ready to discharge so that she could begin school with her peers at the beginning of the school year.

Case Study 2

Sarah (not her real name), a 15 year old girl, was admitted because of anxiety, depression, substance abuse, and conflict with parents. She was perhaps predisposed to these problems, having experienced considerable trauma in her early childhood. Her biological parents were alcoholics and her biological father was physically violent to her mother, beating her often to the point of serious injury. Sarah was a frequent witness to this violence and as a young child demonstrated significant responses to the trauma of her environment including self-mutilation. During this time, she was allowed to wander the streets without adult supervision, and generally went to school only once a week. Parental rights were terminated when she was nine years old and

she moved with her sister and two brothers into a home for parentless children. Neither of her parents contacted their children again, and her mother died a couple years later. Her brothers were adopted together shortly after entering the home, and Sarah and her sister were also adopted together by a different family a year later.

Sarah began exhibiting signs of depression about four years after the adoption. Her depression worsened to the point that she frequently withdrew and isolated from others, failed academic classes, experienced difficulty concentrating, developed sleep disturbances, began cutting on herself, and made one suicide attempt. She also began to act out behaviorally, lying to her parents, sneaking out of the house, and abusing substances. Her substance abuse reflected her distress; she related that she used because it made her feel like everything was okay.

In terms of relationships in her adoptive family, Sarah related that by the time they admitted her to residential treatment her trust with her parents was severely impaired. She complained of difficulty communicating with them, saying her mother frequently interrupted her and her father was always working. Her mother also observed that Sarah seemed to idealize her biological mother, and would often compare her adoptive mother to this idealized image with negative results. But other family relationships seemed good. Both Sarah and her mother reported that the marital relationship was strong and healthy, with appropriate closeness and open communication between parents. Yet Sarah was uncomfortable with this open marital communication because she was frightened by the normal conflict that arose. She displayed some post-traumatic stress symptoms when conflict arose, becoming distressed and having difficulty remembering an upsetting event or her resulting feelings in any degree of detail. She had a strong fear of rejection and reported she didn't feel like she fit into her adoptive family.

The application of the Beavers Family Systems Model to this family was somewhat complex as the family was a blend of two distinct families, a biological and an adoptive one. These two families were very different in both competence and style, but both contributed to Sarah's interactional patterns and sense of self-identity. Therefore,

many of the problems of adapting to her new family were illuminated by looking at both families in terms of competence and family style.

Sarah's biological family rated very low on competence. Chaos reigned, both parents were severe alcoholics, physical violence was prevalent, and Sarah was poorly supervised at a young age. Sarah described herself as "parentified," suggesting a fairly strong parent-child coalition existed between Sarah and her mother. In any case, the coalition between Sarah's parents was very weak. Negotiation and constructive problem-solving was nonexistent, and communication was grossly ineffective. Sarah's parents could not tolerate each other's individuality, and their expression of feelings was limited to violent anger and corresponding fear. The household was depressed and conflicts were unresolvable. On the Competence Dimension of the Beavers Systems Model, Sarah's biological family scored in the Severely Dysfunctional range.

In terms of stylistic components, the family possessed a strong centrifugal (CF) style. Family members sought satisfaction from the outside world, and in Sarah's case this happened at an extremely early age. Intimacy was discouraged, conflicts were very open, family members were aggressive, and warmth was rarely communicated. This family can be categorized as Severely Dysfunctional Centrifugal.

