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The **JOURNAL OF THERAPEUTIC SCHOOLS AND PROGRAMS (JTSP)** is published by the National Association of Therapeutic Schools and Programs and publishes articles that assist readers in providing comprehensive care for adolescents, young adults, and families receiving services from residential and wilderness/outdoor behavioral healthcare treatment programs. Submissions are encouraged that relate relevant theory to clinical practice or provide original research relating to program or treatment outcomes and processes.

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MANUSCRIPTS The editors welcome manuscripts that are the original work of the author(s) and follow the style of APA as presented in the sixth edition of Publication Manual of the American Psychological Association. *Empirical studies (qualitative and quantitative) must have been conducted under the oversight of an Institutional Review Board (IRB).*

ABOUT THE NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS The National Association of Therapeutic Schools and Programs is a nonprofit member organization of schools and programs and was formed to serve as a resource for its members. Through a dynamic process, the National Association of Therapeutic Schools and Programs develops and advocates ethical and practice standards designed to protect consumers while improving the effectiveness of programming within member programs.

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TABLE OF CONTENTS

TABLE OF CONTENTS

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Preface

Brett Talbot, Ph.D.
The Ascent Programs

Esteemed Readers,

It has been my privilege over the past year to serve as guest editor for the Journal for Therapeutic Schools and Programs. To work with the researchers, practitioners, program representatives, and students, etc. involved in this issue has been extremely gratifying and inspirational. This issue highlights some of the most innovative and cutting-edge discussions and approaches in our programs, led by some of the most curious and inquisitive people. The issue could not have been possible without their relentless desire to investigate every aspect of our approach to helping youth, families, and adults. Additionally, I would have been an "adventurer without a map or trail to follow" if it were not for Bryce Poorman and Dr. Ellen Behrens. Likewise, NATSAP's devotion to advancing and improving the safety and quality of services is commendable and honorable.

Articles in the current issue include a variety of important topics, but all are similar in regards to an original and creative approach to addressing some of the most pressing issues and questions facing how we advance. Topics include progress and improvement monitoring, youth narratives, clients who identify as transgender or on the Autism spectrum, cross-cultural learning, and special education in the treatment setting.

I believe the issue to be rich in information and practical application. I invite everyone (not just "traditional researchers") to read and absorb the information and knowledge found herein. I request that the articles are shared and discussed amongst program leadership, treatment teams, and implemented in every way possible. In this way we allow the research to LIVE within our practices and programs, and consequently, will have powerful results for providers and clients alike.

Sincerely,

Brett Talbot, PhD
Senior Director of Research and Quality
Redcliff Ascent

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On Being a Treatment Detective: How Progress Monitoring Offers Clues to Treatment Mysteries

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Pine River Institute[1]

Abstract

Pine River Institute (PRI) is a residential treatment center and outdoor leadership experience for adolescents struggling with mental health issues and addictive behaviors. PRI practices progress monitoring (PM), the periodic assessment of a client's therapeutic progression. The purpose of this paper is to explore how PM can enlighten treatment mysteries and enhance decision making during treatment.

Keywords: progress monitoring, feedback informed treatment, residential treatment, adolescents, substance use

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ON BEING A TREATMENT DETECTIVE

A few months into my role as research associate at Pine River Institute (PRI), I learned about a client - we will call him Ronald - who had completed our program several months prior and was in the midst of a substance use relapse. This relapse with this particular client was puzzling. I knew him as a friendly, easy-going youth who presented mature for his age. This presentation clashed a little with something another staff said when she referred to him as a chameleon who could quickly adapt to any setting with ease. True to this notion, he adapted quite well to being in a therapeutic environment; he experienced social success with his peers, was agreeable with staff, and had a level head in stressful situations. He could convey feedback honestly and kindly, seemed mature and reliable, and could often be counted on for his witty sense of humor for a good laugh. He seemed to apply himself determinedly throughout his process, met therapeutic milestones, and eventually fulfilled a role as leader and mentor among his peers. I sincerely enjoyed joking with him in the hallways and valued our meaningful evening conversations. Really, it appeared that this client thrived throughout his treatment. To me, he was the ideal client and had the promise to be a posterchild for successful outcomes. His post-treatment decline was a mystery indeed.

After hearing of Ronald's post-treatment challenges, his primary clinician approached me with the hopes that our data could uncover a piece of this puzzle: something important that she may have missed during his treatment. At PRI, clinical data are collected before and after treatment, but also at our five key therapeutic milestones. These milestones are progressive stages. Each of these five stages is acquired by consistent demonstration of relevant stage goals. For example, to move from stage one (wilderness therapy) to stage two (residence), a client must demonstrate acceptance that something needs to change in his or her life and engage in collaborative group living, food and shelter tasks, and skill attainment. Later stages require gradual but sustained development of empathy, future orientation, sincere relationships, emotion regulation, ethical behavior, and leadership. At the acquisition of each therapeutic stage, clients are asked to complete a suite of health and behavior related surveys as a part of our progress monitoring protocol. The research team uses these surveys to create feedback forms that display client scores on emotional intelligence, mental health, family functioning, readiness for change, and readiness for therapy. These feedback forms are delivered to his or her primary clinician each time a stage survey has been completed. The clinician will, when appropriate, share the feedback with the client to foster clinical dialogue about progress and next steps.

ON BEING A TREATMENT DETECTIVE

Evaluation and decision-making in psychotherapeutic treatment can be enhanced through progress monitoring (PM), the periodic assessment of a client's therapeutic progression (Russell, Gillis, Law, & Couillard, 2018), and has gained traction in therapeutic communities. Progress Monitoring was introduced in a clinical setting by Howard, Moras, Brill, Martinovich, and Al (1996), as the researchers explored changes in mental health over the course of outpatient psychotherapeutic treatment. Some patient scores improved, demonstrating that the treatment was effective. One patient's scores decreased, however, signifying that this particular treatment was not beneficial for him. This type of information is helpful in evaluating treatment effectiveness and validating a therapeutic approach. Additionally, it can inform whether a client is enrolled in a program or agency that is effective for that individual. In other words, PM allows users to, in real time, determine optimal care for a client.

At PRI, in line with our PM, Ronald completed four survey packages during his 18-month treatment journey at PRI, at stages two, three, four, and five. He did not complete an assessment survey, typically administered just before client entry to the program, and thus we cannot trace his entire data journey. However, his in-treatment scores indicated to his clinician that in all instances that a survey was completed, he reported as healthier than the average PRI client. For example, one of the indicators we measure is emotional intelligence, the ability to identify and manage emotions, using the Trait Emotional Intelligence Questionnaire (TEI-Q; Petrides, et al., 2016). The TEI-Q has four subscales: well-being (self-esteem, optimism, happiness, and fulfillment), self-control (emotion regulation, stress management, and impulse control), emotionality (empathy, emotion perception, and emotion expression), and sociability (emotion management, social awareness, and assertiveness).

Ronald's scores for each are shown below, alongside the average PRI client scores, at each stage he completed this survey. Though there is no benchmark in this survey for healthy or clinically problematic scores, higher scores indicate healthier emotional functioning.

The scores on emotional intelligence suggest that Ronald was as emotionally functional, if not more so, than his peers at each therapeutic stage. One would think that this would have fostered healthy post-treatment decision-making in multiple life domains, including substance use. I observed that although his scores were above the PRI youth average, whose scores increased over time, Ronald's were fairly unchanging or slightly declining. Still, this information was not sufficient in revealing the whole story. Ronald's T-EIQ

scores did not shed much light on his post-treatment decline, nor did his demonstration of seemingly healthy emotional intelligence on an everyday basis over the course of a comprehensive and intensive treatment journey at PRI.

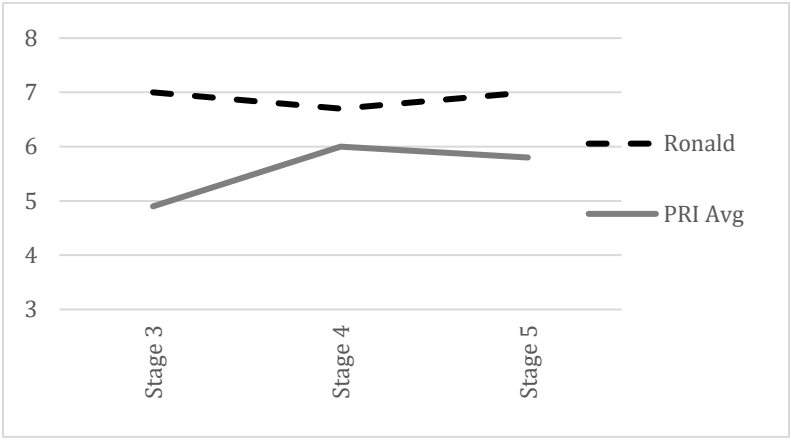

Figure 1a. T-EIQ Emotional Well-Being Trajectories of Individual and PRI Youth Average at Stages 3, 4, and 5.

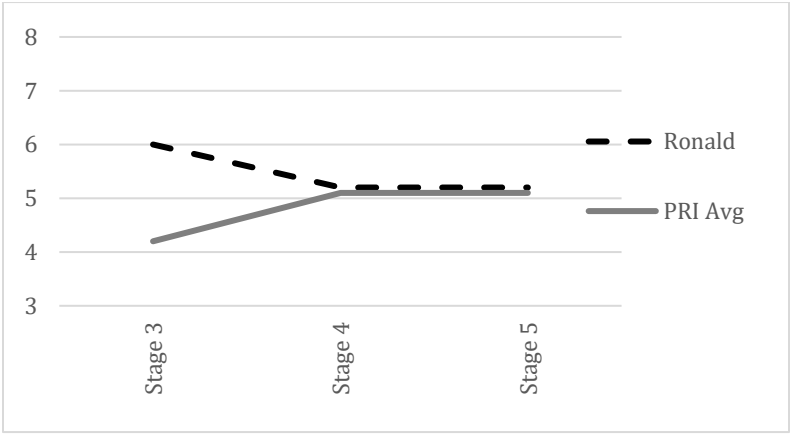

Figure 1b. T-EIQ Self-Control Trajectories of Individual and PRI Youth Average at Stages 3, 4, and 5.

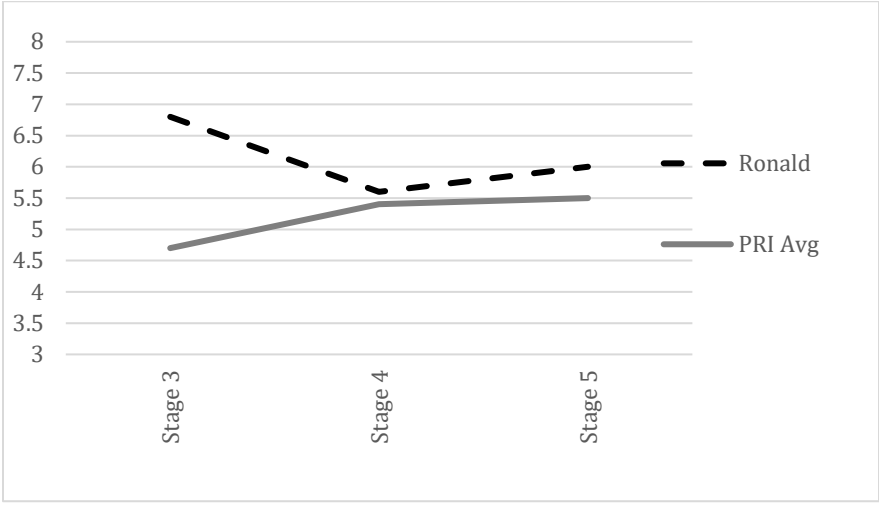

Figure 1c. T-EIQ Emotionality Trajectories of Individual and PRI Youth Average at Stages 3, 4, and 5.

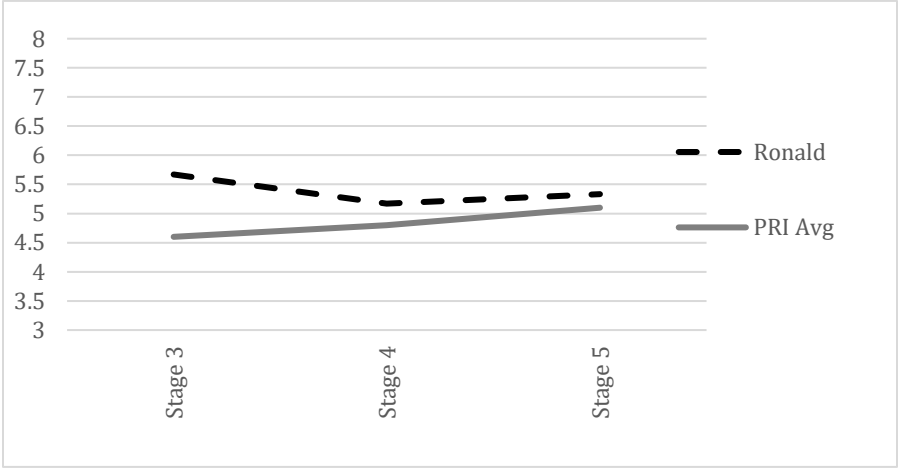

Figure 1d. T-EIQ Sociability Trajectories of Individual and PRI Youth Average at Stages 3, 4, and 5.

**Note: Youth are not obligated to complete all or any of the assessments in the suite of tools; Ronald had incomplete T-EIQ data at Stage 2.*

ON BEING A TREATMENT DETECTIVE

PRI is a residential treatment center and outdoor leadership experience for adolescents struggling with mental health issues and addictive behaviors. Youths engage in individual, group, and family counseling, using evidence-informed strategies such as Dialectical Behavior Therapy and the Satir Family Model of therapy. Youths experience growth across multiple domains, and maturity development is considered a cornerstone at PRI. Youths that complete the program typically do well across health and behavior post treatment, as demonstrated by our ongoing outcomes evaluation (Mills & Kelly, 2017). That this client was collapsing just months after treatment challenged our expected typical outcomes, but was a particular mystery given my expectations for him.

Throughout treatment, Ronald seemed to be healthy in social functioning and mental health. My intuition on this was validated by the data, as one way we measure mental health and behavior is the Outcomes Questionnaire (OQ) suite of tools (Burlingame et al., 2005). These self-report instruments include the Youth OQ (YOQ 2.0 SR) for respondents under 18 and the Outcomes Questionnaire (OQ-45) for young adults (Burlingame et al., 2005). These tools evaluate "psychological, symptomatic, and social functioning" (Russell et al., 2018, p. 408). The two tools contain common subscales of symptom distress (mood problems like depression and anxiety), interpersonal relations (how one acts and feels around peers, family, and others), and social role (respect for the law and other rules of society).

There are benchmark scores to indicate whether a client's score on each sub-scale falls in the clinically problematic or normal range, with higher scores indicating increased severity (Burlingame et al., 2005). Scores on the YOQ 2.0SR and the OQ-45 do not speak to each other. That is, a score of 30 on the YOQ is not equivalent to the score of 30 on the OQ-45. So, if a youth ages from 17 to 18 while in treatment and is administered the appropriate tool, we display scores at each timepoint for each sub-scale as a percentage in relation to the clinical cutoff. As such, the further a score is below the clinical cutoff, the healthier the client is reporting and conversely, the further above the clinical line, the less healthy.

Looking at Ronald's scores during treatment did not offer any clues to suggest he may decline after departure from PRI. Although his scores on all sub-scales did increase slightly (indicating more clinically problematic) throughout treatment, they remained below the clinical benchmark.

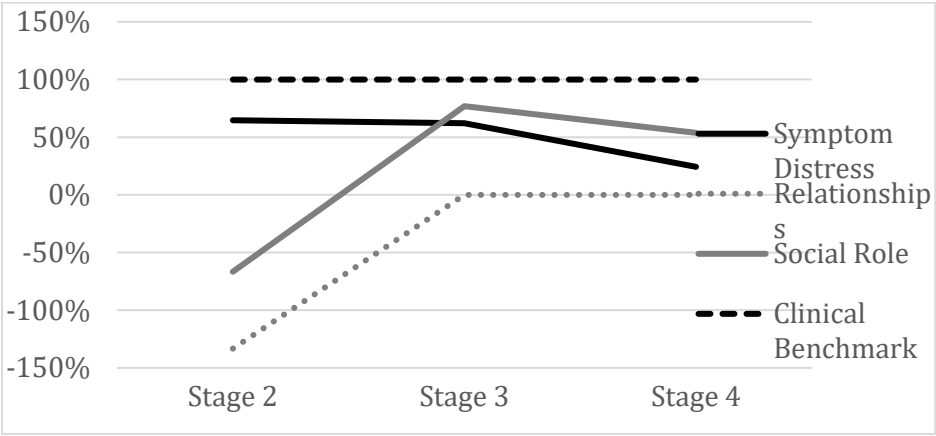

Figure 2. YOQ 2.0SR and OQ-45 Percentage of Clinical Cutoff for Ronald, Stage 2, 3, & 4.

My virtual magnifying glass into this young man's health was not revealing clear answers. I continued my sleuthing, thinking perhaps Ronald was at PRI prematurely and not ready for profound changes. Luckily, as a part of our protocol, we monitor whether a youth is willing and ready for change. The University of Rhode Island Change Assessment (URICA; McConnaughy, Prochaska, & Velicer, 1983) measures a client's readiness for change (recognition that things in life could use a shift) and readiness for therapy (openness to working on those things) and is commonly used as a part of addictions treatment assessments. The instrument has a maximum score of 14, with higher scores indicating higher readiness. As seen below (Figure 3), Ronald's scores indicate a readiness for both change and therapy higher than the PRI youth average at every time point.

The mystery seemed to deepen. According to how Ronald responded to our surveys, his maturity, mental and behavioral health, and readiness and openness for therapeutic change all pointed to healthy development and a platform for sustained therapeutic gains after PRI. My last bit of investigating involved attachment style. I thought perhaps this might offer some insight into Ronald's behavioral decline. Attachment styles are the ways we relate to certain people, often connected to how we navigated relationships early in life that have carried through to adulthood. People who have a secure attachment style tend to

explore life and relationships knowing that the world is safe and that their needs will be met (Bucci, Seymour-Hyde, Harris, & Berry, 2015). Ronald's attachment styles as measured by his self-report consistently indicated that he had secure attachment to his mom, dad, therapist and best friend at each stage in his therapy.