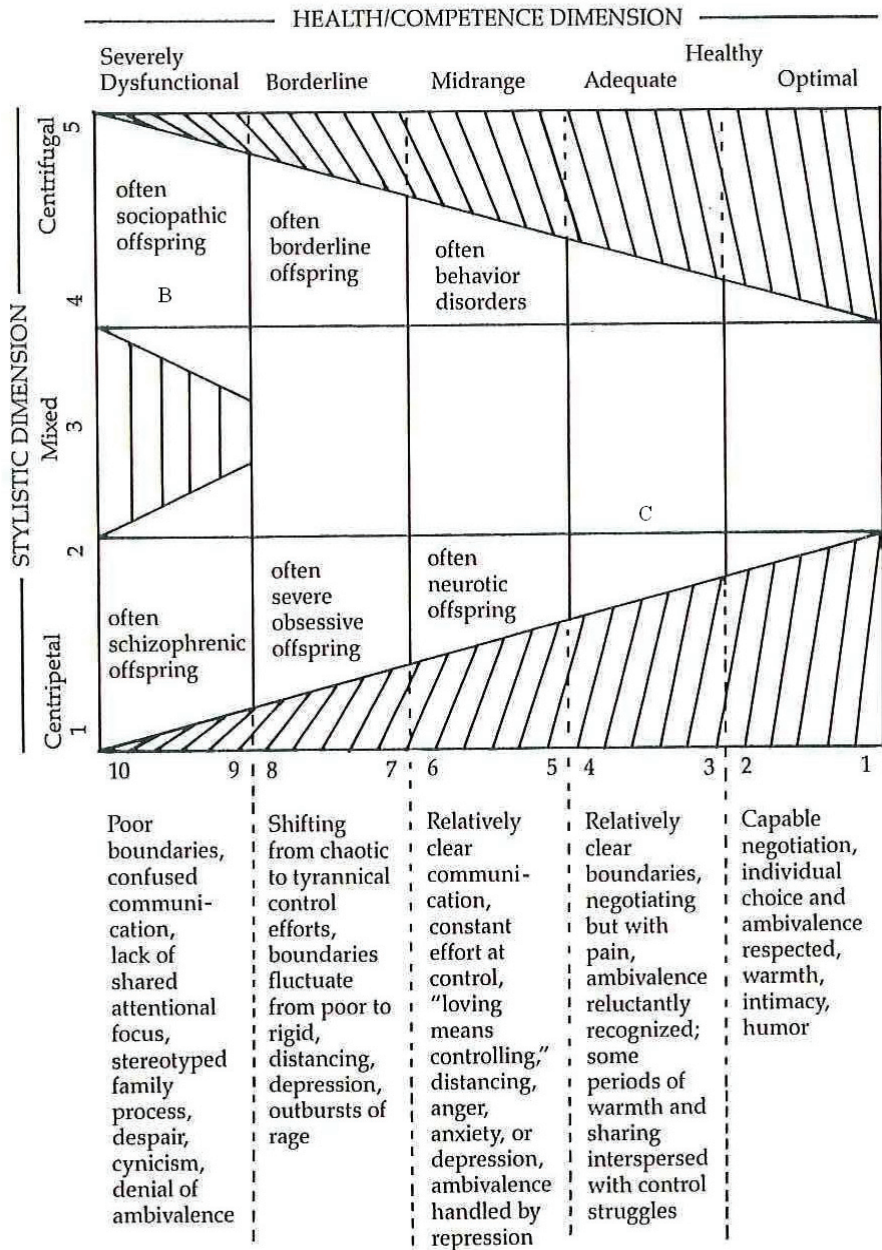
Conversely, Sarah's adoptive family demonstrated a high level of competence. Leadership in this family was shared by her parents, who enjoyed a strong parental coalition. The parents experienced a considerable amount of closeness in the family, but Sarah found this closeness difficult to internalize. Negotiation and conflict resolution between Sarah and her parents was difficult, although her parents were effective in negotiating between themselves and with their other children. In terms of emotional expression, the family's skills were moderate but Sarah's skills were poor. She had trouble understanding what she was feeling, and often projected her fears and worries onto her parents. They were not aware of what she was doing and were limited in their ability to effectively respond to it. In addition, some emotions were mildly discouraged, including anger and sadness. Nevertheless the tone of the family was warm, affectionate, and optimistic. Even during the first family therapy sessions while Sarah was in residential

treatment, family members seemed to enjoy themselves as they interacted with each other. Sarah's adoptive family's overall rating on the competence dimension of the Beavers Systems Model fell in the adequate range. On the style dimension, the family tended toward the centripetal (CP) range, (although the theory behind this model generates the hypothesis that they were able to move flexibly between centripetal and centrifugal styles). They enjoyed being close to one another, and emphasized closeness within the family. This family fell in the Adequate category. (A visual representation of the position of Sarah's families on the Beavers Model is found in Figure 3.)

The effects of blending these families are illustrated by some of Sarah's comments during the interview. She said "I didn't feel safe talking to them or sharing anything about me." She believed "my parents don't love me, they don't care about me," and said "I've always wanted to have a relationship with my parents, but I was always scared of rejection or they won't love me or anything like that." She had difficulty trusting her parents' implicit offers of love and warmth, but instead was fearful that they would abandon and betray her like her biological parents. In other words, she responded to her current family based on her experiences with her former family, thereby injecting the family system with the maladaptive, under-functioning style she was used to experiencing. Based on this assessment, family therapy interventions focused on enhancing emotional safety in the family and supplying Sarah with skills to respond appropriately to that safe environment. This happened in several different ways as treatment progressed. At the beginning, many family therapy sessions began with Sarah feeling upset, worried, fearful, or sad. While the therapist coached, the family practiced listening skills and the expression of empathy. Sarah related "it's so weird, because before my parents were the last ones I ever wanted to talk to before, you know? But now, they're actually more comfortable than talking to staff. I guess that's a good thing because I'm not going to be living with staff all the time, you know?"

The middle months of therapy continued with emphasis on communication and empathy, but also moved into negotiation and conflict resolution. During that time, it was apparent that Sarah expected her parents to respond like her biological parents. She experienced

Figure 3. Sarah’s biological family’s position on the Beavers Model indicated by the letter B and her adoptive family’s position indicated by the letter C. (Figure provided by Robert B. Hampson, adapted and reprinted with permission.)



considerable anxiety when conflicts arose, and was afraid to trust her parents to be balanced and appropriate in their reactions to her. Those fears were a major contributor to the arguments and power struggles they experienced before she entered treatment. In the interview, she said

“the therapist made it safe for me to arrange things. [Talking] to each other, [trying] not to get into a conflict or power struggles and just [finding more] ways where we don’t have to argue or anything like that. We have a compromise. . . he could tell . . . where our conversation was going. If it was going toward a power struggle instead of trying to compromise or deal with things and figure them out, so he tells us where to go towards, you know. That sets a good example for us, I guess.”