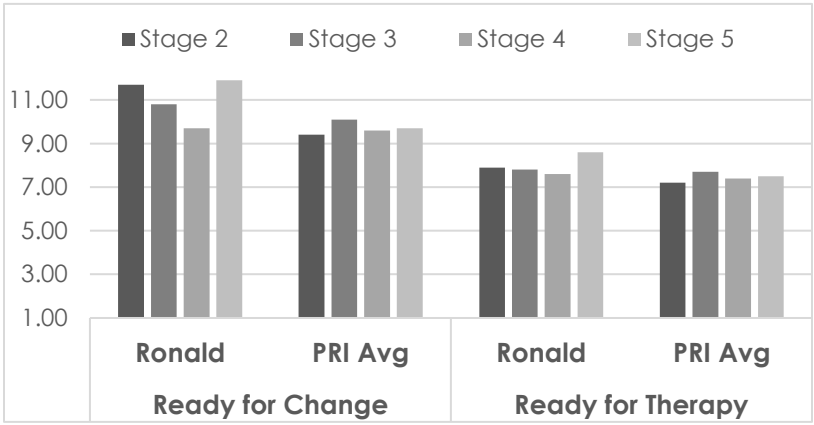

Figure 3. URICA Individual Scores and PRI Youth Average Scores at Stages 2, 3, 4, & 5.

In my review of Ronald's scores, nothing really stood out to me as an obvious indicator or trigger for his post-treatment deterioration. Fortunately, at PRI, our protocol PM is iterative and constantly evolving. A part of this evolution was the implementation of parent health and behavior evaluation, and the subsequent sharing of parent data with clinicians and the parents themselves. We have always asked parents to contribute information-depicting observations of their child's well-being before and after PRI. Our new protocol expanded this to include data collection from parents at each therapeutic stage and add parent-specific measures to the youth observational reports. The parent-specific measures include parenting style, family functioning, parental boundaries, parent emotional intelligence, and parent attachment to their own mother, father, partner, and best friend. We had not yet implemented this area of PM protocol during Ronald's time at PRI, and after discovering that Ronald's data did not seem to shed light on his post treatment deterioration, I wondered if his parents' data could.

ON BEING A TREATMENT DETECTIVE

Ronald's mother completed a survey three months after his departure from PRI, not long before his relapse. I had a look at her scores on parent-child boundaries, and what I found was intriguing. A vital piece of our family therapy work is the establishment and maintenance of healthy boundaries between parents and youths. Clear, hierarchical, attuned boundaries establish parents' roles as authorities and promote development of child individuation and identity (Mayseless & Scharf 2009). We see the effects of inadequate boundaries every day in our work and help parents become more comfortable in the role of healthy authorities in their home. We measure adequate boundaries using the Inadequate Boundaries Questionnaire (IBQ), which is a 35-question survey with five sub-scales: guilt induction, parentification, triangulation, blurred boundaries, and psychological control (Mayseless & Scharf 2009).

Guilt induction is when parents coerce the child to feel and act in a way that complies with their own ways of being, and children often do not express their own wishes and individuality. Parentification is the role reversal where children fulfill their parent's need for care and guidance while dismissing their own same needs. Triangulation is when the child is a mediator or regulator between parents. Blurred boundaries is when the child is an extension of the parent, thereby hampering personal individuation. High psychological control indicates parents intrude on their child's autonomous behaviors, feelings, and thoughts, interrupting the development of the child's identity (Mayseless & Scharf 2009).

Ronald's mother's scores on each of the IBQ subscales are below, with higher scores indicating higher tendency to use each unhealthy parenting strategy. At three months post-PRI, Ronald's mother appeared to have a lack of adequate boundaries with her son and was more prone to using other unhealthy parenting strategies than the average PRI parent (Figure 4). Below are scores for Ronald's mother at three months post treatment accompanied by PRI parent averages.

Finally! This seemed to be a thought-provoking finding. I could not help but wonder whether his mother's use of inadequate boundaries contributed to his collapse post-treatment. Upon consulting PRI's Clinical Director with the data, a picture was painted of why lack of parental boundaries may have been the catalyst for Ronald's progress going awry. Lack of parental boundaries and self-development often pressures the child to perform and operate from a false sense of self. This resonates with the chameleon-like adaptability one staff had mentioned about Ronald. His mother's lack of adequate boundaries interfered

with his own self development and subsequently left him vulnerable to peer pressure and anxiety when required to stand on his own after leaving the program. Without clear, hierarchical, structured boundaries in the home, Ronald was lost as to his own sense of self and likely adopted that of the most accepting of peers. In this case, his peers were not a healthy adoptive environment.

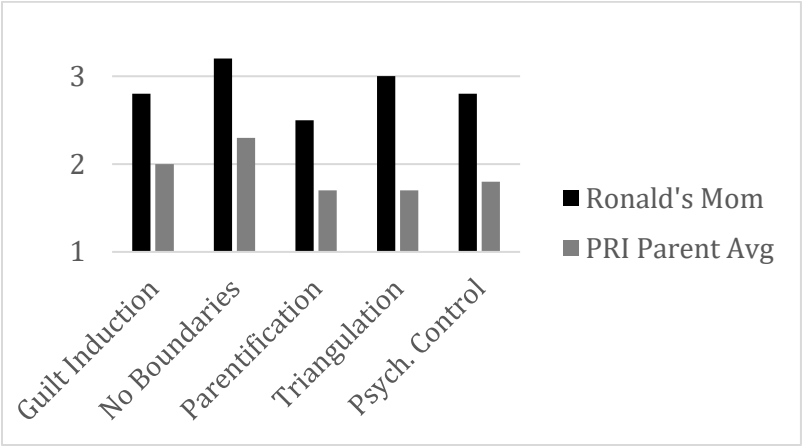

Figure 4. IBQ Individual Mother and PRI Average Parent at 3-Months Post-PRI.

Note: Our implementation of parent IBQ scores was recent and as such we only had three months post-treatment scores for Ronald's mother

Findings like these shed light on the importance of research in fostering a different approach to clinical treatment. Our progress monitoring and its evolution highlighted the importance of parental growth, including parents' need to learn about and work through appropriate boundary setting. Perhaps if we had this parent data sooner in our evaluation evolution, Ronald's mother's use of inadequate boundaries could have been noticed and addressed by his primary clinician while the family was still in our care. We will never know whether Ronald would have sustained post treatment gains if we had been able to inform the clinician about mom's inadequate boundaries, but we can use this insight for future clients. Our recent protocol evolution to measure and share parent health and behavior may indeed be just the catalyst to help another family.

Monitoring parent and youth progress and outcomes made it possible to reflect on this youth's health and behavior, and the information on parenting strategies supplemented the whole picture. To anyone reading this who is not

involved in clinical practice, PM may seem an obvious, unexceptional practice. Sadly, PM is rare. In behavioral healthcare, routinely monitoring progress and outcomes and integrating the findings into clinical practice requires considerable resources, dedication, leadership, flexibility, and patience. As such, even though the return is favorable, the investment is often viewed as too much effort.

Many publicly funded mental health and substance abuse programs across the United States are mandated to monitor client outcomes with standardized instruments (Valenstein, Adler, Berlant, Dixon, Dulit, Goldman, & Sonis, 2009). In some countries, including the Netherlands and United Kingdom, it is obligatory for all mental health organizations to implement PM and report the data to a national registry (Wees, Sanden, Ayanian, Black, Westert, & Schneider, 2014), and several other countries are following suit (Miller, Hubble, Chow, & Seidel, 2015). With the increasing call for PM, it is necessary to expand knowledge about the process and outcomes associated with routinely monitoring progress.

PM is associated with numerous benefits to clients and providers. First, the process of monitoring provides the means for clients and clinicians to evaluate treatment effectiveness by understanding successes and improvements (Bickman, 2011) and gaining knowledge about areas that need clinical attention. Using the results of PM to share data with a client may help him or her better understand symptoms (Scott & Lewis, 2015) and foster related clinical dialogue. Furthermore, shared results may help clients feel more engaged in the process of treatment (Russell et al., 2018), allowing for evaluation-informed and mutually developed treatment goals. As such, PM provides a platform to foster client empowerment (Scott & Lewis, 2015), improving client participation in therapy, and yielding superior outcomes (Scott & Lewis, 2015; Russell et al., 2018). It can increase the efficiency of treatment delivery (Russell et al., 2018), and clients improve significantly faster (Bickman, 2011). Indeed, in a randomized cluster-controlled trial, one group of youths' clinicians received feedback every 90 days, and another group received feedback weekly. All youths in the weekly feedback group improved more quickly than those in the 90-day group (Bickman, 2011). Russell et al. (2018) argued that when PM is adopted, treatment dropout rate is reduced by 50%, treatment deterioration is reduced by one-third, and length of treatment is shortened by two-thirds. These are all important ways to optimize client experience and add value by way of efficient service delivery.

Studies have shown that there are relatively high deterioration rates of clients in treatment; in the early stages, up to one-quarter of clients are worse

than when they entered treatment (Russell et al., 2018). Some potential reasons for this can include client's increase in honesty after developing trust with their treatment provider, or they may begin to open "cans of worms" to work through that have been previously suppressed. This deterioration is not necessarily a cause for alarm or worry, but something to be curious about and explored throughout treatment. With PM, data can be observed so that if a client's well-being continues to decline, appropriate amendments can be made. In some cases, it can determine whether the treatment is a good fit for a client.

For clinicians, PM provides the potential for a more accurate diagnoses of a client, and increased efficiency in record-keeping (Russell et al., 2018). By nature of PM, data must be retained and systematized throughout treatment. Routinely sharing progress with clinicians can enhance decision making in treatment, inform treatment planning, improve accountability, and help identify undetected or underemphasized client issues (Bickman, 2011). Clinicians using PM can make real-time, evaluation-informed treatment shifts based on developing individual client needs, and PM helps inform various treatment planning strategies that may be successful for a diverse client population (Russell et al., 2018). Feedback can help inform clinicians if clients are not responding well to treatment, and unsuitable clients can be referred to a more appropriate intervention. Conversely, when PM is not occurring, it may be difficult to detect the deterioration of a client whose treatment path does not well match his or her needs (Russell et al., 2018).

PM contributes to creating a "culture of excellence" (Miller & Hubble 2011) within an agency; staff are able to discuss client progress in a manner that is not just storytelling, but formal, structured, and supported by data. Excellence is at everyone's fingertips by engaging in work purposefully and procuring continuous feedback (Miller & Hubble 2011). In order to achieve excellence in clinical practice, the professional community must be an environment that supports flourishment and does not chastise risk (Miller & Hubble 2011). Additionally, Miller and Hubble (2011) argue that it is human nature to underemphasize our inadequacies and overstate our success, and thus PM increases awareness and accountability for clinicians, improving the quality of therapy they provide. PM can be beneficial across a breadth of populations and treatment approaches. Scott and Lewis (2015) argue that PM has transdiagnostic relevance, as it has been effectively used with youths and adults who experience a range of concerns spanning substance misuse, mental health issues, and medical conditions. Though it is clear that PM has a positive impact on client

outcomes, Russell et al. (2018) indicate that there is a dearth of research on how process factors relate to treatment outcomes.

There are some constraints that may impact the implementation of PM, such as client resistance (Russell et al., 2018). If not otherwise communicated, Russell et al. (2018) observed that clients may be under suspicion that they are being used in research as pawns to appease program funders. This can be mitigated by explicitly educating clients on motives for and benefits of PM, such as enhanced client outcomes. Scott and Lewis (2015) note that clinicians may oppose the additional time required for the training and implementation of PM in their already arduous practice. Furthermore, clinicians may believe that PM is an unsuitable addition in their style of practice. However, even minimal intervention may affect change, and there are several approaches to implementation (Scott & Lewis, 2015) that may alleviate clinician concerns.

At PRI, client and program effectiveness is understood by way of routine monitoring of client and family health and behavior. These are measured using standardized instruments before entry to treatment, at each therapeutic milestone, and for several years after client departure. PRI developed the research protocol with a treatment-informed research lens. Decisions about instruments, data collection time-points, and target respondents were co-created between the research and clinical teams to ensure optimal resonance with all stakeholders and minimal over-taxation on respondents. The resulting progress and outcomes monitoring enabled a research-informed treatment approach, which has fostered clinical dialogue, treatment planning, and programmatic review. In other words, progress monitoring and sharing this progress with clinicians has helped PRI engage in continuous quality improvement and minimize the gap between research and practice. In Ronald's case, progress monitoring helped us better understand a mysterious post-treatment relapse and validated our efforts to implement and utilize the results of PM.

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The Central Role of Relationships in Youths' Narratives of Change Through a Residential, Wilderness, and Family Therapy Intervention

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Abstract

The goal of this study was to discover youths' perspectives of the changes they made during a residential, wilderness, and family therapy program, and the aspects of the program they believe were responsible for these changes. A semi-structured interview was conducted, and thematic analysis was used. All youths interviewed cited the ability to have healthier relationships as the most significant change they made in the program. Youth also discussed how their family functioning, sense of self, emotional experience, and thinking styles changed as a result of their participation in the program. Across all participants, relationships with staff, therapists, and other youth emerged as the most important factor influencing their journey of change through the program. Results of this study have implications for staff training, program development, and program evaluation.

Keywords: treatment outcomes, youth perspectives, relationships, residential treatment, wilderness therapy, family therapy

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YOUTHS' NARRATIVES OF CHANGE

In the present study, we examined youths' descriptions of their development during an intensive residential, wilderness, and family therapy program for mental health problems and addiction. Much of the literature on the impact of residential treatment has focused on parent or clinician perspectives, with outcome measures often determined by researchers or program staff. There is a growing body of work, however, that examines youths' perceptions about intervention for their mental health and substance use challenges, which is part of a broader movement toward youth-guided treatment (Association of Children's Residential Centers, 2014; Friesen, Koroloff, Walker, & Briggs, 2011; Gyamfi, Keens-Douglas, & Medin, 2007; Polvere, 2011; Ten Brummelaar, Harder, Kalverboer, Post, & Knorth, 2018).

The term "youth voice" is often used to describe experiences in which youth can express themselves and participate fully within contexts that affect them (Serido, Borden, & Perkins, 2011). Serido and colleagues (2011) examined how youth having a voice in youth programs may contribute to positive developmental outcomes. Using data from 748 youth who participated in youth–adult partnership programs, the authors found that young people who develop positive relationships with adults perceive they have more voice in the program, which in turn leads them to perceive more benefits of program participation. Another recent study examined youths' perspectives on the implementation of positive behavior interventions in secure residential juvenile facilities and youths' suggestions for improving these interventions (Jolivette, Boden, Sprague, Parks Ennis, & Kimball, 2015).

A number of studies have focused specifically on youth perceptions of the process and structure of residential treatment. For example, in a quantitative study of 73 adolescents in residential care, youth were asked to complete a questionnaire designed to assess the helpfulness of 16 treatment components and therapeutic services. Youth rated individual psychotherapy as the most helpful relationship intervention and perceived both formalized relationship interventions as well as informal relationships with staff and peers as very helpful (Zimmerman, Abraham, Reddy, & Furr, 2000). A group of researchers have also explored youths' perceptions of barriers and facilitators of residential substance use treatment, including perceptions of treatment seeking, finding, initiating, retention, and participation (Gogel, Cavaleri, Gardin, & Wisdom, 2011; Wisdom, Cavaleri, Gogel, & Nacht, 2011). These researchers conducted interviews with 87 adolescents, parents, and staff from three treatment agencies and found that adolescents cited positive adolescent/staff relationships, strong communication with staff, and parent participation in treatment as important facilitators of treatment.

YOUTHS' NARRATIVES OF CHANGE

Few studies have focused on youths' perceptions of the changes they have made in residential treatment programs for mental health issues in general as opposed to specifically for substance addiction. In one study, Preyde and colleagues interviewed a sub-sample of 33 youths in residential care and 36 youths in intensive home-based treatment regarding their overall well-being after program participation (Preyde et al., 2013). Overall, they found that many youths experienced major improvements in their mental health and life circumstances, while a smaller group of youths continued to struggle. In a small study with six participants, youths described improved family relationships, as well as improved communication, conflict management, and time management skills due to their participation in a stepped residential care program in Australia (Magor-Blatch & Ingham, 2015). Finally, Gallagher and Green (2013) interviewed 16 adolescents who had been in residential care in the United Kingdom and found that these youth had positive outcomes in emotional and behavioral wellbeing, physical health, accommodation, absence of early parenthood, and substance use. Due to the limited research on youth perceptions of changes made throughout residential treatment programs for mental health and substance use challenges, more research is needed in this area.

An Intervention for Youth Who Struggle with Addiction and Mental Health Problems

Pine River Institute (PRI) is a 36-bed residential program for youth struggling with addiction and mental health challenges. Located in Ontario, Canada, PRI combines four services: wilderness therapy, residential treatment, parent intervention, and aftercare. There are five stages of the program: Stage 1 is the wilderness phase, Stages 2 - 4 take place at the residential site, and Stage 5 involves the provision of aftercare services while youth transition back to their homes and communities. The wilderness therapy component occurs during the first two months of the program, where youth live in a wilderness environment, camp in tents or yurts, and engage in physical activities such as hiking and canoeing. Personal growth is facilitated through group initiatives, individual therapy, journaling, and other therapeutic activities. After youth graduate from the wilderness, they spend the next eight to ten months at the residential campus completing high school credits, living collectively, and participating in individual, group, and family therapy.

An important aspect of the program is the requirement of parent involvement. Parents meet individually with staff and in groups to learn how to respond to their adolescents in developmentally appropriate ways. Furthermore, youth and parents engage in family therapy. The program uses the Satir Family

Therapy model to support change throughout the youth's family system. More information about the family therapy component of PRI's program can be found in a recent article by van Ryn and Creighton (2019). In the final phase of the program, youth are reintegrated into the community with the support of aftercare services. Since PRI is the only organization in Canada that combines these four types of services, research is necessary to document the impact of the program on youths and their families, as well as to inform expectations related to the types of changes that can be anticipated from a multimodal treatment program.

The goal of this study was to understand youths' perspectives of the changes they made through treatment and the program elements they perceive to be responsible for these changes. In this qualitative study, we interviewed adolescents struggling with mental health challenges and addiction about their experience in a treatment program. The qualitative approach enabled us to derive an in-depth understanding of youths' experiences in their own words and to answer two main research questions: (1) What do youth perceive to be the most significant changes they made through this multimodal treatment program? (2) What do youth view as the most impactful aspects of the program?

Method

This study was conducted at Pine River Institute (PRI) with ethics approval from the York University Ethics Review Board. Parents were informed about the research project and provided written consent for youth to participate. Parental consent was obtained for 24 youth (71%). Only youth with parental consent participated in this study and the youth themselves assented to participate. Youth were informed that if they declined to participate in the study, it would not jeopardize their relationships with staff nor the services they received at PRI. Conversely, they were told that if they chose to participate, every effort would be made to de-identify their responses. They were cautioned that it was possible that individuals who knew them well might recognize quotations as belonging to them.

Participants

Youth were informed about the study by the PRI principal and were invited to speak with the first author if they wanted more information about the study and/or were interested in participating. It was decided a priori that the sample would be 10 youth, as this is an ideal sample size when conducting in-depth interviews and doing qualitative analyses. The total sample consisted of seven boys and three girls. Youth were chosen for the interviews to represent the gender ratio at PRI, which ranges from 66% to 85% male (Pine River Institute,

2014). During daily activities, six male youths mentioned that they were interested in being interviewed. All six of these youths were interviewed. For the remaining four participants, four girls were selected from diverse stages in the program. Of the youth invited to participate, one female youth declined, and a male youth who was interested in the study was chosen instead.

Youth were also chosen from different stages of the program: two participants were from Stage 2, four from Stage 3 and four from Stage 4. No youth were from Stages 1 or 5 as they were not present in the center. Similar to the population at PRI, all 10 youth who participated in this study were white and their average age was 17.5 years old, with an age range between 14 and 18 years old (Pine River Institute, 2015). Half of the participants were from the Greater Toronto Area and the others were from within the province of Ontario.

More than half of youth admitted to PRI have been diagnosed with a significant mental health challenge, the most common challenges being anxiety, depression, bipolar disorder, and attention deficit hyperactivity disorder. Similarly, many of the youth in this sample struggled with a range of mental health challenges in addition to addiction, including self-harm, school refusal, family conflict, and past trauma. Information on socioeconomic status (SES)/income is not formally collected by the program; however, clinicians have reported that most youth tend to be from mid-to-high SES families. At the time of interview, the youth in this study had been in the program for an average of 8.5 months, whereas youth typically spend an average of 11 months in the program in total (Pine River Institute, 2015).

Procedure

The first step in developing this study was to meet with the clinical staff to discuss the project and receive feedback on the research goals and procedures. The research questions and methods were mutually decided upon with the clinical staff. The first author spent a few days a week at PRI for about eight months, participating in daily activities with the youth and staff. This extended time at PRI was essential in developing trusting relationships with the youth and staff, as well as getting a deeper understanding of the program. Since the goal of this study was to capture the perspectives of youth in their own words, open-ended interviews were conducted with the youth.

Analyses

The semi-structured interview guide contained 15 main questions, which are included in Table 1. These questions were intentionally broad to give youth

Table 1

Main Question from Interview Guide

1. Think of yourself before you came to Pine River. How would you have described yourself? How would your parents have described you?
2. Now think of who you are at this moment, how would you describe yourself? What has changed?
3. What challenges led you to participate in this program?
4. Since you've been at Pine River, have you noticed any changes? What part(s) of the program was (were) most helpful in making these changes?
5. Think of a time you felt you could be yourself around someone else. Who was this person? Who else do you feel like you can be yourself around?
6. Think back to the circle of trust activity you completed at the beginning of the program. What did your circle of trust look like then? What does your circle of trust look like now?
7. Has your relationship with your parents changed since coming to Pine River? If so, how has it changed? What aspects of the program helped you and your parents make these changes?
8. Think back to when you wrote your letter of accountability to your parents. Describe the experience of writing the letter in as much detail as you can remember. Did this letter impact your relationship with your parents?
9. Describe your relationships with your friends before you came to Pine River. Have these friendships changed at all in the time you've been at Pine River?
10. Describe your romantic relationships before you came to Pine River. Have these relationships changed at all in the time you've been at Pine River?
11. Please describe your relationships with the staff at Pine River.
12. Please describe your relationships with your team members.
13. Please describe what it's like to participate in the weekly process groups.
14. How would you summarize your experience in this program overall?
15. What do you think the future holds for you? What are your plans after you finish at Pine River?

the opportunity to discuss the aspects of themselves and their experiences that they considered most important. Subsequent follow-up questions were asked, such as asking youth to provide more information about something they had shared. Interviews lasted between 30 and 90 minutes, with the majority of interviews lasting 60 minutes. Thematic analysis was chosen to analyze the transcripts. Thematic analysis is a flexible and accessible approach for identifying, analyzing, and reporting patterns within data (Braun & Clarke, 2006).

In short, and like other qualitative methods, thematic analysis is a way of parsing qualitative data into themes that are internally coherent, consistent, and distinctive. The decision to use a descriptive approach as opposed to a more interpretive approach was made before beginning the analysis. In the analysis phase, the first author worked on bracketing assumptions from previous reading, research, and personal experiences to allow the themes to emerge from the data, as is consistent with an inductive approach (Braun & Clarke, 2006; Patton, 1990). In line with this inductive approach, care was taken to stick closely to the language of the participants when creating categories and to limit the amount of interpretation (Braun & Clarke, 2006).

In the first phase of the analysis, transcripts of the 10 interviews were coded using NVivo software with the initial main categories and subcategories identified. NVivo is a software used to organize data. It allows the researcher to manually highlight sections of text and code it with the name of a theme that the researcher creates. All parts of the text that have been given the same theme name can then be viewed in one section to allow the researcher to then assess the theme for internal consistency.

In the second phase, all 10 interviews were re-coded to identify any additional examples of existing categories, as well as to identify new categories. In the third stage of analysis, each category was examined to ensure it was internally consistent (i.e., the properties within the category were conceptually similar), as well as to ensure the category was conceptually distinct from other categories. All categories that contained properties from only one or two participants were excluded from the final model. The final step was sorting all categories into domains, and the main categories and subcategories that fall under those domains. A consensus was reached amongst researchers on the structure of domains, categories, and subcategories.

Results

Changes Made in the Program

During the interviews, youths spoke excitedly about the changes they had made in the program, resulting in the emergence of five main categories in the *Changes* domain (see Figure 1).

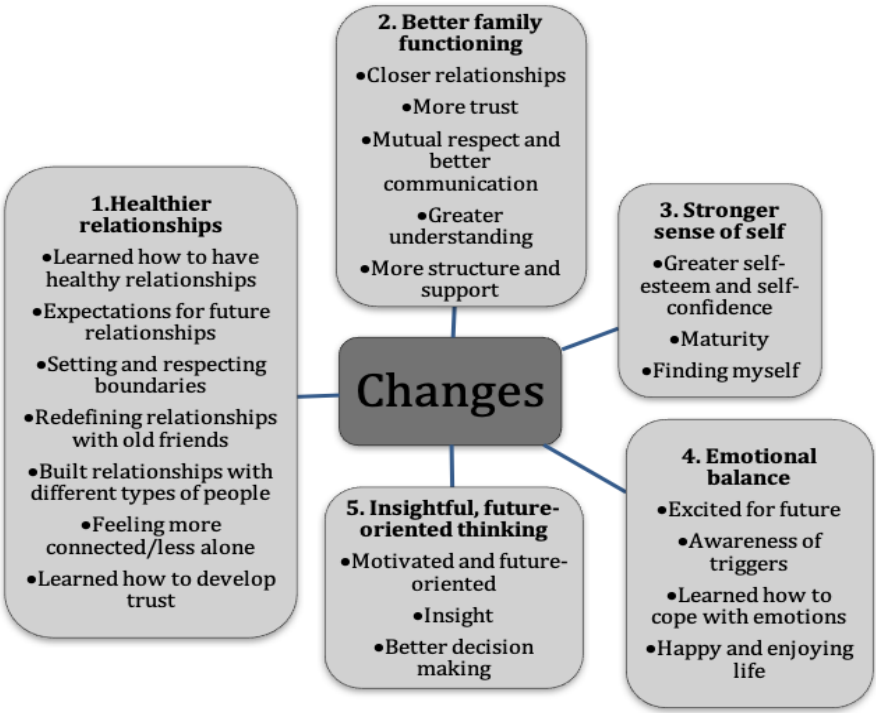

Figure 1. Youths' perspectives of the main changes they through the program

Healthier relationships. This first main category was the most prevalent change participants discussed and involved a shift in their understanding of and experiences in relationships. This main category comprised seven subcategories.

Learned how to have healthy relationships. Participants mentioned changes in their ability to have positive relationships with the people around them. One youth who discussed experiencing a lot of distance in their previous

relationships mentioned that through the program they "learned how to deal with interpersonal situations."

Expectations for future relationships. Youth discussed having new expectations for future relationships. One participant shared their intention to seek out "friends that are supportive and mature," whereas another participant explained that they planned to seek out new relationships based on shared values. A third participant indicated, "You set a new standard for yourself…I deserve for someone to be there for me. I deserve someone who's going to care about me ... I care about myself more, and I want more for myself."

Setting and respecting boundaries. Half of the youths interviewed indicated that setting boundaries and respecting the boundaries of others are essential interpersonal skills they gained through the program. One youth shared their process of developing these skills: "I've gotten a lot better at setting boundaries with people. And I've found that setting those boundaries has made it a lot easier, and feels really good, because I don't have to feel guilty about it." This language of boundaries is part of the clinical model at PRI, which the youth have taken up in their narrative of change.

Redefining relationships with old friends. Many youth discussed having to redefine relationships with old friends and carefully consider which friends to reconnect with when returning home after the program. One youth explained this by saying:

> If they do want to come in my life as someone who I'm not using with, then like that's perfect. That's great, and then I'll be able to support them, but it would be rebuilding the friendship from start, and if they don't accept me for the person I am now, then whatever. Like, they can just live their life and I'll live mine.

Built relationships with different types of people. Youths discussed changes in their willingness to have relationships with others who they perceive to be unlike them. One participant admitted, "I didn't really like adults back home, and I didn't talk to them that much, and I thought they all judged teenagers and they all didn't like us. But I realized that I can have a friendship with an adult."

Feeling more connected/less alone. Youths explained that through their participation in the program, they felt more connected to the people in their lives and less alone. One youth stated, "I'm not alone anymore and that's an awesome feeling." Another student described changes in their circle of trust, which is a

drawing youth do at the beginning of the program in which those close to the inside of the circle are people they trust the most. Comparing their circle of trust before and after the program, one youth said:

> Yeah it's pretty different … I probably would have only had two or three people on there before and now I would probably say I have at least, you know like six or seven people on there … all those people would be closer than anyone that would be on there before, so yeah it's definitely changed a lot.

Learned how to develop trust. Another important change involved learning how to develop trust in relationships in an appropriate way and at an appropriate pace. One youth said, "I kind of trust too early. So, as soon as I thought, 'yeah, we're going to have a relationship,' I immediately put all my trust in [them], which was wrong because I should have developed it later."

Better family functioning. The second most prevalent main category was an improvement in family relationships. The five subcategories of family functioning are described below.

Closer relationships. Most youth described their family relationships as much closer due to their experiences at PRI. One youth articulated this by saying, "I'm very close with my mom now. She's been through a lot with herself, as well as my dad. So I'm very close with both of them now, I'm pretty happy about that." Other comments in this category included sharing more personal things with their family, asking family members for support or advice, and wanting to spend time with their family.

More trust. Students described building more mutual trust in their family relationships. Participants talked about all they have gone through with their family in their journey to seek treatment, how they now trust their parents more, and how there is more mutual honesty in their relationships. Many youth also commented that their parents trust them more because of all the work they have done at PRI. One youth explained that in their current relationship with their mother, "she takes my word on things. Which is really important. Whenever I said anything to her before, she had zero faith in me."

Mutual respect and better communication. Youth spoke about greater mutual respect and communication in their relationships with their families. One youth mentioned that their parents "respect me a lot for coming to Pine River, I think that was the first measure point, after that it's been steady since." Other youth mentioned that their communication with their parents has greatly

improved over their time at PRI, partly because they respect each other more. One youth explained:

> I think they've learned how to communicate … now [my dad]'s able to tell me why he makes certain decisions instead of just saying, 'This is how it's going to be.' He's able to say, 'I want it to be like that because of this.' And I can completely empathize with that … even if I don't agree with it…that's fine and I understand that and I think that's helped our relationship a lot.

Greater understanding. A few youth spoke about their families having a greater understanding of them as a person. For example, one youth believed their parents had "developed more understanding for my issues and where I'm coming from. They understand a lot more about me and my past."

More structure and support. The final change in family functioning involved their parents creating a more structured and supportive home environment. As one youth stated, "We're slowly building a new dynamic that has a bit more structure in it," and another participant said that their parents now "know how to be more supportive of me."

Stronger sense of self. The third main category captures how youth define, describe, and feel about themselves.

Greater self-esteem and self-confidence. Most youth indicated that having more confidence in who they are was one of the greatest changes they had made in the program. One youth commented, "I was very self-conscious and very uncomfortable with myself, and here, I've developed the ability to have a whole lot of confidence." Another youth mentioned feeling a lack of self-confidence until a staff mentored this youth during the wilderness component and taught them about positive affirmations. This youth shared some of these affirmations such as, "I'm proud that I was helping today … I'm proud that I cooked for people. And all those little things add up, and you can really look and be like 'wow, there's a lot of things I should be proud of.'"

Maturity. Youth felt they had matured over their time at PRI, and many described themselves as a mature person. For example, one youth was asked how they would describe themselves at this moment in time. They replied, "Smart. Future oriented. Hopeful. Happy. Mature and grounded."

Finding myself. Some youth described being in the process of "finding themselves," or building a sense of identity through their interactions with the world. One youth described their journey as:

> I've worked a bit on identifying who I am, I guess when I came I didn't really know who I was, because I'd been like browsing around, looking for someone's personality to try on. Like a new pair of pants, or something. Now I guess I'm a bit more comfortable in where I stand.

Emotional balance (enjoying positive emotions, coping with negative emotions). In this fourth main category, youth reported that they were now able to enjoy positive emotions such as happiness and excitement for the future, while also coping more effectively with negative emotions.

Excited for future. The most common subcategory of emotional balance was feeling hopeful and excited for the future. This feeling of excitement for the future is captured in this participant's words: "I actually can now look forward to life. I never saw a future for myself, and that's pretty scary, and now I'm really excited for tomorrow and for whatever is to come, which is ridiculously unbelievable."

Awareness of triggers. Half of the participants cited a growing awareness of how external events make them feel. They use the term "trigger" to refer to an experience that causes them to have an intense, often negative, emotional experience. Gaining awareness of one's triggers is a part of the clinical framework at PRI, and youth have taken up this language in how they describe their journey of change. For example, one youth who was planning to remain sober after the program reflected, "I was thinking about living on residence for university and then I thought about it, and I think that would be pretty triggering. I think it would be hard to be around a bunch of people who were constantly partying."

Learned how to cope with emotions. Many youths discussed being able to cope with strong emotions more effectively. As one participant commented, "I think that's what's really good about here, is that you learn how to work through those feelings."

Happy and enjoying life. Finally, youth explained that they experienced more joy and were able to enjoy life after beginning the program. For example, one youth stated:

> I was on anti-depressants for really close to three years, the highest dose. I thought I was going to be severely depressed my whole life ... I just had all these medications and now I'm not on any medication. I'm actually genuinely happy. I enjoy living, I enjoy my life, I enjoy my relationships with my friends and my family. I have goals set for the future. And I'm usually in a calm, good mood.

YOUTHS' NARRATIVES OF CHANGE

Insightful, future-oriented thinking. The fifth main category of change is related to developing a greater future orientation. Youth noted changes in their thinking patterns, including greater motivation, insight, and better decision-making abilities.

More motivated and future oriented. Participants mentioned that they were thinking about and planning for the future much more after being at PRI. When asked how they would describe themselves at this point in time, one youth answered, "more future oriented, more aware of what I need to get done, a better sense of what I want to do after I'm done high school." Moreover, some youth felt that they were more motivated because of their participation in the program and had the drive to work towards their goals.

Insight. After participating in the program, participants had greater insight into their past behavior and articulated their place in relationships with greater clarity. For example, when asked to summarize their experiences in the program overall, one youth said, "Overall, I would say that it is eye-opening … because you can clearly see that there were things wrong with the way you were living before."

Better decision-making. Youth commented on the advances they had made in their decision-making abilities, including their ability to effectively analyze situations and make choices that contribute to their wellbeing. One participant mentioned:

> I wasn't always very good at thinking through difficult situations, which made me make stupid decisions, and it caused problems. Now I think I have a better understanding of what will benefit me and what will be destructive. Which I think will help me make better decisions in the future.

Program Elements Linked to Change

Youth discussed the key aspects of the program that they considered highly influential in their development, resulting in the emergence of four main categories in this domain, each with a number of sub-categories, as detailed below (see Figure 2).

Development through critical relationships. Across all participants, relationships with staff, therapists, and peers emerged as the single most important factor influencing youths' journey of change through the program.

YOUTHS' NARRATIVES OF CHANGE

Relationships with staff. All ten participants talked extensively about how their relationships with staff were essential in their development as a person. One youth reflected, "I developed a close relationship with the staff … they just helped me so much with my life, and [staff name]. He was the main role model for me to be a man and an adult". The youth articulated how staff modeled what a healthy relationship looks like, and through these relationships they learned how to have healthier relationships with others in their lives. For example, one youth said, "I don't know if you remember [staff name] … I'm like super close to her so yeah that helped me understand how to build those relationships and then I can do that for the rest of my life with other people." Other youth talked about what it felt like to be cared for unconditionally by an adult. This was significant for many of these youth, as some of them had experienced abuse, trauma, and ongoing conflict in their family and peer relationships before beginning the program. When asked what the most helpful thing about the program was, one youth answered, "They just care. They care about you. They give you everything you need."