Ultimately, when asked “what helped you to really improve your relationship with your family?” She answered:

“I guess for me to realize that they do care about me, that’s the big thing. Because before I came I was like, ‘Oh my parents don’t love me, they don’t care about me.’ . . . Just realizing that my parents do care about me and love me. They also want me to get into a closer relationship with them. I don’t know, kind of myself giving, opening up myself to others. Before I used to do things all on my own, I didn’t want anyone’s support, but when I open up more it brings me closer to other people.”

Conclusion

The Beavers Systems Models skillfully encompasses the systematic elements comprising family competence. Using this model to characterize families in treatment creates a framework where effective interventions can be designed and then implemented and where progress in treatment can be tracked. In order for this to work, ongoing assessment is necessary.

Ongoing assessment involves regularly evaluating the family’s functioning on both the competency and style dimensions. Beavers

and Hampson suggest using the Beavers Interactional Scales to do so (Beavers and Hampson, 1990; 2003). The Beavers Interactional Scales have therapists videotape the family while they discuss what they would like to change in their family. Then, while watching the video, they rate the family's interactions on 11 competence and 8 style continuums. Ratings are tabulated and plotted on the model. (Videotaping families during residential treatment can be impractical, but having them complete the discussion over the phone can be an acceptable alternative.) Completing the Beavers Interactional Scales is instructive as the components of competence and style are well defined within the scale, and so the areas in which to intervene are clearly identified.

For example, as mentioned, Sarah's adoptive family fell in the Adequate range at the beginning of treatment. Using the competence areas from the Beavers Interactional Scales, their strengths included a strong parental coalition, leadership shared between parents, a higher degree of openness and receptiveness to each other, and a positive, warm tone within the family. Their weaknesses were moderate difficulty with negotiation, Sarah's tendency to keep secrets from her parents resulting in a lack of clarity in communication, a mild lack of accountability within different family members, restrictions in the amount and type of affect the family would tolerate, and mild difficulty feeling and expressing empathy for each other. Family therapy focused on communication skills and appropriate responding to others' emotions. By conducting periodic evaluations during the course of therapy, the therapist could note whether the family was improving in these target areas and whether they were weakening in any of the other competency areas.

Using ongoing assessment to direct treatment planning is beneficial as therapists treat the complex and challenging family issues commonly encountered in adolescent residential treatment. Doing so can help to maintain the focus of therapy on critical areas in the face of distractions, can assist the therapist in recognizing when efforts meet with systemic resistance to change, and can decrease potential frustration and confusion as families' complexities are delimited and categorized.

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Issues in School Placement for “Twice Exceptional” Children: Meeting a Dual Agenda

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Abstract

“Twice exceptional” refers to children who are intellectually gifted but also experience an educational or psychological disorder. Identifying appropriate programs for this population can be a unique challenge due to the ways their giftedness and disorders can interact, mask, and compensate for each other. In many cases psychiatric diagnoses are assigned to behaviors that are the result of the child’s giftedness rather than the result of pathology (e.g., divergent or tangential thinking is a characteristic of gifted children as well as children diagnosed with attention deficit/hyperactivity disorder). At other times a child’s complex needs can appear contradictory (e.g., a gifted child’s quick mind, leaping ahead to the next step, may conflict with his anxiety that urges reticence). Dabrowski’s theory of over-excitabilities and other approaches are examined to shed light on how parents and professionals can identify programs meeting the dual agenda of this often-misunderstood population.

***Key words:* twice exceptional, misdiagnosis, childhood disorders, over-excitabilities**

Overview of “twice exceptionality”

“Twice exceptional” is frequently used to describe children who are both gifted and learning disabled. It is also used to describe gifted children diagnosed with emotional or psychosocial disorders such as attention deficit/hyperactivity disorder (AD/HD), Asperger’s syndrome, anxiety disorders, or obsessive-compulsive disorder (www.uniquelygifted.org). Other terms sometimes used for this population include Dual Exceptionalities, Uniquely Gifted, Gifted/LD, and Twice Gifted. These labels are used interchangeably and often imprecisely, since

“twice exceptional” is not an officially recognized classification with discrete criteria. Neither educators nor mental health professionals have formally endorsed the category; [i.e., it does not appear on the list of 13 categories of children entitled to special educational services under IDEA (the Individuals with Disabilities Education Improvement Act of 2004) or in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders published by the American Psychological Association)]. Since there is no appropriate and comprehensive category, professionals working with twice exceptional children are often required to choose one of their exceptionalities while failing to address the other. To qualify for educational or therapeutic services they are often defined by their disability, setting aside the condition of giftedness. Or to qualify for gifted programs, their disability is ignored.

Because of the exclusivity of these coding systems, twice exceptional children are often misunderstood and misplaced by school personnel. When their giftedness is viewed as dominant, their problems with attention or emotional needs may be dismissed as motivational issues (e.g., as if their high IQs meant they could do the work, pay attention, and behave if sufficiently motivated). Conversely, the high intelligence of children with learning or attention difficulties may be disregarded because their disabilities dominate and define them. Identifying appropriate educational programs for these children presents a unique challenge, particularly because inventories of available schools (e.g., Peterson’s Private Secondary Schools, available online at www.petersons.com) have no category called “twice exceptionality” to guide such a search.

This article presents a model for identifying schools and programs that can meet the dual agenda of twice exceptional children. Characteristics of twice exceptional children are discussed, with examples of how interaction between the two conditions can result in a distortion of a *primary* issue or development of a *secondary* emotional or behavioral difficulty. Dabrowski’s theory of over-excitabilities is presented to demonstrate how the intensity of gifted children can be mistaken for, or transformed into, a psychosocial disorder. To prevent this from occurring, the most effective intervention may be a change in the child’s context (i.e., a change in educational placement). A

three-step model is presented for determining an appropriate program, together with discussion of public and private alternatives as well as internal and external obstacles parents may encounter.

Characteristics and issues of twice exceptional children

In the *Twice Exceptional Newsletter* (www.2enewsletter.com), Neumann (2004) quotes statistics from Deslisle and Galbraith (2002) suggesting that two to five percent of all students may be twice exceptional. This is only an estimate however; no formal data have been collected on these students since clear criteria have not been established. In fact, little research of any kind has been conducted to identify characteristics of this population, prevalence, or trends.

Distinct criteria for a classification of “twice exceptionality” may be developed and endorsed by the educational and mental health communities in the future. In the interim, Neumann suggests a profile for identifying these students. Strengths in this profile include:

- high levels of creativity and problem-solving ability
- curiosity and imagination
- a wide range of interests (not necessarily related to school)
- a specific talent or consuming interest
- advanced ideas and penetrating insight into complex issues, though simple tasks such as rote memorization (multiplication tables, spelling words) may be difficult
- a sophisticated sense of humor.

Weaknesses indicated in the profile (which may stem from the child’s disability *or* from giftedness) include:

- extreme sensitivity to criticism, with ensuing emotional reactivity
- poor social skills and peer relationships
- disorganization, including poor handwriting and/or study skills
- weak performance in one or more academic areas
- a striking gap between verbal and performance skills
- impulsivity
- stubbornness and an opinionated, seemingly arrogant demeanor

- sensory processing difficulty
- perfectionism
- irritability and moodiness
- anxiety
- social isolation

Though presented as separate lists of strengths and weaknesses, these traits do not appear in isolation. Twice exceptional children do not simply have two sets of issues; it is the *interaction* between the conditions that can produce a unique set of challenges. Webb et al. (2005) address this in their book about gifted children and adults, pointing out that sometimes there are two conditions (i.e., dual diagnosis) in need of consideration. Specific observed symptoms (e.g., hyperactivity, distractibility, rigidity, remoteness) may be due to either the psychological disorder or to the giftedness, since both are present. It may be difficult to determine the cause of a child's behavior or to distinguish symptoms because the lines between talents, coping devices, and deficits become blurred. Consciously or unconsciously, children may also use their talents to mask or compensate for their disability.

At other times, behaviors caused by a child's giftedness are mistaken for indications of a disorder (i.e., misdiagnosis). For example, much has been written (Baum, Olenchak & Owen, 1998; Gray and Bain, 2006; Lovecky, 2004) about how gifted children tend to be misdiagnosed with AD/HD. Both children who are gifted and children with AD/HD may be divergent thinkers, drawn to tangential issues or unconventional interpretations. Children with one or both conditions are often restless, impatient, impulsive, self-critical, nonconforming, stubborn when engrossed, and prone to inattentiveness (Gray and Bain, 2006). Diagnoses of Asperger's syndrome have been assigned to gifted introverts who, wrapped up in their own thoughts and indifferent to peers, appear to possess a social communication disorder. Similarly, gifted children may feel deeply about the world's tragedies and sufferings; and adults, misunderstanding their sorrow, may assume they are psychologically depressed. In other instances, children with heightened sensitivity who withdraw as a defense against sensory or cognitive overload may receive diagnoses of anxiety disorder.

Some of these conditions experienced by twice exceptional children are genetic and can be considered *primary* issues (e.g., dyslexia, sensory integration disorder). Much has been written about innate differences in learning style (Kiesa, 2000; Levine, 2002), particularly when an individual is a visual-spatial learner (Silverman, 2002, www.visualspatial.org). There is also extensive literature about children with sensory processing disorder (Smith & Gouze, 2004; Miller, 2006).