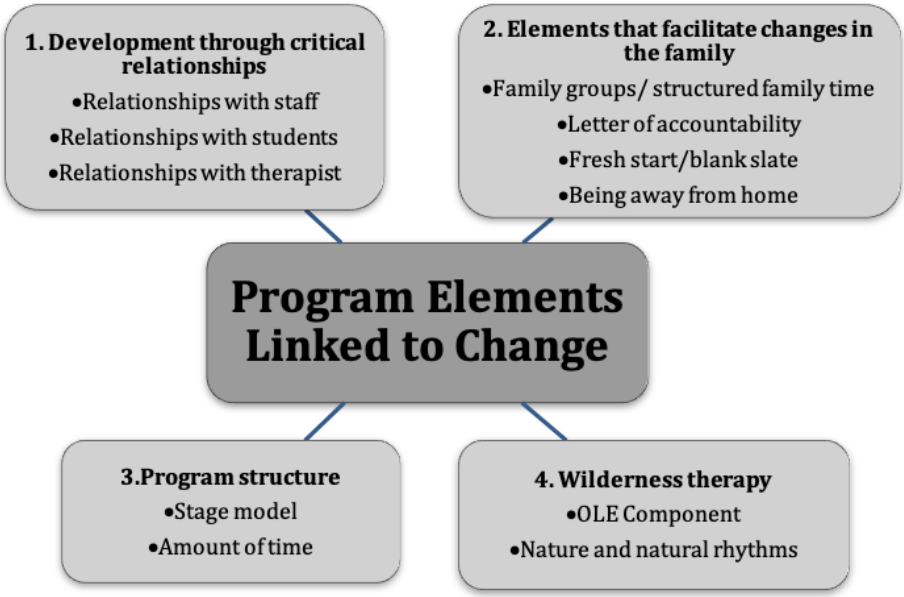

Figure 2. The four main aspects of the program that youth discussed as highly influential in their journey of change.

YOUTHS' NARRATIVES OF CHANGE

Relationships with students. All youth mentioned their relationships with other students as important to the progress they made in the program. When asked what the most helpful parts of the program were, one student responded, "the students that you're living with. They're the ones you do most of your work with. Whether you like them or not, they teach you so much." Another student described their relationships with other students as "really deep … you open up about everything that you never plan on opening up about, in your life, with these people." It was also common for participants to discuss how their work with other students at the school transferred to their relationships with friends and family. For example, one youth said, **"**I feel like they have the team dynamic as a mimic of your family… it teaches you that you can't escape it. You gotta deal with it. You can't just bury it down."

Relationship with therapist. Youth mentioned that their relationship with their therapist helped them develop a deeper sense of their identity, as well as work through the problematic aspects of their relationships with people at PRI and at home. One youth said that without their therapist, "I would never have found out who I was." Other students talked about their therapist encouraging them to be more open and push their comfort zone, connect with other students on a deeper level, and be more aware of how certain behaviors impacted those around them. Similar to relationships with other staff, the experience of being cared about unconditionally was mentioned as a defining feature of the relationship with their therapist. For example, one participant explained, "She'll constantly tell me, 'I still care about you, just as much as I did before. Just because I called you out on something, I don't stop caring about you because of that.'"

Elements that facilitate changes in the family. During the interviews, youth were also asked what parts of the program helped them to shift their family dynamic and improve their relationships with family members. They responded that the family groups and structured family time, letter of accountability, fresh start with their parents, and time away from home were all important in facilitating changes in their family relationships.

Family groups/structured family time. Youth mentioned that the family therapy and structured family time were core components of the program that helped repair their family relationships. One youth stated that family therapy was "incredible. I never thought I'd talk to [my family] again, or … have a meaningful, respectful relationship. I never thought that would ever happen. And it's happened." When asked what had helped them make these changes, they shared, "It's the gradual re-integration of them into your life, as well as therapy

with a person to listen to what's going on and step in when necessary." Other participants discussed the changes their parents had made due to their participation in the family therapy. Through the parent support groups and family therapy, parents gain skills such as setting boundaries, communication, and coping with emotions. The parents' growth and development is essential in improving the quality of family relationships, which in turn impacts youths' wellbeing.

Letter of accountability. In the first stage of the program, parents write a letter to their youth naming the youth's problematic behaviors and explaining how these behaviors impacted the family. Youth are then expected to write a letter in response, taking responsibility for their behavior before PRI. The youth interviewed cited this letter as an important part of their therapeutic process. One youth described the effect of this letter as making them "just really realize like, how much I need help. How much I need to change things. That was a huge wake up call."

Fresh start/blank slate. Youth describe the program as a whole as giving them a fresh start with their parents. When asked about the most helpful components of the program, one youth replied, "really just being away from all the influences at home, a fresh start I guess, especially with my parents." In this way, the program acts to interrupt the negative patterns of interactions and helps parents and youth create a new foundation for their relationship.

Being away from home. Youth discussed being away from all of the influences of home as central to the improvements they made in the program. One youth elucidated this process:

> I think probably one of the most helpful things was the way it takes you out of your life completely … I hadn't seen any people I used to hang out with, or had any form of communication with them for just under a year… it helped me not worry about those relationships and just deal with that I need to work on here … so just being disconnected from those kinds of things and being able to work on myself is helpful.

Program structure. Youths mentioned two aspects of the program structure as helpful in their journey of change: the stage model and the amount of time spent in the program.

Stage model. The PRI program is set up so students must pass through five stages. This process is valuable because students in higher stages offer mentorship and support to newer students. To pass through each stage, the

student must meet a specific set of maturity measures and relationship skills (e.g., honesty, accountability, etc.). If a student has regressed into old patterns, it is possible for them to be demoted to the previous stage. One student explained how getting "stage dropped" was a valuable learning experience for them: "I took an honest look and asked, 'what's not going right?' and then I looked at the relationships I had … If I didn't get stage dropped … I think I would have stayed in a very rough spot." Another aspect of the stage model is slowly transitioning back into the home environment and participating in the after-care stage. One youth explained, "you slowly see your parents first every other weekend, then every weekend, then you start going out with them … and then you visit home … it's a slow transition".

Amount of time. Many youth interviewed mentioned the importance of being at PRI for a long period of time in order to make profound and lasting changes. This can be seen in this student's passionate monologue: "Such a long process, you know? It needs to be long… Most of these characteristics I learned it over what? 16 years or something? You think you're going to break that in six months? Gimme a break." Many youth felt that the program's principle to only discharge students when they are ready, as opposed to having a set length of time that each student is in the program, was one of the program's greatest strengths. One youth explained:

> It's not like 'okay, after five months, we're sending you home' … They say 'We're going to send you home when we feel confident that you're ready. And if you go home, and you really start hitting problems, you can come back to the school.'

Wilderness Component. Youth identified the opportunity to become more connected to the natural world as important in their journey of change. This included the Outdoor Leadership Experience (OLE) component of the program, as well as being able to connect with nature and to engage in more natural rhythms.

Outdoor Leadership Experience (OLE). The Outdoor Leadership Experience (OLE) takes place in a northern Canadian wilderness setting and is the first component of the program that the youth experience. Youth typically spend about two months in this first stage of the program, although the length of time depends on how long it takes each youth to meet the goals of this stage. For some, the experience was quite physically and emotionally demanding, and their self-confidence increased after having completed this part of the program. One

youth explained how the wilderness component helped in their development of self in relationships:

> I loved being smelly and greasy and getting to know these people. And they're not judging you because they're gross too you know? And that was probably one of my favourite parts was not feeling self-conscious. That was a really important thing for me was to feel okay being myself, just physically, and then it kind of transferred to emotionally. I could be more real, I guess…

A number of participants also reflected on the role of the OLE as helping them develop gratitude for the things in their life. For example, one youth said, "another part of the woods that's really important is that it takes you away from everything and makes you really more appreciative and grateful for the things like school."

Nature and natural rhythms. Youth identified the experience of being connected with the natural world as a contributing factor to changes in their mood and overall wellbeing. One youth suggested, "You need the quietness because it allows you to not have a million things going through your head, or kind of have that over-stimulation … you have that time to sit down and actually reflect." Youth also described how the natural setting, both in the OLE and at the main campus, helped them develop a more natural circadian rhythm. One participant described this as "resetting, like everything in your body feels really good, you eat at a regular time every day, you go to bed when it's dark and wake up when it's light and you just feel natural."

Discussion

The goal of this study was to enhance understanding of youths' development through residential treatment and to document what was most impactful in this development. According to the youth interviewed, the changes they made in their relationships, including family relationships, represented the most salient part of their transformation through the program. Consistent with ecological perspectives on development, which emphasize the primary role of relationships in adolescent development (Collins & Steinberg, 2006; Smetana, Campione-Barr, & Metzger, 2006), this study suggests that the development of healthy relationships is foundational to making progress in other developmental tasks, such as emotion regulation and sense of self. When describing their personal growth, the main category *Sense of Self* emerged, in which youth discussed feeling self-confident, mature, and engaging in a process of finding themselves. Many of the changes map onto the components of Lerner's model of

Positive Youth Development (Lerner et al., 2005). That is, youths in the present study expressed increases in the five domains of this model: confidence (*self-confidence* in the *sense of self* category), competence (*maturity* in the *sense of self* category), connection (*changes in relationships* and *family changes* categories), caring (*changes in relationships* and *family changes* categories), and coping skills (*emotional balance* category). The emergence of a healthy sense of self represents a major developmental gain for the youth in this study and can only occur in the context of caring relationships.

The presence of a positive peer culture and close relationships with other students were mentioned as important by all ten youth interviewed. Although there is much less research on peer relationships in residential treatment, one study of a wilderness therapy program showed that a positive group experience was associated with a statistically significant decrease in depression (Norton, 2010). Early research on wilderness therapy suggests that "the peer group is often one of the most powerful contexts in adolescence for identity development and intimacy … the group may provide relational experiences that can help rework or resolve developmental crises and dysfunctional patterns that were not dealt with earlier" (Miles & Priest, 1999). Similarly, in one study with a wilderness therapy program in Norway, youth noted that connecting with diverse peers "became a source of positive stimuli and interest while contributing toward creating an inclusive and supportive milieu" (Fernee, Mesel, Andersen, & Gabrielsen, 2019). The youth in this study discussed how support from peers could be as important or sometimes more important than support from therapists (Fernee et al., 2019). Russell and Farnum (2004) suggested that the "social self" is one of the core aspects of wilderness therapy, such that wilderness experiences help youth learn more cooperative behaviors and supports group members forming close interpersonal relationships. Further, Russell and Gillis (2017) included peer relationships as a factor in their Adventure Therapy Experience Scale, which they defined as engaging in conversation with other participants about their experiences during the program. More research within the residential treatment field is needed to understand the impact of positive peer relationships on treatment outcomes and how to promote these types of relationships within a treatment setting.

The youth interviewed described their relationships with staff and therapists as one of the most important program elements that helped them in their journey of change. This finding is consistent with surveys and interviews with youth placed in residential care who cite relationships with staff as among the most helpful and positive aspects of their residential experience (Zimmerman et al., 2000; Anglin, 2004; Gallagher & Green, 2012; Smith, McKay, &

Chakrabarti, 2004). Fernee and colleagues (2019) reported that the amount of time therapists spent with clients and the familiarity that unfolded when doing activities such as hiking together contributed to establishing a strong therapeutic alliance. A group of children and adolescents with emotional and behavioral disorders from a program in Finland cited the availability of staff, as well as a clear set of rules and boundaries, as the most helpful aspects of treatment (Soenen, D'Oosterlinck, & Broekaert, 2013). Conversely, they listed strictness, not listening, and inappropriate staff attitudes and interventions as counterproductive elements of treatment (Soenen et al., 2013). These findings point to the importance of training staff in residential treatment centres to relate with youth in ways that foster their optimal development.

Youth identified several additional elements that helped facilitate changes. In terms of the importance of a "fresh start" and time away from families, Harper and Russell (2008) described how this "meaningful separation" is an important way for youth to reflect on how their negative behaviors affected their families. The finding that youth felt they needed to be in the program for a long period of time stands in contrast to previous residential treatment research, which asserts that most therapeutic gains are made in the first 6 months of treatment (Hair, 2005). From youths' perspectives in this study, it was important that they could take as long as needed to master the tasks in each stage, to be "stage dropped" if they were regressing back to old patterns, and to have their progress through the program trailered to their own trajectory. These youth recognized that they had developed mental health and substance abuse problems over several years, and that it takes a long time to catch up developmentally, repair relationships, and embark on a healthier pathway. Finally, the helpfulness of the wilderness component is consistent with previous research on the effectiveness of wilderness therapy programs for youth struggling with emotional and behavioral problems (Norton, 2010; Russell & Gillis, 2017; Wilson & Lipsey, 2000). The youth that Fernee and colleagues (2019) interviewed cited the wilderness as one of the most impactful aspects of the program, helping youth move from a sense of chaos to a feeling of calm, and helping them disconnect from technology and reconnect with the present moment (Fernee et al., 2019).

Limitations

Given the highly personal nature of this research, it was important to allow youth to self-select into this study. This led to a potential sampling bias, as the participants may have over-represented youth who had a positive attitude toward and who had benefitted from the program. Furthermore, the present study had a small sample size and contained youth from one treatment program. As

such, findings from this sample of youth may not generalize to other programs. It is important to follow up on this research with a larger sample size and a mixed-methods approach with youth from other programs and in other geographic regions. It would also be interesting to conduct a follow-up study asking youth to rank the most impactful components of the program, as Russell and Gillis (2017) had youth do when developing the Adventure Therapy Experience Scale.

In future research, it might be advantageous to interview youth who have graduated from PRI and other programs to explore the lasting impact. Previous research in wilderness therapy has documented a "halo effect," in which respondents provide higher scores if given the survey immediately following program completion (Graham & Robinson, 2007; Norton, 2010). Longitudinal research is needed to determine whether these changes are sustained long-term and to measure the underlying processes responsible for these changes. Moreover, to get a more complete picture of the changes youth make in themselves and in their relationships, it would be useful to interview parents and others with whom the youth have close relationships. These limitations present important avenues for future research.

Implications for Prevention and Intervention

Given the central role of relationships in youths' description of their changes in the program, cultivating healthy relationships emerges as a primary process in remediating emotional and behavioral challenges. Youths' insights in the present study suggest a cluster of outcomes to be considered in program development and evaluation. These include changes in understanding of and capacity for relationships, changes in the quality of relationships, and changes in specific social skills such as setting boundaries and building trust.

Youth discussed the importance of their relationships with staff. These findings highlight the importance of training staff who work with adolescents to be attuned to the nature of youths' developmental tasks and challenges, as well as to the quality of their relationships with youth. To ensure youth are able to develop authentically within their relationships, it is essential for staff to create a positive peer culture and teach youth how to support each other's journey of change. Future research is needed to examine how specific experiences in relationships within different programs relate to the diverse range of outcomes youth achieve during these programs designed to guide them onto healthy pathways.

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Best Practices for Working with Clients who Identify as Transgender in Outdoor Behavioral Healthcare

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Abstract

Research suggests that simply identifying an individual as transgender does not necessarily indicate the existence of other mental health concerns. However, many transgender adolescents experience significant psychosocial and mental health concerns, which are likely due to the challenges faced by youth with nonconforming gender identity and expression. Though issues related to gender identity are rarely the primary reason why individuals seek mental health treatment, it is important for mental health practitioners to possess some knowledge of the issues affecting the transgender community to provide effective treatment. This paper examines the clinical needs of youth who identify as transgender, and best practices for working with transgender clients in Outdoor Behavioral Healthcare. Recommendations for best practices include ensuring that clinicians and other staff members are adequately educated on issues related to gender identity, examining bias on a personal and institutional level, taking corrective action to create more trans-affirming environments, and promoting client self-determination and voice before and during treatment. In addition, more research on the topic of transgender clients in mental health treatment, and specifically in OBH programs, is needed to better inform clinical practice.

Keywords: Transgender, LGBTQ+, outdoor behavioral healthcare, wilderness therapy, social justice

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BEST PRACTICES WITH TRANSGENDER CLIENTS

In the United States an estimated 0.7% of youth ages 13-17, or approximately 150,000 youth, identify as transgender (Herman, Flores, Brown, Wilson & Conron, 2017). A recent study also estimated that 0.7% of young adults ages 18-24, 0.6% of adults ages 25-64, and 0.6% of adults ages 65 and older identify as transgender, making the U.S. youth and young adult populations the largest percentages of transgender individuals in the world (Herman et al., 2017). As defined by the National Association of Social Work (2009), transgender is:

> "An umbrella term that describes people whose gender identity or gender expression differs from expectations associated with the sex assigned to them at birth. This term may include pre-operative transsexuals, post-operative transsexuals, non-operative transsexuals, cross-dressers, androgynous people, gender benders, drag kings, and drag queens. Transgender people may be heterosexual, bisexual, gay, lesbian, or asexual" (NASW, 2009, p. 32).

Research suggests that simply identifying an individual as transgender does not necessarily indicate the existence of other mental health concerns. However, many transgender adolescents experience significant psychosocial and mental health concerns, which are likely due to the challenges faced by youth with nonconforming gender identity and expression (Benson, 2013). Psychosocial concerns for transgender youth include family rejection, peer rejection, harassment, trauma, abuse, inadequate housing, legal problems, lack of financial support, and educational problems (APA Task Force, 2008).

Though issues related to gender identity are rarely the only reason why transgender individuals seek mental health treatment, it is important for mental health practitioners to possess knowledge of the issues affecting the transgender community to provide effective treatment. As such, this paper seeks to provide a review of the literature on the mental health needs of youth and young adults who identify as transgender, along with best practices for working with clients who identify as transgender in Outdoor Behavioral Healthcare (OBH). A clinical example is provided to illuminate one client's experiences being transgender in an OBH program and is aligned with the literature in order to make recommendations for ethical and effective practice.

Mental Health Concerns among Youth Who Identify as Transgender

There is evidence to suggest that transgender youth and young adults are at an increased risk of mental health concerns such as depression, anxiety, and suicidal ideation and/or attempt, as compared to their cisgender counterparts

(Reisner et al., 2015). In fact, research suggests that almost 1 out of 3 youth who identify as transgender have clinical depression and have attempted suicide (Olsen, Durwood, DeMeules, & McLaughlin, 2016). Youth also struggle with body image and how others see their bodies (Diemer, Grant, Munn-Chernoff, Patterson, & Duncan, 2015), have an overrepresentation of eating disorders (Diemer et al., 2015), and are at an increased risk of non-suicide self-harm (Arcelus, Claes, Witcomb, Marshall & Bouman, 2016). Youth who identify as transgender experience high levels of stigma across their environments including denial of access to medical and mental health treatment, homophobia and oppression, which all impact their mental health (Hope, Mocarski, Bautista, & Holt, 2016; Johnson, Singh & Gonzalez, 2014).

LGBTQ+ children and youth experience greater risk for abuse, violence, harassment, school sanctions, and various forms of discrimination than their heterosexual counterparts (Himmelstein & Brückner, 2010). With the lack of support at home, the routine stigmatization, and bullying and rejection at school, youth who identify as transgender can experience serious academic difficulties and drop out of school (Kaltiala-Heino, Bergman, Työläjärvi, & Frisén, 2018). Clark et al. (2014) found that transgender-identifying adolescents had 4.5-fold increased odds of being bullied and were approximately twice as likely to report being afraid for their personal safety, being in a serious physical fight, and being hit or otherwise harmed by others, compared with their cisgender-identifying peers. Grossman and D'Augelli (2009), in their focus group research, found that the most important transgender youths' concerns were safety issues related to being potential victims of violence including sexual harassment, the disclosure of their transgender status or that information being disclosed by others (Grossman & D'Augelli, 2009). Although they have come to rely on avoidance coping skills and seeking supportive others as their main coping mechanisms, the lack of competent mental health services to assist them reflects, in their view, their marginality and unimportance to society (Grossman & D'Augelli, 2009).

In addition, homophobia and heterosexism negatively affect transgender identity and can be exacerbated in the family system; however, parental acceptance during adolescence can have a strong effect in protecting against negative outcomes for lesbian, gay, bisexual and transgender (LGBT) young adults (Travers, Bauer, Pyne, & Bradley, 2012). In fact, transgender youth who are supported in their gender identity and social transition have been shown to have normative levels of depression and anxiety, supporting the idea that mental health disorders are not inevitable within this population (Olson et al., 2016).

BEST PRACTICES WITH TRANSGENDER CLIENTS

Outdoor Behavioral Healthcare

Youth who identify as transgender who receive mental health treatment face unique challenges and it is important for providers to understand how best to work with this population without further stigmatizing them. One type of mental health treatment for youth, Outdoor Behavioral Health or OBH, is currently seeing a rise in youth clients who identify as transgender (Brown & Cheyette, 2019); however, no literature yet identifies how to work with this population in this unique setting. OBH has emerged as a viable mental health treatment modality for youth experiencing a range of emotional and behavioral difficulties and diagnoses (Russell, 2003) and is part of the larger field of adventure therapy, which focuses on the intentional use of adventure activities by licensed clinicians to promote clinical change (Gass, Gillis, & Russell, 2012). Clients who attend OBH programs typically live outside on expedition, in small groups of 8-10 participants, with two field guides who are responsible for the supervision of the group. Each week, the clinical teams for the program go out into the field for a couple of days and meet with participants for counseling sessions. For adolescent clients, weekly family sessions are conducted either on the phone or online through a video conference, and typically the family travels at least once during the program to attend a face-to-face family session with the clinician and the youth (Tucker, Widmer, Faddis, Randolph, & Gass, 2016). Parents often send youth to OBH as their last option when traditional therapeutic options in the community have failed (Tucker, Bettman, Norton, & Comart, 2015).

Research has shown that youth who participate in OBH report significant improvements post-treatment (Bettmann, Gillis, Speelman, Parry & Case, 2016), changes which last six to twelve months post-treatment (DeMille et al., 2018; Tucker et al., 2018). Despite the growing research supporting the effectiveness of OBH, very little discussion in OBH has focused on gender and none have discussed transgender considerations (Karoff, Tucker, Norton, Gass & Foerster, 2019; Rothblum, Cole & Tallman, 2014). However, gender has been a topic of concern in outdoor education and adventure therapy, as women have historically been underrepresented (Mitten, Gray, Allen-Craig, Loeffler, & Carpenter, 2018; Warren, 2005). Warren, Roberts, Bruenig, and Alvarez (2014) highlight the need for outdoor adventure programs to critically evaluate the ways they perpetuate systemic oppression and to incorporate training and research that addresses specific steps toward more socially just programming. As OBH works to emphasize inclusivity and diversity, specific attention must be paid to the voices and experiences of transgender individuals who participate in OBH programs.

BEST PRACTICES WITH TRANSGENDER CLIENTS

Trans-Affirming Therapy

Since no literature has specifically looked at considerations for transgender youth in OBH, research from the larger mental health field must be used to guide this discussion. There is an existing framework for addressing the unique challenges this population faces, as well as recommendations for providers geared toward facilitating trans-affirming therapy. Themes in the literature include the need for all forms of gender identity and exploration to be affirmed rather than pathologized (Bess & Stabb, 2009; Burnes et al., 2010; Carroll, Gilroy, & Ryan, 2002; Collazo, Austin, & Craig, 2013; Holman & Goldberg, 2006; Katz-Wise et al., 2017). It is important for mental health providers to examine biases and acknowledge the oppression and stigma that affect the experiences of transgender individuals in mental treatment (Ansara & Hegarty, 2012; Benson, 2013; Burnes et al., 2010; Carroll et al., 2002; Collazo et al., 2013; Willging, Salvador, & Kano, 2006). Furthermore, it is important for mental health professionals to possess knowledge of transgender issues so they may adequately offer information and resources to clients (Benson, 2013; Bess & Stabb, 2009; Burnes et al., 2010; Carroll et al., 2002; Hellman & Klein, 2004; Lev, 2004).

There is a great need for therapy that is trans-affirming, rather than simply tolerant of or indifferent to individuals who identify as transgender (Hope et al., 2016). In several studies that included perspectives of transgender clients, researchers concluded that it is essential for the clinician to possess prior knowledge of transgender risk and protective factors, current language, options for different approaches to transition and their associated pros and cons, and resources for additional support (Benson, 2013; Bess & Stabb, 2009; Collazo et al., 2013). Too often, transgender clients are in a position of having to educate their clinicians who often have little to no knowledge of relevant issues (Hope et al., 2016). Collazo et al. (2013) highlight the need for clinical professionals to seek training and collect resources to be able to offer clients useful information and psychoeducation. Staff training is equally important (Hellman & Klein, 2004). Holman and Goldberg (2006) emphasize the ethical responsibility of mental health professionals to proactively seek knowledge of the most up-to-date considerations for this population and to be prepared to disperse relevant resources to clients. Additionally, possessing knowledge of and being able to educate clients on the history of the transgender community can be a way for clinicians to facilitate identity development and affirmation for transgender clients who have previously felt isolated and unseen (Carroll et al., 2002).

BEST PRACTICES WITH TRANSGENDER CLIENTS

In addition to possessing relevant knowledge, mental health professionals are also ethically obligated to examine the ways in which personal and institutional biases affect their work with clients with clients who identify as transgender (Benson, 2013; Hope et al., 2016). It is essential that clinicians acknowledge and work to prevent assumptions based on society's dominant narratives related to gender identity, such as the prevalent need to fit into a gender classification that is rooted in a binary, rather than expansive, perception (Bess & Stabb, 2009). The American Counseling Association's set of competencies for working with transgender clients includes an emphasis on recognizing bias and advocating actively, challenging stereotypes, and engaging in critical discussions within the field of mental health to routinely examine the ethics and best practices for working with transgender people (Burnes et al., 2010). Trans-affirming therapy must extend beyond the clinician's office and include advocacy in the broader community; clinicians must address their own internally held biases and work to change discriminatory practices in their workplaces and communities (Willging et al., 2006).

Trans-affirming therapy involves encouraging clients to explore gender identity by facilitating a safe and nurturing therapy environment in which all forms of gender identity and expression are welcomed (Hope et al., 2016). Clinicians are encouraged to shift away from the gatekeeper role and toward the role of supportive advocate (Collazo et al., 2013). Bess and Stabb (2009) emphasize the importance of therapy that focuses on facilitating wholeness and integration rather than on attempting to eliminate some pathological problem.

For adolescents, it is important to create a therapy environment where positive development of competence, confidence, and social connection are the focus of treatment (Holman & Goldberg, 2006). Because transgender youth are often in a more fluid position of questioning their gender identity, it is recommended that clinicians encourage exploration with a variety of forms of expression, terminology, and disclosure (Holman & Goldberg, 2006). Clinicians should avoid thinking in absolutes and putting pressure on clients to choose one binary gender or come out publicly before having adequate time to explore, weigh the pros and cons, and gather information (Katz-Wise et al., 2017). Understanding how best to support these youth is imperative in mental health treatment.

Implications for Practice in OBH with Transgender Clients

Based on these recommendations, it seems clear that clients who identify as transgender in OBH can benefit from having the opportunity to work with clinicians who are educated in relevant issues and who can help them navigate

and explore their emerging identities (Hope et al., 2016). It is essential for providers to be attuned to trans-specific considerations in OBH, such as the need for flexibility in policies related to dividing participants into single-gender groups (Hope et al., 2016) preferred pronouns and logistics that may need attention due to the biological needs of the clients. Living, eating and traveling together in the wilderness provide opportunities for youth to gain a better awareness of themselves, gain meaningful connections with peers, and improve their own relationships with themselves; however, for transgender clients, there is also the risk of further stigma if client voice is not supported and the group environment is not safe from oppression and bullying. Hence, the following recommendations are offered for any mental health provider who wants to follow best practices when working with clients who identify as transgender in OBH programs:

1. Promote client self-determination (Gass et al., 2012). This includes avoiding assumptions about clients' identities and welcoming all forms of gender identity and expression (Holman & Goldberg, 2006). Consulting with clients about group placement when groups are divided by gender can be an essential factor in helping clients find a sense of belonging in OBH programs.
2. Maintain knowledge of gender identity variations, experiences, and different options for transition (Benson, 2013; Bess & Stabb, 2009; Collazo et al., 2013). Possessing this knowledge will reduce the incidence of putting clients in the position of having to educate the program staff.
3. Maintain knowledge of risk and protective factors specific to transgender youth and young adults and focus on group norms that promote and protect youth who identify as transgender.
4. Promote parental involvement (parental education programs, educate on how essential parental support is, parent support groups) (Travers et al., 2012); however, do not assume that transgender youth are receiving supports at home. Indeed, research shows that parental responses at home could be the root cause of many adverse health and well-being outcomes (Travers et al., 2012).
5. In working with the transgender population, it is crucial to collaborate with multidisciplinary teams so that youth have access to appropriate integrated care and feel affirmed in their search for potential medical interventions.
6. Foster program-wide awareness of bias and institutionalized oppression and how those biases affect treatment (Hope et al., 2016; Willging et al., 2006). Use destigmatizing language in all paperwork and interactions,

including using clients' preferred names and pronouns and allowing a broad range of options for gender identity (Hope et al., 2016).

7. Build and maintain knowledge of local, state, and federal laws affecting transgender individuals, and be aware of trans-affirming resources and trans-affirming employers with non-discrimination policies (Hope et al., 2016). In OBH, trans-affirming resources will likely include options for aftercare for youth who leave OBH and go to another program afterwards.
8. When possible, support the transgender community through advocacy and attendance at relevant community events (Hope et al., 2016). In OBH, this form of support may allow programs to maintain up-to-date knowledge of local and national issues affecting the transgender community and to have greater visibility as proponents of social justice.
9. OBH providers should co-create action steps with youth returning to their normal settings following OBH, as well as provide community resources to assist transgender youth and their families, especially including suicide crisis lines (Johnson et al., 2014). Trans-inclusive youth programs that provide trans youth with a safe and confidential space to access professional and peer supports are crucial in helping to decrease feelings of depression and the despair that precedes suicidal ideation and attempts. (Travers et al., 2012).
10. There is a potential for higher burnout and turnover when staff are asked to deal with more challenges (Marchand, 2008). Supervisors must be attuned to staff well-being and support staff through training, emotional support, and time-off.

Highlighting the Client's Voice: Dylan's Story

To highlight how OBH programs can engage in trans-affirming practices, one client's treatment experience is described. As with any marginalized group, the importance of client voice is key to understanding their perspectives, educating others about their experience and is the basis for good clinical treatment (Cooper, Norcross, Raymond-Barker, & Hogan, 2019).

The Institutional Review Board for Human Subjects approval from the authors' institution was given in order to conduct this interview and a pseudonym was used to protect the client's confidentiality. We chose to highlight one client's experience in an OBH program to begin to create space for client voice and increase the presence of feedback-informed treatment (FIT) in OBH. Though FIT is usually considered an approach that uses a client's feedback to inform their

individual treatment, this client's testimony may provide feedback that can inform the larger field of OBH (Tartakovsky, 2018).

Dylan is a 17-year-old individual who identifies as "not way on the masculine side but very much in the masculine zone of the spectrum". He describes his gender identity as having evolved over time, and he has become more non-binary since he enrolled in an OBH program. Overall, Dylan's wilderness experience was a positive and affirming one where he experienced a sense of belonging. He attributed much of his success in the program to being accepted for who he was. In his words:

> Being put into a boys' group was I think singlehandedly the best thing wilderness did for me … I'm still alive because of wilderness … I would not have survived this long without having been in a boys' group and having felt that, you know, in that group, no one had to question me. No one had to be like, 'oh are you a boy or are you a girl', it was just, everyone in the group was a boy, and it was, beyond words.

Dylan was referred to OBH treatment after experiencing depression, suicidal ideation, self-harming behaviors, and symptoms of Post-Traumatic Stress Disorder. He described his relationships with his parents as being distant and conflictual prior to his wilderness experience. Although being transgender played a role in his therapy sessions in the OBH program, Dylan's reasons for being in treatment were unrelated to his gender identity: "Going to wilderness had nothing to do with me being trans … someone with brown hair doesn't go to wilderness because they have brown hair. That's just also something that's a part of them".

Dylan described his treatment with an OBH clinician as being more beneficial than previous experiences of therapy: "He accepted me for who I am, and he didn't try to dictate that. He didn't try to tell me what to feel or who to be … he was the first therapist I've really opened up to". When asked how his clinician created a trans-affirming environment, Dylan stated, "It's not specifically that he was … doing anything to create a trans-affirming environment. He was just creating a people-affirming environment … he was really nice, and he never questioned me". Similarly, Dylan described the field staff as providing a safe environment for all participants by facilitating respectful conversations and being sure to step in whenever the conversation in the group looked like it might be heading in the direction of targeting specific individuals or groups:

> They used the right pronouns … there was never in my 99 days … no one said any trans insults … No one said anything to make me feel like I

> didn't belong there, or like I didn't belong on this Earth, um, which, you know, a lot of people outside of wilderness say stuff like that, and so, in the entire three months that I was there, I didn't get a single, you know, insult or anything like that.

He summed up his experience of this affirming environment with a powerful comment: "My group was probably the safest place I've ever been".

Dylan offered a few specific recommendations for OBH programs to follow in promoting the well-being of transgender clients. He stressed the importance of letting clients have a voice in the decision about which group they should join upon admission to the program. Dylan also suggested that programs incorporate policies that allow for greater fluidity in gender identity and expression, either by allowing clients to switch groups if they start to feel that they would be more comfortable in the other gender group, or by shifting the structure to include non-binary groups as an option for clients who would experience a greater sense of belonging and acceptance in a group that would not require them to identify as male or female.

Dylan also stressed the importance of a program's ability to promote acceptance and awareness. When Dylan's parents were choosing which program to send him to, they chose the program that would allow him to be in the boys' group. Unfortunately, they were not given the same option when it came to applying for aftercare in a therapeutic boarding school. Dylan reported that of all the schools his parents applied to while he was getting ready to transition out of the wilderness, none would accept him because he was transgender. After being in the safe and affirming environment of the OBH program, Dylan stated that he would have been devastated to be treated as a girl in a boarding school: "Therapy's not going to help you if it's constantly telling you that you aren't real, that you aren't valid".

> To promote acceptance and trans-affirming environments, Dylan encouraged educating the staff, and not just, you know, if you have a trans kid in one group, don't just educate the staff when they go to that group. Educate all the staff. Because you never know if you have a trans kid in one of the other groups and they just don't realize that that's what they're feeling.

Dylan reported that, while educating people about transgender issues is part of his life, it was not a major factor of his OBH experience. He attributed this disparity to his perception that the OBH program was already effectively educating its staff on relevant issues, thereby allowing Dylan to describe his

unique experience of being transgender, rather than having to be a token spokesperson for the whole transgender community.

In Dylan's experience, being affirmed in his gender identity was the most important part of his wilderness experience. In sharing his story, he continually stressed the huge role that acceptance and affirmation had on his ability to experience growth while enrolled in the program:

> I think wilderness, um, was one of the hardest things that I've ever done. But, I just imagine how much harder it would have been if I was in a girls' group. You know, I don't think it would have helped me then, because every day, I would have been waking up thinking about how I was in the wrong group. And I would have, I would have been devastated.

He further stated:

> [My program] accepted me as a trans person. It wasn't just [my clinician], it wasn't just a staff person, you know, the entire thing accepted me as a trans person, and that, was like, this entire company saying yes you are a real person and you should be here even if there are people saying that you shouldn't. And it was just life-changing.

Conclusion

Dylan's experience highlights the need for OBH programs to critically evaluate their policies affecting clients who identify as transgender. In his perspective, he was fortunate to be able to attend a program that had already put effort toward considering and accommodating the unique needs of transgender participants; however, not all programs are practicing at the same level of ethical standards. As ethical standards for trans-affirming mental health treatment continue to evolve, it will be important for OBH programs to adopt, maintain, and stay current regarding recommended best practices.