However there are other issues that appear to be *secondary* – that is, emotional and behavioral responses to the stress of not fitting in, not feeling successful, or not being understood (King, 2005). Children diagnosed with depression, anxiety, oppositional defiant disorder, obsessive-compulsive disorder, or bipolar disorder may have developed these conditions as a result of learning differences, sensory issues, or another twice exceptionality qualities that were incorrectly addressed or not addressed at all. What began as a *difference* may end as a *disorder*. In some cases children who receive labels of severe emotional dysfunction end up in highly restrictive placements, possibly due to chronic stress stemming from the tension and contradiction inherent in being twice exceptional and not because of an inherent biochemical disorder.

To illustrate these stressors, Strop and Goldman (2003) described emotional issues that may arise for twice exceptional students, adversely affecting their educational experience:

- ***Anger***, due to frustration and resentment about high performance expectations imposed by others and/or self. Aggression and outbursts of violence may follow.
- ***Fear of failure and expectation of failure***, exhibiting as anger or task avoidance and often leading to labels such as oppositional defiant disorder.
- ***Low self esteem***, lower risk-taking, unwillingness to put forth effort, defensiveness, and avoidant behavior.
- ***Fear of success*** because success is viewed as increasing pressure for additional success and thus increases anxiety.

Dabrowski's overexcitabilities:

Kazimierz Dabrowski, a Polish psychologist and psychiatrist writing in the 1960s, developed a theory he believed could explain the intensity, sensitivity, and unusual behavior of gifted individuals (Lind, 2001; Mendaglio, 2002). His Theory of Positive Disintegration is based on five *over-excitabilities* that, according to Dabrowski, tend to characterize gifted children and influence their behavior. His theory is worth examining because it may shed light on how giftedness interacts with, or is transformed into, psychosocial disorder.

For Dabrowski, over-excitability is a heightened responsiveness to stimuli. Involving not just psychological factors but also a central nervous system sensitivity, over-excitability is assumed to be innate. If Dabrowski were writing today, no doubt these over-excitabilities would be studied by functional MRIs and neurobiological analyses to see if they represent differences in neurochemistry or activity in different regions of the brain. However, because his writings of 40 years ago have not been extensively translated or published in the United States, they have attracted little attention outside the gifted community.

The five over-excitabilities identified by Dabrowski are:

- (1) *Psychomotor over-excitability* – As the name suggests, this is more than just an excess of physical energy or a constant need for movement. It is physical responsiveness expressed as rapid speech, gesturing, nervous habits, restlessness, impulsiveness, difficulty letting go of the mind's activity in order to go to sleep, and a source of boundless energy and stamina. A gifted child with psychomotor over-excitability, continually interrupting and racing to engage in activity, might easily be misdiagnosed with AD/HD. Gray and Bain (2006) note that there are no objective markers and the “knack of discriminating between the constant movement associated with ADHD and the psychomotor over-excitability associated with giftedness seems to hinge upon qualitative judgment” (p. 11).

- (2) *Sensual over-excitability* – This can manifest itself as intense reactions to sound, light, touch, texture, smell – an over-sensitivity to elements of ordinary life, similar to what is now called sensory processing disorder (Miller, 2006). It can also appear as esthetic appreciation. The line can be blurred between a gift (e.g., refined discrimination for taste or color) and a disorder (e.g., sensory modulation dysfunction). In a supportive context, a child with sensual over-excitability may find a life of passion and engagement. In an environment lacking sufficient stimulation or, conversely, with a chronic over-abundance of stimulation, the same child may become volatile, anxious, irritable or withdrawn – emotional states indicating a need for therapeutic intervention.
- (3) *Emotional over-excitability* – This over-excitability can appear as dramatic highs and lows resembling a mood disorder. As Maxwell (1998) points out, the difference is that “with over-excitabilities, we are looking at greater responsiveness to actual stimuli (which can include thoughts and memories). So, even if the responses seem excessive, they are responses” (www.sengifted.org, p.1). With a psychiatric conditions like bipolar disorder, emotional swings take place according to their own neurochemical rhythm, and not in response to particular stimuli. If this difference is overlooked a child might easily be misdiagnosed. Emotional over-excitability can also be expressed in positive traits of empathy and connectedness.
- (4) *Imaginational over-excitability* – This is characterized by vivid dreams and imagery, creativity, love of fantasy, and inventiveness. Here again, traits that may appear symptomatic of AD/HD (requiring treatment) can also be viewed as talents (requiring expression). Instead of being considered at risk for attention or delusional disorders, children who become lost in a fantasy world or insist on idiosyncratic interpretations may be poets, artists, and

inventors. If their outlets for expression are denied or even punished, they may develop secondary problems (e.g., anger, depression, low self-esteem).