Likewise, Dylan's experience highlights the need for OBH programs to focus on inclusion and acceptance as important therapeutic variables. Inclusion and acceptance are important for all clients in therapeutic settings but are especially true for youth who identify as transgender. If transgender youth can experience OBH as an accepting space, it may give them a reference point for what a positive peer community can look like. This may be the first time that youth who identify as transgender may have experienced this level of acceptance, which can create a context of hope for these courageous young people. Wagaman et al.'s (2019) research affirms this, stating that "connection to a trans-affirming

community has been most commonly identified as a protective factor and a resilience strategy for TGE (transgender and gender expansive) youth" (p. 47). The implications of feeling connected to an accepting community can create a sense of belonging and enhance well-being for transgender youth (Wagaman et al., 2019).

Advocacy implications from this study include the importance of including transgender youth in the process of both research and program planning using participatory action research (Johnson et al., 2014). This type of research can bridge the gap between research and practice and provides a more comprehensive understanding of the challenges faced by transgender youth and may also raise important considerations for best practices with transgender clients in OBH (Gonzalez & McNulty, 2010).

More research on the topic of transgender clients in mental health treatment and specifically in OBH programs, is needed. This paper was limited in its scope, with only one client's perspective; however, given that transgender clients are participating in OBH programs, their voices need to be heard if OBH is to develop adequate, informed responses to their unique strengths and needs.

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Adolescents and Adults on the Autism Spectrum Enrolled in an Outdoor Behavioral Health Program: Outcomes from the Practice Research Network of the National Association of Therapeutic Schools and Programs

Denise K. Savidge, Ph.D.

Abstract

This study explored a data set of outcome scores on self-reported psychosocial functioning of adolescents and adults on the Autism Spectrum who were enrolled in 18 different outdoor behavioral health programs in the United States, all of which are members or cooperating programs of the National Association of Therapeutic Schools and Programs (NATSAP) Practice Research Network. Data suggest that the self-reported outcome scores for both adolescents and adults demonstrated statistically significant change after the intervention. However, when the data were examined for clinical significance, ASD-diagnosed adolescent paired scores had a 51% probability of membership in the Clinical Change Categories of "Unchanged" or "Deteriorated" as defined by the clinical cut-off score and the Reliable Change Index reported in the scoring manuals of the outcome questionnaires (Lambert, Kahler, Harmon, Burlingame, Shimokawa, & White, 2013; Wells, Burlingame & Rose, 2003) and derived by Jacobson and Truax (1991).

Keywords: Outdoor Behavioral Health, Wilderness Therapy, Autism, ASD, Young Adults, Adolescents, Outcomes, Outcome Questionnaire 45.2, Youth Outcome Questionnaire YOQ-SR, NATSAP.

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ADOLESCENTS AND ADULTS ON THE SPECTRUM

Autism Spectrum Disorder (ASD) has been the subject of much research, debate, and change since the 1940s when it was first identified. Outdoor Behavioral Health (OBH) also has been the subject of controversy and research while becoming a growing intervention in psychological and mental health. Of note, the percentage of enrollees diagnosed with ASD comprise more than double the percentage of individuals reported in the national average, based on a comparison of CDC data from 2018 to NATSAP PRN data from 2017. This suggests that Outdoor Behavioral Healthcare (OBH) is becoming an intervention of choice for referring professionals. Recent studies have gathered evidence demonstrating OBH as an effective intervention to improve self-concept, gain social skills, decrease substance abuse, alleviate depression, and improve general functioning for youth and their families (Behrens & Satterfield, 2011; Bettmann, Tucker, Behrens, & Vanderloo, 2017; Curtis, Briggs, & Behrens, 2018; DeMille et al., 2018; Gass, Gillis, & Russell, 2012; Harper, Russell, Cooley, & Cupples, 2007). In the first OBH study to include a Treatment As Usual (TAU) group for comparison, DeMille et al. (2018) found sustained positive effects for youth who attended the program versus those who did not when reported by their parents.

Likewise, research on how adolescents with ASD respond to interventions aimed at improving these same issues continues to accumulate (Butwicka et al., 2017; Jamison & Schuttler, 2017; Leaf et al., 2017). However, research on the intersection of ASD and OBH is sparse and studies are needed to determine if outdoor behavioral health enrollment is an appropriate, evidence-based practice for helping individuals learn to navigate life with ASD abilities and challenges.

Identifiers of ASD and Prevalence in the U.S.

The current definition of Autism spectrum disorders (ASDs) requires deficits in social interaction and social communication across multiple contexts in addition to restricted repetitive patterns of behavior, interests, or activities (American Psychiatric Association [APA], 2013). Physicians are directed to specify whether the ASD has "accompanying intellectual impairment," "accompanying language impairment," a "known medical or genetic condition or environmental factor," whether it is "associated with another neurodevelopmental, mental or behavioral disorder," or if catatonia is present (APA, 2013, p. 51).

There are currently three severity levels for ASD: "Requiring very substantial support" (Level 3), "Requiring substantial support" (Level 2), or "Requiring support" (Level 1) (APA, 2013, p. 52). Autism spectrum disorder with its three levels encompasses autism, Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive development disorder not otherwise

specified, all of which had separate diagnostic criteria in the DSM-IV-TR (APA, 2000). Editors added social (pragmatic) communication disorder (SCD), a separate condition involving persistent difficulties in the social uses of verbal and nonverbal communication, which does not require the restricted and repetitive behaviors criteria of the DSM-5 (APA, 2013, p. 47).

According to researchers at the Center for Disease Control, current estimates of ASD diagnosis are 16.8 per 1000 children, or 1 in every 59 children using data reported by 11 Autism and Developmental Disabilities Monitoring (ADDM) sites in 2014 (CDC, 2018). Autism diagnosis criteria have undergone two revisions since 2000 when ADDM data collection began, including a text revision in 2000 which completely rewrote the criteria for Asperger's and Pervasive Developmental Disorder Not Otherwise Specified that had been outlined in the 1994 version (APA, 1994; APA, 2000; First & Pincus, 2002).

Studies on ASD and Co-Occurring Diagnoses

ASD is classified as a neurodevelopmental disorder in the *Diagnostic and Statistical Manual Fifth Edition* (2013) and individuals rarely are diagnosed with this disorder alone. Seventy percent of ASD participants in a 2008 study had at least one comorbid disorder and 41% had two or more (Simonoff et al., 2008). ADDM network statisticians reported in 2016 that the co-occurrence of one or more non-ASD developmental diagnoses was 83%. The co-occurrence of one or more psychiatric diagnoses was 10% (ADDM network, 2016). Most common co-diagnoses were attention deficit-hyperactivity disorder (ADHD), social anxiety (Ghaziuddin, 2002), and oppositional defiant disorder (Orinstein et al., 2015). Leitner (2014) found the prevalence of ADHD in children with ASD is between 37% and 85%. Simonoff et al. (2008) found one of the more common diagnoses was social anxiety disorder (29.2%).

Researchers found that many individuals with autism fall within the mentally retarded range when taking developmentally appropriate standardized tests (Rutter, Bailey, Bolton, & Le Couter, 1994). However, they also found that about 44% of children with ASD had average or above average intellectual ability (Christensen et al., 2012).

Of concern, anxiety disorder can intensify the social impairment that is one of the rule-in factors of ASD (White, Oswald, Ollendick, & Scahill, 2009). A common assumption has been that individuals with ASD prefer little social contact and sometimes complete isolation, however, many of those diagnosed are aware of their occasionally awkward social skills and seem to wish it could be

different (Attwood, 2000; Myles, Barnhill, Hagiwara, Griswold, & Simpson, 2001); overall, the researchers concluded the social anxiety those with ASD felt promoted further isolation.

Co-morbid diagnoses for ASD are similar worldwide. The most commonly occurring diagnoses found among ten to 14-year-old adolescents in the UK with ASD were social anxiety disorder, (29.2%) attention-deficit/hyperactivity disorder (28.2%), and oppositional defiant disorder (28.1%) (Simonoff et al., 2008). Additionally, adolescents with ASD were often isolated, bullied, or excluded due to their inability to perceive and act upon social cues given by others in their peer groups (Blake, Lund, Zhou, Kwok, & Benz, 2012).

Having autism also increases the risk for other physical problems such as seizure disorders. Covariance rates reported in research range a great deal, from 8.6% to 25%, of individuals with autism developing a seizure disorder or epilepsy (Rutter, 1970; Volkmar & Nelson, 1990; Thomas, Hovinga, Rai, & Lee, 2017). Those with ASD have also been found to have increased issues with gastro-intestinal and mucosal pathology (Chaidez, Hansen, & Hertz-Picciotto, 2014; Gorrindo et al., 2012; Hsiao, 2014).

Researchers calculate that ASD diagnosed individuals have an estimated annual cost of healthcare, childcare, and special education of $17,000 per year, of which $8,610 is allocated to elevated education costs (Lavelle et al., 2014). Researchers also found that ASD youth 12- to 21-years-old accessed emergency department services four times as often as non-ASD youth, affecting public safety costs for communities (Liu, Pearl, Kong, Leslie, & Murray, 2017). Among 130,000 participants, Swedish researchers found an almost doubled risk for substance abuse and related problems, further elevating lifetime healthcare costs (Butwicka et al, 2017).

As well, Croen, Najjar, and Ray (2006) found children without ASD are six times more likely to be psychiatrically hospitalized than children without ASD. McGuire et al. (2015) noted this was of particular concern given the limited number of specialized psychiatric units for children and adolescents in general, but with staff trained in ASD in particular. They concluded the deficit resulted in many adolescents with ASD having to be admitted to general child and adolescent psychiatric units in which the treatment approach and therapeutic milieu could be poorly suited to children with ASD (McGuire et al., 2015).

ADOLESCENTS AND ADULTS ON THE SPECTRUM

Self Harm and Suicidal Thoughts in Those with ASD

Social skills deficits are an impairment evident at all levels of the autism spectrum and are targeted skills that can improve in both individual therapy (Koegel & Frea, 1993; Koegel, Koegel, Hurley, and Frea, 1992) and group therapy (Kalyva & Avramidis, 2005; Frederickson & Turner, 2003; both of which are essential components of OBH. However, research has found transferring the skills from a formalized intervention to a more natural environment can prove problematic for ASD children (Barry et al., 2003; Ozonoff & Miller, 1995; Rogers, 2000).

Numerous studies confirm a high incidence of co-occurring depression in individuals with ASD; specifically, De-la-Iglesia and Olivar (2015) found that in high-functioning ASD individuals, "The factors that present the greatest specific risk are higher cognitive functioning, self-awareness of deficit, capacity for introspection, stressful life events, adolescence, quality of social relationships, and alexithymia" (para. 1). With more prevalence of anxiety, social skill deficits, depression, and ADHD, it is not surprising that co-occurrences of self-harming behavior, self-injurious behavior, attempted suicides, and completed suicides are higher in those diagnosed with ASD than with peers developing in a neuro-typical manner. A 2016 study with 8,065 participants found that 28% of 8-year-olds with ASD had evidence of self-injurious behaviors (Soke et al., 2016). French researchers Huguet, Contejean and Doyen (2015) found 21.3% of their study's participants with ASD reported suicidal ideation, had attempted suicide, or died by suicide.

Studies Examining OBH Outcomes

Early studies within the NATSAP Practice Research Network (PRN), which is maintained in partnership with the University of New Hampshire, measured anxiety/depression, withdrawal/depression, somatic complaints, social problems, thought problems, attention problems, rule breaking behaviors, and aggressive behaviors. Russell (2002) reported reductions of behavioral and emotional symptoms using the Youth Outcome Questionnaire (YOQ; Wells, Burlingame, & Lambert, 1999) parent and self-reports as a measurement tool. In a follow-up study on the same sample of youth conducted two years later, Russell (2005) found the participants had maintained therapeutic progress. Additional research, focused on longevity of treatment, indicated that declines in youth problems from admission to discharge were maintained up to a year post-discharge from a residential treatment program (Behrens & Satterfield, 2011).

Several studies that measured changes in suicidal ideation, anxiety, substance abuse, social conflict, sleep disruption, depression, violence, impulsivity, hostility, and defiance were conducted in a coordinated program evaluation of wilderness programs and those researchers confirmed Russell's findings of statistically significant positive changes in both the initial and follow-up measures (Lewis et al., 2007; Rogers et al., 2007[a]; Rogers et al., 2007[b]).

Norton (2010) studied individuals who participated in a therapeutic wilderness experience and their outcomes related to depression and psychosocial development. Her findings indicated that after participation in a 28-day canoeing trip, scores of depression were reduced at statistically and clinically significant levels. More recent studies finding positive change for adult and adolescent participants in OBH will be discussed and used as comparative studies following the results section.

Studies in OBH find mixed results when controlling for certain variables. Magle-Haberek, Tucker, and Gass (2012) found no significant correlation between length of stay, program type, and decreased (improved) outcome scores. However, a second study focusing on both OBH and residential treatment centers found gender, intake functioning, and length of time engaging in adventure therapy in groups were significant predictors of improved scores (Tucker, Smith, & Gass, 2014).

Studies on ASD Participants Undergoing Outdoor-Based Interventions

While the intersection of OBH and ASD specifically has not been explored, the literature base is growing with examples of natural setting and summer camp interventions that have proven effective for teaching social skills to ASD individuals (Apel, 2007; Brookman-Frazee et al., 2003; Hung & Thelander, 1978; Walker, Barry, & Bader, 2010). The interventions in these examples were as short as four days and as long as six weeks. However, many of these studies listed limitations that prevent broad generalization of findings, such as small numbers of participants.

Vice-Reshel (2017) found the integration of Pivotal Response Therapy and Nature Therapy, which she termed Integrated Nature Therapy, resulted in three participating ASD children showing an increase in desire to play outdoors, a decrease of maladaptive behaviors, and an increase in self-management skills. However, Vice-Reshel noted that there was a reoccurrence of behaviors once the Integrated Nature Therapy interventions ended.

Schreiber implemented the Social Skills Improvement Scales – Student Rating Scales (SSIS-SRS; Gresham & Elliott, 2008) to do pre- and post-test measurements for high functioning autism or Asperger-like syndrome diagnosed adolescents who participated in a four-day adventure therapy (Schreiber, 2009). She found increased perceptions of self-efficacy and social competency among 14- to 18-year-old males.

Wenninger (2012) explored the effectiveness of an eight-week, summer day camp for 7- to 9-year-old students diagnosed with ASD using applied behavioral analysis to decrease maladaptive behaviors and increase prosocial behaviors of the participants. Wenninger found all of the students had decreased target behaviors and increased replacement behaviors, with 65% demonstrating moderate change in the intended direction following the eight-week intervention (Wenninger, 2012).

In Snell's (2012) study of 43 ASD individuals between ages five and 18, the participants were observed for the effects of a summer therapeutic activities program designed to teach social skills using cognitive behavior therapy and targeting social awareness, motivation, communication, and cognition. Following the 30-day intervention, Snell used the Social Responsiveness Scale (SRS) to measure results and found clinically significant gains, however generalization and maintenance of the gains were not apparent in her 10-month follow-up report.

The summer camp studies included several more short-term interventions with moderate rates of success. Hung and Thelander (1978) conducted a three-week study on 18 children, nine of whom were nonverbal. They found 79% of them showed 15% improvement in the targeted social behaviors. Walker et al. (2010) concluded their study provided preliminary evidence of the positive role summer camps may play in building social skills for children age three to seven with ASD.

Research Questions Under Study

The present study was undertaken to add to the growing body of research focusing on Outdoor Behavioral Health (OBH) programs as an option for adolescents and young adults diagnosed with Autism Spectrum Disorder (ASD) using outcome scores of participants in 18 OBH programs. The research questions for this study were:

1. Is there statistically and clinically significant change in outcome scores for adolescent and young adult clients with ASD attending an OBH program?
2. Are those change scores comparable to those reported for a generalized, nonspecific sample?

Method

The data for this study were obtained from the National Association of Therapeutic Schools and Programs (NATSAP) Practice Research Network (PRN). The PRN is maintained in partnership with the University of New Hampshire (Young & Gass, 2008). Clemson University's Institutional Review Board approved this study. The NATSAP PRN is a research initiative in which participating programs, including residential treatment centers, therapeutic boarding schools, transition programs, and outdoor behavioral health programs, track client data at intake, discharge, and post-discharge up to one year. The data for this study were obtained from clients at 18 OBH programs who were enrolled between January 2009 and January 2018. In addition to the YOQ® and OQ® measurement instruments, other data were collected through NATSAP PRN background questionnaires completed by program staff and clients.

The data were aggregated into young adult (18 years of age or more) or adolescent (under age 18) for analysis. Network data on ASD clients were winnowed to include only data from outdoor behavioral health programs and only those with paired intake and discharge tests. Data from admission and discharge outcome scores then underwent paired *t*-tests to determine change in scores that occurred following the intervention. Finally, scores were categorized into Clinical Change Categories that indicated clinical significance.

Measures

The OQ-45.2 (Lambert & Burlingame, 1996) is used for adults entering a PRN wilderness program. The 45-item Outcome Questionnaire is filled out at intake and again at discharge by the client and is a valid and reliable measure of adult psychosocial functioning (Beckstead et al., 2003). The Outcome Questionnaire includes subscale measurements for Symptom Distress, Interpersonal Relations, and Social Role. Clinically significant scores indicate that a patient's individual functioning changes meaningfully following a psychosocial or medical intervention. It is considered a valid and reliable measurement in research due to its ability to classify each individual patient's status with regard to

normative functioning as opposed to group averages or between-group comparisons (Lambert et al., 2013). The range of scores for all three subscales is zero to +180 with 63 being the cutoff score indicating a problematic number of symptoms, interpersonal difficulties, and dissatisfaction with quality of life.

There are four critical items probing suicide, substance abuse, and violence that require a follow-up clinical interview for any answer other than zero (Lambert et al., 2013). While the three subscales also have clinical cut-off scores and reliable change indices (RCI), only the Total score change and RCI were used for this study. Beckstead et al. (2003) validated the cutoff scores by comparing concordance rates with cutoff scores based on other measures of psychotherapy outcome. These two criteria classify individuals as "Recovered," (i.e. passed both cutoff and RCI criteria), "Improved," (i.e. passed RCI criteria but not the cutoff), "Unchanged," (i.e. passed neither criteria), or "Deteriorated," (i.e. passed RCI criteria but towards a worsening direction) (Lambert et al., 2013, p. 34). These four classifications were used as nominal categories for analysis.

Table 1

Change Scores and Clinical Change Classification

Age	RCI	Cutoff Criteria	Clinical Change
Adults (18+ years old)	RCI ≤ -14	63 or below	Recovered
Adult	RCI ≤ -14	64 or above	Improved
Adult	RCI 0-13	64 or above	Unchanged
Adult	RCI ≥ +1 or more	64 or above	Deteriorated
Adolescent (≤17 years old)	RCI ≤ -18	46 or below	Recovered
Adolescent	RCI ≤ -18	47 or above	Improved
Adolescent	RCI 0-17	47 or above	Unchanged
Adolescent	RCI ≥ +1 or more	47 or above	Deteriorated

The YOQ-2.0-SR (Lambert & Burlingame, 2005) is a 64-item self-report completed by clients age 12-18 who are receiving mental health treatment and has been established as a valid and reliable measure of adolescent psychosocial functioning (Ridge, Warren, Burlingame & Tumblin, 2009).

It measures treatment progress for children and adolescents receiving a mental health intervention to track change in functioning. TheY-OQ-2.0-SR measures interpersonal distress, somatic, interpersonal relationships, social problems, behavioral dysfunction, and critical items. The range of scores for all subscales is -16 to +240 and high scores represent a more clinically distressed client (Burlingame et al., 2005). Jacobsen and Truax's cutoff score formula and RCI apply to this test as well, and the cutoff score is 47.

As with the adult questionnaire, only the Total score change was analyzed. Although not addressed in the YOQ-2.0-SR Scoring manual, Jacobson and Truax's (1991) score classifications of Recovered, Improved, Unchanged, and Deteriorated were verified as applicable to this questionnaire as well (C. Bowers, personal communication, March 28, 2018). Table 1 summarizes the RCI and cutoff scores needed for clinical change categories.

NATSAP PRN Adolescent, Adult, and Staff Questionnaires.

The NATSAP PRN Questionnaires were used to collect client demographic data from staff members and the clients themselves who were enrolled in 18 OBH programs across the United States. The data were collected by staff on the Staff Questionnaire Intake and Discharge (SQ-I and SQ-D), the Adult Questionnaire Intake and Discharge (Adult-I and Adult-D), and the Adolescent Questionnaire Intake and Discharge (AQ-I and AQ-D).

Sample.

The participants with paired admission and discharge scores included 139 adolescents and 64 adults, all of whom had a diagnosis of autism, autism spectrum disorder, or Asperger's disorder, dependent upon the *DSM* version used at intake. If pervasive developmental disorder – not otherwise specified was the only reason for referral indicated, the client was eliminated from the study due to the diagnostic and terminology changes implemented in publication of the DSM IV-TR and DSM 5.

The demographic breakdown of participants were 82.8% males for Adults, 87.5% males for Adolescents. Ethnicity was 85.7% Caucasian in total. Although some clients had post-discharge data available from six and/or 12 months after their discharge, only the intake (pre) score and discharge (post) score were used. Missing data points were left unknown; no effort was made to estimate possible values. Table 2 illustrates the demographic breakdown of participants.

Table 2

Demographic Data

Adolescent Sample	N	%	Adult Sample	N	%
Age (M=15.25; SD=1.56)	139		Age (*M*=20.51; *SD*=1.84)	64	
11	32	23.0%	18	16	25%
12	41	29.5%	19	13	20.3%
13	28	20.1%	20	14	21.9%
14	23	16.5%	21	6	9.4%
15	2	1.4%	22	7	10.9%
16	9	6.5%	23	5	7.8%
17	32	23.0%	24	2	3.1%
			25	1	1.6%
Gender			Gender		
Male	120	86.3%	Male	53	83%
Female	171	2.2%	Female	11	17%
Unspecified	2	1.4%			
Reasons for Referral (Totals will exceed 100% due to more than one reason indicated)			Reasons for Referral (Totals will exceed 100% due to more than one reason indicated)		
Alcohol/Substance Abuse	22	15.8%	Alcohol/Substance Abuse	11	17.2%
ADD/ADHD	39	28.1%	ADD/ADHD	12	18.8%
Anxiety	54	38.8%	Anxiety	28	43.8%
Autism Spectrum Disorder	139	100%	Autism Spectrum Disorder	64	100%
Depression/Mood Disorder	61	43.9%	Depression/Mood Disorder	29	45.3%
Learning Disability	12	8.6%	Learning Disability	6	9.4%
Oppositional Defiance/Conduct Issues	28	20.1%	Oppositional Defiance/Conduct Issues	4	6.3%
PTSD	5	3.6%	PTSD	2	3.1%
3 or More Diagnoses			3 or More Diagnoses		
Yes	93	66.9%	Yes	25	39.1%
No	45	32.4%	No	35	54.7%
Unknown	1	0.7%	Unknown	4	6.3%
Birth Order			Birth Order		
First	55	43.0%	First	23	25.9%
Second	55	43.0%	Second	20	31.3%
Third	13	10.1%	Third	9	14.1%
Fourth	4	3.1%	Fourth	1	1.6%
Fifth	1	0.0%	Fifth	2	3.1%
Missing	11	7.9%	Sixth	1	1.6%
			Missing	8	12.5%

Ethnicity			Ethnicity		
African-American	1	0.1%	African-American	0	0.0%
Asian-American	3	3.5%	Asian-American	4	6.3%
Hispanic	4	2.8%	Hispanic	1	1.6%
Native American	0	0.0%	Native American	0	0.0%
Caucasian	119	85.6%	Caucasian	55	85.9%
Other	3	2.1%	Other	3	4.7%
Missing Data	7	5.0%	Missing Data	1	1.6%

Note. * Although ODD/Conduct was listed as a reason for referral on NATSAP's adult questionnaire, the *DSM-5* further defines adult behaviors regarding conduct and personality with diagnoses such as Antisocial Personality Disorder and Borderline Personality Disorder, among others. It is assumed adult individuals with these diagnoses could be included here.

Results

Paired *t*-test of Adult Outcome Scores

The average decrease in outcome scores for young adults with ASD attending an OBH (M=-23.6, SD=21.5) was found statistically significant; $t(63) = -8.81$, $p<.0001$, $d=.91$. Mean Total Scores (M=48.41, SD=26.34) were below the cutoff score of 63. Since the Reliable Change Index (RCI) identifies whether the magnitude of change is clinically significant and statistical significance does not always equate to clinical significance (Jacobson & Truax, 1991), the probability of membership in each category is shown in Table 3.

Table 3

Adult ASD Participants' Probability of Membership in Clinical Change Categories

Age	RCI	Cut-off Criteria	Clinical Change Category	Probability of Membership
Adults (18+ years old)	RCI ≤ -14	63 or below	Recovered	0.59
Adult	RCI ≤ -14	64 or above	Improved	0.08
Adult	RCI 0-13	64 or above	Unchanged	0.20
Adult	RCI ≥ +1 or more	64 or above	Deteriorated	0.13

The RCI requirement to be considered "Recovered," was a total score of 63 or less and a paired *t*-test score of negative 14 or less. The terms "Recovered" and others discussed herein relate only to the variables measure by the YOQ, not the symptoms of ASD. An "Improved" rating indicated a total score decreased by at least 14 points but remain at 64 or above. Those in the "Unchanged" category had score changes between zero and negative 13. Finally, those in the "Deterioration" category had scores that increased, indicating an increase in symptomology from intake to discharge (Jacobson & Truax, 1991).

The ASD adult participants in this study had a 67% probability of scores showing positive movement on the scale, a 20% probability of no change, and 13% probability of deteriorated scores.

Paired *t*-tests of Adolescent Outcome Scores

The average decrease in outcome scores for adolescents with ASD attending an OBH (M=-15.8, SD=32.07) was found statistically significant; $t(138)$=-5.83, $p < .001$, d =.91). Mean Total Scores (M=44.77, SD=32.01) were below the cutoff score of 47.

The "Recovered" category required a total score of 46 or less and a paired *t*-test score of negative 14 or less. An "Improved" rating indicated a total score lowered by at least 14 points but remaining at or above the cutoff of 47. Those in the "Unchanged" category had score changes between zero and negative 13. Finally, those in the "Deterioration" category had scores that increased, indicating an increase in symptomology from intake to discharge (Jacobson & Truax, 1991).

Table 4

Adolescent ASD Participants' Probability of Membership in Clinical Change Categories

Age	RCI[1]	Cutoff Criteria	Clinical Change Category	Probability of Membership
Adolescent (≤17 years old)	RCI ≤ -18	46 or below	Recovered	0.12
Adolescent	RCI ≤ -18	47 or above	Improved	0.37
Adolescent	RCI 0-17	47 or above	Unchanged	0.22
Adolescent	RCI ≥ +1 or more	47 or above	Deteriorated	0.29

The ASD adolescent clients in this study had a 49% probability of scores showing positive movement on the scale, a 22% probability of no change, and 29% probability of deteriorated scores. Table 4 illustrates the probability of membership in each clinical change category.

Mean scores of both groups demonstrate that adolescents and young adults with ASD benefit from participation in an outdoor behavioral health intervention. However, the mean for adolescents in both total scores and RCI scores, plus the 51% chance of membership in a category showing a lack of growth, suggest that further analysis is warranted to explore possible explanations or causes.

Table 5

Outcome Scores and Comparisons for ASD Clients Attending OBH Programs

	Mean Score	Cutoff Score	Mean RCI	RCI Score	Probability of Deterioration or No Change
Adults	48.41	63	-23.6	-14	0.33
Adolescents	44.70	46	-15.8	-18	0.51

Comparing Recent Studies on Adult OBH Participant Outcome Scores

Researchers within the NATSAP PRN membership have found significant statistical and clinical change for adults when using admission and discharge OQ-45.2 data. While not all the studies reported complete demographic information or standard deviation scores for exact comparison, each one used scores from a single program or multiple programs that were associated with the NATSAP PRN. Therefore, it was reasonable to assume they were comparable. Table 6 summarizes the findings of the previous studies on generalized samples of adolescents and young adults in OBH programs, which would include those with ASD as a primary or secondary reason for referral.

Curtis et al. (2018) reported positive trends in self-reported outcomes. Demographic comparisons between this study and the current study indicated the two samples were similarly comprised and that 3.7% of their sample indicated autism as the primary reason for referral. Primary reasons for referral in Curtis et al.'s study included alcohol/substance abuse (36%), anxiety (20.6%) and depression/mood disorder (25.7%). Because the participants in this study were in

OBH programs between 2009 and 2017, it is reasonable to assume all clients diagnosed with ASD, except those discharged between January 2018 and March 2018, were included in both studies.

The mean change of -34.37 from admit to discharge on the OQ-45.2 was statistically and clinically significant ($F_{1, 216}$=204.00, p<.001). This study also noted large standard deviation scores (SD=23.94 $_{\text{admit,}}$ 23 $_{\text{discharge}}$). While mean scores between Curtis et al.'s study and the current study were within three points, mean change in scores were more than 10 points apart.

A factor that may have affected a higher mean change in scores is that Curtis's study had twice the percentage of females as participants. That may have been a contributing factor given that researchers find prevalence of ASD around 1:4.5 in females versus males (ADDM, 2016). Previous studies have also found that females have a greater tendency to self-report higher ratings of dysfunction at intake than males, resulting in greater change at discharge (Magle-Haberek et al., 2012; Russell, 2003; Tucker, Javorski, Tracy, & Beale, 2013). Curtis et al.'s study was also performed on a multi-site sample, similar to the current study.

Bettmann et al. (2017) conducted a study on late adolescents' and young adults' outcomes whose most common diagnoses included depression (64.4%), substance abuse (63.7%) and anxiety (45.2%). Their focus was to study outcomes on mental health as well as attachment relationships and psychological individuation from parents. Similar to the current study, all Axis I reasons for referral were included, so totals are above 100%. Bettmann et al.'s (2017) study also found clinical and statistical significance on OQ-45.2 scores from intake to discharge; t(136)=10.74, p<.001, d=1.70. Bettmann et al.'s (2017) study also included almost double the number of female participants, although its mean change scores were closest to those found in the current study at an average of -24.3 mean change in score.

Hoag, Massey, Roberts, and Logan (2013) conducted a three-year, longitudinal study on young adult participants in OBH with similar age and gender demographics. Though primary reasons for referral and ethnicity were not stated, it is reasonable to assume they are similar since the choices of reasons for referral were the same on the intake questionnaires and the majority of OBH participants are Caucasian. Their findings indicated statistically and clinically significant change on the OQ45.2® from admit to discharge; t(147)=16.87; p<.001; d=1.36, though they also implemented multiple iterations to narrow the critical point of change. The mean change score in their study was -28.49, less than five points variance from that of the current study.

Table 6

Comparison of Adult ASD Client demographics and OQ-45.2 Scores to Previous Studies of OBH Client Outcome Scores

Author	Year published	Ethnicity	Age Mean (*SD*)	Gender	Mean Admit Score (*SD*)	Mean Discharge Score (*SD*)	Mean Change in Score (*SD*)
Curtis et al. *N*=217	2018	Caucasian 89%	20.39 (1.96)	*M*=65.9% *F*=34.1%	79.89 (23.95)	45.52 (23)	- 34.34 (*)
Bettmann et al. *N*=157	2017	Caucasian 94.8%	20.2 (2.3)	*M*=64.7% *F*=36.3%	79.5 (21.9)	57.2 (17.2)	- 24.3 (*)
Hoag et al. *N*=115	2013	*	20.2 (*)	*M*=73% *F*=27%	67.32 (21.6)	38.83 (20.2)	- 28.49 (*)
Roberts et al. *N*=186	2016	*	20.3 (2.59)	*M*=82.3% *F*=17.7%	71 ** (*)	≅ 42** (*)	≅ - 29** (*)
ASD *N*=64		Caucasian 85.9%	20.51 (1.84)	*M*=83.0% *F*=17.0%	72.04 (25.55)	48.41 (26.34)	- 23.6 (21.5)

Note. *Not Reported, ** Approximations retrieved from graph with five-point intervals.

Roberts, Stroud, Hoag, and Combs (2016) studied the constructs of age, gender, primary diagnosis, therapist assignment, and length of stay to determine their effect on wilderness outcomes. They found that reported outcome scores showed no significant variation in scores regardless of these variables. This was, however, a single-site study, and therapists were similarly trained, used the same resources, and had similar, extensive experience in the field. They did not report exact discharge scores, however a graph indicating mean scores within a five-

point range provided scores for visual comparison to scores in this study. Table 6 summarizes findings of the four studies in comparison to the current study with ASD-diagnosed participants. When comparing the mean discharge scores and mean changes in score, there is indication that adult ASD clients appear to have a similar experience as that of the generalized, samples. Although the mean change score of -23.6 in this study was the lowest of all five, the range of scores was less than 11 points – significantly smaller than those found within the adolescent studies.

Comparing Recent Studies on Adolescent OBH Participant Outcome Scores

Zelov, Tucker, and Javorski (2013) conducted a NATSAP PRN study of outcomes for adolescents attending OBH programs which utilized the YOQ-SR 2.0 as outcome measurement. The dataset was accumulated between December 2007 and May 2012 and resulted in clinically significant changes following treatment; $t(73) = 7.94$, $d=1.31$, $p<.001$. The relatively small number of participants was a factor of changing measurement tools from the YOQ 30-item questionnaire to the more comprehensive, 64-question YOQ-SR 2.0 in July 2011. Presenting issues of the entire database accumulated since 2007, including those with paired admit-discharge scores and those without, indicated 49.8% male clients, a mean age of 15.8 years ($SD=1.6$), and predominant presenting issues of depression and attention issues (24.4%), learning disabilities (15.9%) and anxiety (1.3%). Zelov et al.'s (2013) study showed mean change scores of nearly 20 points better than those of this study. An earlier study by Tucker, Zelov, and Young (2011) which utilized the YOQ-30, resulted in similar outcome trends ($M=40.0$, $SD=16.5_{admit}$; $M=23.4$, $SD=15.2_{discharge}$) and statistical significance ($F = 97$; $p < .001$).

One of the largest and earliest studies on adolescents in wilderness therapy (Russell, 2003) examined 523 youth enrolled between May 1, 2000 and December 1, 2000. Statistically significant change between YOQ-SR scores from intake to discharge was reported; $t(522) = 14.38$, $p< .0001$. This study did not use the YOQ-2.0-SR, but its predecessor, the YOQ-SR. Though Russell (2013) reported clinically significant change with mean change scores at -21.59, only 43% of participants in their self-reports and 46% of parent-reported scores were below the normal range functioning cutoff score of 47. Russell's (2013) reported scores were the closest to those of the participants in the current study.

Hoag, Combs, Roberts, and Logan (2006) studied 118 adolescents who completed at least five weeks of a wilderness program and analyzed intake and discharge scores by several demographic factors, including gender, parents'

marital status, previous treatment, and ethnicity. They found statistically significant differences in scores at discharge if parents were married; $t(79) = -2.23$, $p=0.29$, $d=-0.495$ and scores approaching statistical significance for gender, with females reporting scores 12 points higher than males; $t(78) = 1.76$, $p=.082$. Overall, the sample's reported intake ($M=58.9$, $SD=32.8$) and discharge ($M=20.7$, $SD=27.8$) scores demonstrated clients reporting significant clinical and statistical change; $t(79) = 11.75$; $p<.001$, $d=1.3$. Hoag et al.'s study reflected a gender pattern that has appeared in other studies (Magle-Haberek et al., 2012; Russell, 2003; Tucker et al., 2011) in which females scored themselves higher for dysfunction at intake and had a greater response to treatment than males. The mean change scores of Hoag's study were greater than 22 points more favorable than those in this study.