- (5) *Intellectual over-excitability* – Dabrowski's fifth category is the insatiable appetite for questioning and learning, discovery, and finding solutions to problems. Such children can seem annoying or arrogant, and their stubborn individuality can be misperceived as defiance toward adult authority or indifference to social context. Properly channeled, this trait can lead to the pursuit of new knowledge and academic excellence. However, when gifted children's intellectual drives become focused on a narrow or esoteric topic, they may be assumed to have Asperger's syndrome. In a culture valuing a well-rounded personality, over-specialization in children can be perceived as a pathological symptom requiring correction.

While Dabrowski's theory of over-excitability has not been subject to rigorous study, it does present an intriguing approach and raises important questions about the origin of emotional disorders in gifted children. Identification of the specific over-excitability at the root of a child's problematic behavior can be a productive first step. Rather than trying to correct the psychological symptom (e.g., anxiety or hyperactivity), it may be better to seek a supportive environment where the fundamental characteristic (e.g., emotional over-excitability) can find appropriate expression.

Salience of context for twice exceptional children

Altering the context may be the most powerful intervention for a troubled twice exceptional youth. Neihart (1999) posits three factors that "interact synergistically" to affect the psychological well-being of gifted children: (a) type of giftedness, (b) educational fit, and (c) personal characteristics. Educational fit is especially important for twice exceptional children who struggle to balance the expectations of being gifted with the stress of a learning or emotional disorder.

Locating a school or program that can address all the needs of a twice exceptional child is clearly a challenge. When the second exceptionality is a learning disability (LD), this task can be somewhat easier since many good programs exist for LD youngsters. When the second exceptionality is a psychosocial disorder, however, the task is often more difficult. Therapeutic programs designed to address emotional or behavioral problems may not be appropriate for children who are also gifted, and academically enriched programs may be unprepared to meet the needs of a youngster with an emotional disability.

To identify an appropriate program, parents need to begin a step back from where a school search typically begins. Looking for schools that meet certain criteria (e.g., on-site psychotherapy or instructors trained in the Orton-Gillingham method) is like beginning with solutions before the appropriate questions have been asked. Before *program* features can be specified, the *child's* features should be defined. Since giftedness and disability can become intertwined, parents should start the process by simply identifying their child's core features *apart from any diagnostic label*. By compiling a list that is precise and value-free, parents can identify educational elements that best match their child's traits and *then* look for schools that provide those elements.

Twice exceptional children are best served by schools fostering strengths while addressing weaknesses. Programs lacking this two-pronged capacity will not be appropriate for these children, no matter how attractive they seem; neither a program aimed at high achievers nor a program focusing primarily on the child's difficulties is likely to be a good match. The best schools are probably those using unconventional approaches rather than conventional schools with a few extra features. These schools often possess the flexibility to adapt to the child's needs, rather than requiring the child to adapt to the school's structure (e.g., as public schools must do in order to educate large numbers of children, and as elite private schools often do in order to maintain their reputations).

Stop and Goldman (2003) suggest three features good programs for twice exceptional students to possess:

- (1) To support the youngsters' giftedness, programming options should be available that allow them to pursue areas of interest or talent rather than expecting them to be generalists, good at everything just because they are good at some things.
- (2) To support the students' disabilities, opportunities should be provided to explicitly and concretely learn compensatory skills.
- (3) To support the emotional stress resulting from the condition of twice exceptionality, there needs to be an active support system among teachers, counselors, and peers.

Determining core traits and corresponding program features: A three-step model

Given the complex needs and importance of context for twice exceptional children, parents and professionals can benefit from a three-step process in identifying appropriate educational placement:

- (1) *Specify the child's core traits, without labeling them as symptoms, talents or problems, and without being limited to what seem like purely educational issues* – A value- and category-free list will help to guard against pathological bias and ensure key features are not overlooked. All traits affecting behavior or learning should be included. For example, a child might be a divergent thinker, have an unusually wide or narrow range of interest, need to learn by using hands or body, be emotionally sensitive, need time alone, crave variety, have an artistic flair, tend toward perfectionism, or have a slow or fast tempo of interpersonal interaction.
- (2) *For each trait, identify elements of the environment that would suit a person who possessed that quality* – Since context can determine whether a trait is functional or dysfunctional (i.e., what social workers call “person-environment fit”), this can be the key to beneficial placement of a twice exceptional student. For example, a divergent thinker may benefit from the opportunity for open-ended exploration in a science laboratory or engagement on a craft without having to complete projects on a timetable, while an intense and driven child

might need the challenge of competition. A child might need clear structure or loose structure, an abundance and variety of peers or a small setting with few students, frequent changes of activity or time to pursue an interest without interruption, opportunity to compete and excel or de-emphasis on grades and freedom to learn at one's own pace.

- (3) *Prioritize and rank elements essential for the child's well-being* – While the purpose of the previous two steps is to insure against omission of important traits, this third step narrows the focus to traits that define a child's fundamental nature. Corresponding to essential traits, high priority items should include features the child *must* have in a school. Other features may not be as important (e.g., class size, facilities, location, co-educational or same-sex classes). These features may be attractive but not essential for this particular child.

Using this model, parents and professionals can search for programs where services, setting, staff, and school philosophy correspond to the child's specific needs. The search will have to be conducted by careful perusal of school literature and site visits, since there are no distinct categories to search for on the Internet. Moreover, website descriptions can be misleading. Some schools seeming ideal for "quirky" youngsters who have not succeeded in traditional environments may actually be populated by youth with more serious problems and less academic capability. Some schools will only take children with formal diagnoses of LD who have no history of disruptive behavior, and they might not be willing to accept children considered volatile or high-maintenance. And some schools may be too high-pressured for twice exceptional children, who may be fragile despite their talents.

Programs for twice exceptional students may be public (i.e., funded by tax dollars and operated by city or county school systems) or private (i.e., funded by tuition, regardless of whether tuition is paid by scholarship, insurance company, or parents). *Public* alternatives vary from district to district, according to budget constraints, priorities, and the style of the Special Education administration (i.e., the gatekeeper for services, assuming the child's LD, AD/HD, or other diagnosis

leads to special education classification). Federal law states every child is entitled to an “appropriate” educational program and district personnel may feel that the child can manage perfectly well in a regular school with extra supports and enrichment activities. The burden is on parents to prove otherwise.

Even if school personnel do agree to external placements, and the school district is willing to find (and fund) another program, it still has to be the “least restrictive” or closest to mainstream schooling. Children sometimes need to go through a series of failed placements before the district will pay for a more comprehensive or expensive program actually addressing each child’s needs. The process can take a long time and waste valuable years – years when a child can become frustrated, angry, or depressed. Parents’ only options may be: (a) to present a compelling legal and medical case to justify skipping intermediate placements, (b) to accept the placement that is offered and supplement it with privately-obtained services, or (c) to seek a private school alternative.

Private alternatives, for those with the financial means, are often the speediest solution. Caution is needed in this process, however. Private schools may exaggerate their capability or flexibility in order to compete for business. Parents may find themselves tempted by a prestigious program that accepts a certain number of youngsters with Asperger’s syndrome or AD/HD, but they need to be sure that services are provided to help those students succeed. When a school tries to serve two agendas (first, accepting children with issues in order to boost enrollment or qualify for funding, and second, maintaining the image of a traditional prep school to please parents and donors), it is the twice exceptional youngster, caught between agendas, who can suffer the most.

When looking at private schools, the most important criterion is the *fit*. *Fit* comes not only from the school’s philosophy, but also from the students and staff who comprise its community. Since programs change character from year to year depending on the students who are enrolled, it is important to visit rather than rely on alumni data or printed testimonials reflecting the school’s past (and not necessarily its present) character. Guidelines about what to look for during a

visit and questions to ask may be found at www.petersons.com and www.natsap.org/right-school.asp. Educational consultants can also provide valuable assistance (e.g., www.educationalconsulting.org, www.iecaonline.org).

Obstacles to placement

Having identified suitable programs, parents may still encounter obstacles to placement. These may be *external* obstacles (e.g., constraints of location and tuition). Cost is obviously a factor in considering a specialized private school, especially those with small class sizes and other features like individualized instruction, tutorial services, and counseling. Parents may need to be creative about financing a child's schooling. If the school has a therapeutic component, health insurance carriers may be willing to assume the therapeutic portion. If the home school district will pay for the educational portion, families may only need to cover incidentals and residential costs (e.g., room and board if appropriate). If parents feel the educational system has refused to meet their child's needs, taking a public school district to court may be a way to finance tuition, but this can be a long, difficult, and uncertain road. Alternatively, if a child sees a psychiatrist willing to state that a specialized program is required, parents may be able to deduct a percentage of tuition from taxes as a medical expense. A child's giftedness may also provide access to loans and scholarships like the Davidson Young Scholars Program, part of the Davidson Institute for Talent Development (www.ditd.org). FinAid (www.finaid.org) also provides extensive information about loans, scholarships, and other ways to finance private schooling.

If an appropriate program is identified that is far away, parents face an additional dilemma. Should they relocate, perhaps temporarily? Should they consider boarding school? Sending a child to boarding school can be a hard decision, making parents feel they are giving up control, losing their place in the child's life, or that they have failed at home. Adjusting to boarding school is often more difficult for the parents than for the child, especially if the child is happy and has found peers, perhaps for the first time.

Parents may also face *internal* obstacles to the acceptance that a child needs something more than strictly a gifted education. These

may require a shift in expectations and the abandonment of old dreams. Both parents may not go through this process in the same manner or at the same time, and strained family relations can result. This can be especially true with members of the extended family who may not understand what parents are going through or why they want to “send their child away.”

In summary, finding a school meeting the dual agenda of twice exceptional children (i.e., that can address their therapeutic needs while also supporting their giftedness) is a unique challenge. It is best approached by focusing on a child’s specific traits (both strengths and weaknesses), determining for each trait what an ideal environment would be like, and assigning priorities while remaining flexible and open-minded about other features.

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The PACT by Sampson Davis, George Jenkins,
and Rameck Hunt, with Lisa Frazier Page
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A division of Penguin Group (USA)
2002

A Book Review

Jeffrey Brain, MA
The Family Foundation School

The PACT is a compelling and inspiring true story of three boys who grow up to become doctors. For those with money, a nurturing family, social connections, and the means to afford higher education, this would be the American dream – and frankly, a less than inspiring story. But *The PACT* is not about those types of boys. The PACT tells the story of three African American boys raised amidst the chaos and pressures of a fragmented community. These boys were not the suburban picture of early success; they were the type of young boys many people get nervous passing on the street. These boys were told and taught they had no hope for the future. They questioned if they could survive in the neighborhood past their teens, with two of the three authors in juvenile detention centers before their 18th birthdays.

These intertwined autobiographies depict a remarkable journey away from poverty, drugs, and crime to medical school. Throughout this journey the authors work to close economic, cultural, achievement, and generational gaps. They model and impart valuable lessons about courage, trust, perseverance, hope, drive, and most importantly, the positive power of friendship. These are universal lessons to be learned by all readers, young and old. Each author tells his personal account of the doubts, struggles, and demons he faced in his individual struggle to achieve as well as survive. You will be drawn into their lives, silently rooting for their survival. As you are reading, you may surprise yourself as you identify with their personal struggles. The boys facing their challenges struggle with the same issues as most people: needing to belong, to be loved, accepted, to feel safe, validated as human beings, and longing to achieve. But they are also frightened of what it will take to overcome the obstacles so clearly in the way.

The obstacles of self-doubt, fear, addiction, easy money, and “good enough” achievements are found in *The PACT*, but also is suicide, AIDS, gangs, violence, and blatant victimization.

The PACT is about the alliance between three boys who are determined to “make it,” yet found that at every turn their “pact” was challenged. Written in direct language that teens will not only find authentic but also easy and compelling to read, the authors lead the reader to recognize there is a path to success...even from the “hood.” Through the power of their relationships with one another, they triumph in an “every man for himself” society that overemphasizes independence and minimizes the value of meaningful, intimate relationships with friends and family. *The PACT* offers an important message for today’s teens: Do not go it alone – search for and hold on to positive peer relationships. In fact, these relationships may be the only way to survive and succeed. “We know firsthand that the wrong friends can lead you into trouble. But even more, they can tear down hopes, dreams, and possibilities. We know, too, that the right friends inspire you, pull you through, rise with you.” (p. 3). It took only one of the boys’ dreaming about becoming a doctor to positively influence the others. It took each one of the boys to help, support, push, and force the others not to give up at critical points along the journey. “We knew we’d never survive if we went after it alone. And so we made a pact: we’d help each other through, no matter what.” (p. 2).

You might initially be tempted to dismiss this extraordinary friendship as luck – like winning the lottery or being in the right place at the right time. However, in telling their story the authors model how to be the right kind of friend, how to develop trust, work through conflict, hold each other accountable, how to want for each other what we want for ourselves, and how to never give up. Both the hard work and rewards of being a good friend are clearly portrayed.

The PACT teaches the youth we work with (and even us) that it is okay to dream big, and that it is possible to overcome what appear to be insurmountable odds. It walks us through how to identify our needs, trust others to help, have faith in ourselves, in God, and in each other. In fact, it repeatedly reinforces how very important we are to one another.

The PACT also says a lot about coming of age in today's society, especially for young men. It speaks to the challenges of transitions: from high school to college, from college to work (or advanced study), from a life of addiction to sobriety, from stagnation to achievement, from failure to success, from despair to hope, from loneliness to finding worth, as well as addressing the value in helping others. It also addresses the superficiality (and paradoxical complexity) of male friendships, the power and influence of relationships with girls, and the special relationship with one's parents and siblings. When reading the authors' vivid descriptions of their families, you may find tears welling up in your eyes – both for the tragedies suffered and for the extraordinary love and commitment demonstrated. The authors demonstrate how influential the role of an individual can be in the development of a young person's potential: whether a teacher, distant relative, or other member of their kin.

Just through the reading of it, *The PACT* will motivate and teach on its own. It also is a catalyst for teachers, counselors, and parents to engage youth in a discussion of the realities of their own personal life experience. I found myself renewed and encouraged in my work with troubled youth, and more inclined to see their potential and motivated to communicate my belief in them.

These three doctors have committed their lives not only to practicing medicine, but also to reaching youth with their message of hope. The epilogue of *The PACT* is a prescription of practical steps for uniting friendships and reaching short and long term goals. It is the authors' legacy of ongoing service to youth supported through their not-for-profit organization that provides education, public speaking, mentoring, health awareness, scholarships, and even a website (www.threedoctorsfoundation.org) offering support and resources to youth focusing on positive peer relationships and commitment to community.

The PACT's raison d'être is to inspire each reader, whether youth or adult, with the epiphany that if they can do it, maybe so can I. Maybe I could influence someone else to achieve his or her dream – and in so doing, realize mine as well.



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