Table 7 summarizes adolescent demographic information, admission scores, and discharge scores of previous studies to compare whether outcomes reported by ASD participants enrolled in OBH are similar.

Table 7

Comparison of Adolescent ASD Client Demographics and YOQ-SR Scores to Previous Studies of OBH Clients

Group	Year Published	Primary Ethnicity	Age Mean (*SD*)	Gender	Mean Admit Score(*SD*)	Mean Discharge Score (*SD*)	Mean Change in Score (*SD*)
Zelov et al. *N*=74	2017	*	15.8 (1.6)	*M*=49.8% *F*= 50.2%	70.5 (38.6)	36.9 (32.3)	- 33.6 (*)
Russell *N*=523	2003	*	Reported 83% were age 15-19	*M*=64.7% *F*= 35.3%	70.53 (32.85)	48.95 (32.23)	- 21.59 (*)
Hoag et al. *N*=54	2016	*	15.9 (*)	*M*=69.5% *F*= 30.5%	58.9 (32.8)	20.7 (27.8)	- 38.2 (*)
ASD *N*=139	2018	Caucasian 85.6%	15.25 (1.56)	*M*=87.6% *F*= 12.4%	60.61 (32.28)	44.77 (32.01)	- 15.85 (32.07)

Note. * Not Reported.

Comparing the current study on ASD participants to previous studies of generalized samples of clients raises some concerns about the resulting mean change scores. The variance of 5.64 to 22.35 points between adolescent ASD scores and the other studies includes the -18 change score necessary to be considered a Reliable Change (Jacobson & Truax, 1991), however the mean change for adolescents with ASD is below the RCI. Using these descriptive statistics, it is evident the number of female participants in the ASD sample is half or less than those in the prior studies, which may have influenced change scores. However, comparing all the results suggests further research to determine which clients with ASD are best suited for inclusion in OBH programs is needed.

Discussion

Outdoor Behavioral Health research is gaining traction in reporting positive effects on individuals with a wide range of symptoms. This study is the first to explore adolescent and adult treatment outcomes for individuals with ASD using the data in the NATSAP PRN. It was an exploratory study and intended to open discussion on whether individuals with ASD are experiencing similar outcomes to neuro-typical individuals in wilderness settings when using the same outcome measurement tool. Past studies may have included the data of these individuals along with individuals not diagnosed with ASD, but this is the first to disaggregate their data for a focused study. While this study's research questions sought to answer whether ASD clients reported significant change following an OBH intervention, it also sought to answer how outcomes of clients with ASD would compare to those of generalized samples.

Results indicated that both adults and adolescents with ASD benefit from a wilderness intervention when measuring statistical significance. However, the mean scores of the adolescent group were close to both the cutoff score and reliable change index (RCI) that Jacobson and Truax (1991) calculated for significant clinical change, which is equally important, if not more so, in mental health research. This study found the Categories of Clinical Change indicating "positive" results (Recovered and Improved) compared to the categories that show "non-positive" results (Unchanged or Deteriorated), resulted in only 49% odds of adolescents reporting a positive outcome. These findings for adolescents are significantly lower than most previous studies on general, neuro-typical samples. Adults in the study had greater odds of reporting positive change; 67%, had membership in the Recovered or Improved category.

In a meta-analysis on treatment outcomes measured by the YOQ® and YOQ-SR®, Gillis et al. (2016) found that "treatment programs for youth using these instruments are indicating strong and positive effects from pre to post testing" (p. 851). The effect sizes for the self-report; *g*=.98, 95% *CI*s (.71, 1.26), were obtained from 11 studies, all using the SR version. Gender effects are prominent in many studies (Hoag et al., 2016; Magle-Haberek et al., 2012; Russell, 2003; Tucker et al., 2011) with females rating themselves higher in dysfunction at intake, resulting in greater change scores.

The current study prompts more questions than provides answers and the factors which may have contributed to the difference in scores for individuals with ASD are many. Students with ASD struggle with rigidity which may have influenced their ability to adapt to an outdoor environment or to being away from home. Their sensory issues may have been compounded by foreign noises present in the outdoors that often seem magnified in the dark. Rigid thinking may affect movement away from blaming their parents for the placement toward accountability for their own actions which brought them there. Communications issues with a community in which they likely knew no one prior to arrival might have impeded making connections vital to therapeutic benefits.

Additionally, research has demonstrated uneven cognitive development in individuals with ASD (Goldstein et al., 2008; Joseph, Tager-Flusberg, & Lord, 2002; Melling & Swinson, 2016) which may have negatively impacted either the treatment itself or comprehension of the questions asked on the outcome measures. An examination of the YOQ® measurement tool for its appropriateness in application to the ASD population is also warranted. The Administration and Scoring Manual for the YOQ-SR 2.0® acknowledges the cut-off scores recommended are based "on large, diverse samples." If special populations are being assessed, however, it may be more appropriate to construct new normative samples and compute new cut-off scores for that particular group (Wells et al., 2003, p. 6). Within the dataset used for this study, there was no indication that accommodations were made for the ASD participants while answering any of the outcome questionnaires, so the assumption is that none were given.

The differences in reported outcome results implies that, for adolescents in particular, further investigation of intervention technique variance between programs would be helpful. OBH programs are designed to address developing self-efficacy, making social connections, learning to adapt to change, exploring identity, improving executive functioning, increasing cause and effect awareness, and acquiring practical skills. A review of the interventions listed on the websites of the participating OBH programs indicated prominent use of "Established"

interventions identified in the 2015 National Standards Project review by the National Autism Center (NAC). Follow-up interviews might clarify details on implementation or illuminate additional interventions that might be made for an ASD client given the recommendations of the NAC.

Since OBH is typically a short-term intervention when compared to other residential care options, recommendations for OBH practice could include more frequent monitoring of ASD adolescent progress while in OBH, adjusting an individual's treatment plan to address the symptoms and behaviors that are not reported as decreasing mid-intervention, and ensuring comprehension of the questions that are asked on the outcome questionnaires to ensure reporting is adequately measured and maximized. Additionally, making appropriate recommendations for next steps after the intervention are critical to increase the odds of Recovered or Improved change beyond OBH for ASD individuals. Future research studies might seek to define which individuals with ASD would benefit from a longer term, residential intervention and which are more appropriate for the OBH intervention.

With the ASD enrollment in OBH programs reported most recently at 2.9% and 3.7% for adults and adolescents respectively (Curtis et al., 2018), significantly higher than the national percentage of 1.5 across the nation, it is clear parents are choosing OBH programs as an option for their adolescent or adult child with ASD. Whether that choice was made to alleviate adolescents' or young adults' anxiety, abate their depression or mood disorder, curb their substance abuse, redirect their oppositional behavior, or manage their ADD/ADHD co-diagnoses, reported outcomes that show positive, medium or large effects for the generalized population are not as well defined for the ASD individual. Opening a discussion on how to best serve this population and meet their specific therapeutic needs or, alternatively, examine how better to measure their symptom abatement, was the intention of this study.

This study can be further strengthened with more robust designs, including outcome measurements by individual programs and follow-up interviews with program leaders and staff members to identify the specific types of therapy used in each program. Further research would benefit from the inclusion of a measurement tool such as the Autism Spectrum Rating Scale ™, the Autism Behavior Checklist, Social Communication Questionnaire, or the Social Responsiveness Scale for more comparative data. Additionally, increasing the use of robust research methods such as TAU groups or disaggregating results for specific clientele would continue the momentum of significant research contributions validating OBH's benefits.

Assumptions and Limitations

This study has assumptions and limitations which must be acknowledged. There is an assumption of relative similarity in the approaches to OBH intervention between all 18 programs whose data were reported to the PRN. Additionally, it is assumed that staff members for each program were familiar with and used standardized criteria for rating client behaviors they observed. Participants were assumed to truthfully answer the self-reports used to measure change.

Limitations include the lack of information on which rating scale or other means were used to determine the ASD diagnosis of the individual prior to enrolling in the program as well as the level of severity within the diagnosis. Another limitation is the changed criteria itself from the 2000 to 2013 *DSM* editions. Not only is knowledge of the criteria necessary, but there are studies showing how the changed criteria directly affected numbers of those diagnosed as well as caused a small percentage of individuals to lose their diagnosis following the changes (Kim et al., 2014). A common challenge and limitation to field-based outcome research overall is the variety of direct care staff interactions, constantly evolving group dynamics, differing challenges of experiential experience, and teachable moments encountered by each individual in a wilderness experience (Roberts et al., 2016).

This study is limited by the lack of racial and ethnic representation. Predominately, participants were Caucasian and it is believed this is reflective of the larger population of adolescents and young adults in NATSAP programs because other studies have found in the body of research related to NATSAP programs (Behrens & Satterfield, 2011; Bettman et al., 2017; Russell, 2005; Tucker, Paul, Hobson, Karoff, & Gass, 2016). Additionally, the conflicting answers on the ethnicity question caused some participants to be labeled as "unknown" rather than their true ethnicity.

Missing paired *t*-tests for intake and outcome decreased the number of possible participants in the study, which is an additional limitation to the study. Although there were more than 1000 individuals with ASD found in the NATSAP dataset representing all options of residential treatment, only 203 had matched intake and outcome while enrolled in an OBH program.

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Building Wilderness Therapy Programs Through Evaluation and Targeted Improvement: Using Delphi, IPA, and DMAIC Methods

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Abstract

This paper describes techniques well suited for a multi-phase process of program evaluation and improvement in wildness program contexts. The Delphi method and Importance-Performance Analysis are introduced as effective methods for program evaluation. The Delphi method may be used initially to identify program outcomes and features stakeholders highly value. Once identified, Importance-Performance Analysis (IPA) facilitates measurement of the relative importance of service components and measures stakeholders' perception of performance in these areas. The results of the IPA may then be used to identify areas for quality improvement. The Define, Measure, Analyze, Improve, Control (DMAIC) process is described as a simple and effective way to implement quality improvement. In addition, a program-specific case study is provided to demonstrate how these methods may be implemented to achieve excellence. The potential benefits for therapeutic programs of engaging in the process are discussed.

Key Words: Importance-Performance Analysis, Delphi Technique, quality improvement, wilderness therapy, program evaluation, program improvement, Define, Measure, Analyze, Improve, Control (DMAIC)

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IMPORTANCE-PERFORMANCE ANALYSIS

Outcome research in wilderness therapy has received significant attention in the literature (Behrens & Satterfield, 2007; Gassner, Kahlid, & Russell, 2006; Russell, 2000; 2003). The focus is often on specific changes in client functioning in areas such as self-concept, locus of control, interpersonal relationships, behavioral dysfunction, and social problems (Bettman, Gillis, Speelman, Parry, & Case, 2016; Gillis et al., 2016). Samples are typically drawn from populations representing a type of service rather than specific agencies. Studying outcomes explores the effectiveness of service models or treatment genres such as wilderness therapy.

Program evaluation takes place at the program level within an agency. It is a systematic approach to data collection to determine if an intervention is achieving the intended results (Babbie, 2016). The information is used to make decisions about program improvement and development. Outcome evaluation and program evaluation can complement each other. When data from an outcome evaluation indicates key outcomes are not being achieved at a satisfactory level, program evaluation may be used within an agency to determine where program changes may be made to improve outcomes (Introduction to Program Evaluation for Public Health Programs, 2012).

Taken together, these two aspects of evaluation are critical to quality care in mental health. This paper extends the research corpus by highlighting the importance of and processes involved in program evaluation. The process of program evaluation in healthcare and other related industries, however, can be complex, expensive, and time-consuming (Cryns, Nichols, Katz, & Calkins, 1989; Granello, Granello, & Lee, 1999; Kane, 1997).

The use of the Delphi Technique (Hsu & Sandford, 2010) and Importance-Performance Analysis (IPA) (Martilla & James, 1977) provides a simple and powerful evaluation method to identify and measure factors important to stakeholders and to determine how well stakeholders believe a program is performing. This information is valuable in the quality improvement process, marketing, and accreditation. Hospitals and other healthcare organizations have effectively implemented this process (Kennedy, 1986; Scholl, Glanz, & Davison, 2006; Whynes & Reed, 1995). The purpose of this paper is to describe the steps for effectively implementing program evaluation using the Delphi Technique and IPA in wilderness programs. In addition, we describe a process for program improvement using the DMAIC method. A case is also provided.

Identifying factors to be studied in the Program Evaluation: The Delphi Technique

The Delphi Technique employs multiple iterations, or "rounds," of soliciting feedback. It encourages participants to identify themes or values on a specific topic (Hsu & Sandford, 2010), in this case, on the topic of wilderness therapy. For example, in a particular program, a group of about 10-15 parents/guardians of recently discharged students could be selected to represent a knowledge base pertaining to the program. This group would represent "expert" knowledge since they would have had first-hand experience with the program's full range of services.

After selecting and recruiting participants, round one begins by asking open-ended questions about the parent/guardian experience with the program (Hsu & Sandford, 2010; Okoli & Pawlowski, 2004). This may be done using a questionnaire or in focus groups (if the parents can come to a central location). The questions should focus on the outcomes they hoped would be achieved with their children and the program features. Program features include all the touchpoints parents have with an agency. This may have begun with their interaction with an educational consultant who recommended the program, their experience visiting the website, calling the agency, speaking with admissions, admitting their child, working with the therapist, and every other step up to and including the final discharge and transition of care. Asking participants to talk about the most important and valuable parts of their experience will lead to the identification of key aspects to be studied in the IPA process. For example, operational aspects or program features may involve the quality of equipment, staff, therapists, food, communications, and parent seminars. Treatment outcomes may include changes in behavior, attitude, relationships, substance use, school performance, and coping skills. The responses are analyzed to identify the program outcomes and features that are most important to the parents and guardians. Any method of qualitative analysis is appropriate, such as the commonly used and accessible system NVivo (Powerful research made easy, 2019).

The results of the first round are used to frame questions for the second round (Okoli & Pawlowski, 2004). In round 2, participants review the summary data resulting from the first round. Participants then rank order the importance of the outcomes and program features identified in round one. To obtain fully representative information they are also asked to provide critical feedback and

insights into their answers as they review the results of round one and consider their response in the context of the responses from other participants from round one. (Hsu & Sandford, 2010). The responses from the second round are then analyzed to summarize the answers and identify the most important program outcomes and features. This information is used to create a refined set of questions for a third round of data collection. The third round follows the same process as the previous rounds. Multiple rounds are used to continue to refine the results. Typically, three rounds are sufficient to identify the most important program outcomes and features.

In the case below, we extended the Delphi method by creating a questionnaire based on the content identified by the participants. Each of these outcomes and program features was included as an item with a Likert-type format so the participants rate the importance of each. An online survey platform was used to administer the questionnaire to a larger number of participants (n=30) than the original group. We invited parents and guardians of youth who had completed the program in the prior six months to participate. We analyzed the data by calculating the mean and standard deviation for each item. Items with higher means and lower relative standard deviations indicated factors participants find important. As expected, some of the items were rated substantially lower and had greater variance than the others. A decision was then made regarding the number of items to be included in the IPA. In our experience, a survey of 12 to 25 questions is short enough that most participants will complete the questionnaire and it is likely to also meaningfully represent key program aspects. In our case, the therapeutic agency was concerned about burdening the respondents with more surveys and limited the length of the questionnaire to 21 items.

Designing and implementing an Importance-Performance Analysis for Performance Evaluation

The Delphi Method helps agencies identify what is important to stakeholders. Once the areas of importance are identified, IPA provides a method to gather data from parents and guardians, obtains quantitative information about exactly how important each aspect is, and how well the agency is performing. IPA takes the Delphi results and provides valuable insights into the respective importance of each area. The combined information about importance and performance provides uniquely valuable information. An Importance-Performance Analysis (IPA) can be conducted with the original Delphi group of 10-15 members.

IMPORTANCE-PERFORMANCE ANALYSIS

IPA was initially introduced by Martilla and James (1977) in a business marketing context. They argued that marketing research often focuses on "either attribute importance or attribute performance" (p.77); however, research suggests customer satisfaction involves both judgments about how important a product or service is and how well the product or provider performs. They provide an example of an automobile dealership struggling with customer retention. Fourteen service attributes believed to affect customer retention were identified. A questionnaire representing these service attributes was presented to gather information about importance and performance (Martilla & James, 1977).

Below we provide examples of the type of questions that might be used in the context of therapeutic programs and schools.

Example item 1:

"How important is positive emotional growth?"

"How well did "Agency" promote positive emotional growth in your child?"

Example Item 2:

"How important is safety?"

"How well did the agency keep your child safe?"

Example Item 3:

"How important is having a competent therapist?"

"How competent was your therapist?"

Example Item 4:

"How important is improving your relationship with your child?"

"How effective was the "agency" at improving your relationship with your child?"

Example Item 5:

"How important is transition planning?"

"How well did the treatment team perform in planning your child's transition?"

IPA has been used effectively in settings beyond the auto industry. For example, it has been used in tourism and recreation management, education, food services, banking, public administration, e-business, and IT (Azzopardi & Nash, 2013), and it has been widely used in healthcare (Coghlan, 2012; Hendricks, Schneider, & Budruk, 2004; Whynes & Reed, 1995). The IPA method, however, is ideally suited for wilderness programs. It allows agencies to determine what stakeholders view as important and to determine how well they are performing in a simple and effective process. Although our discussion focuses on parents and guardians as stakeholders, clearly other groups are stakeholders in the

effectiveness and performance of therapeutic programs and schools. For example, educational consultants, insurance companies and other referral sources may provide important evaluation information. Some research suggests segmenting by these types of groups in IPA can enhance the process and identify differences between stakeholders (Bruyere, Rodriguez, & Vaske, 2002).

Program Evaluation: Data analysis and interpretation

Once IPA data is gathered it is analyzed to determine the means for each item on importance and performance. The difference between the importance and performance (I/P) is a measure of the discrepancy or gap perceived by parents and guardians (Azzopardi & Nash, 2013). The results may be displayed in a simple form for easy interpretation as seen in *Figure 1*.

Figure 1

Importance-Performance Matrix

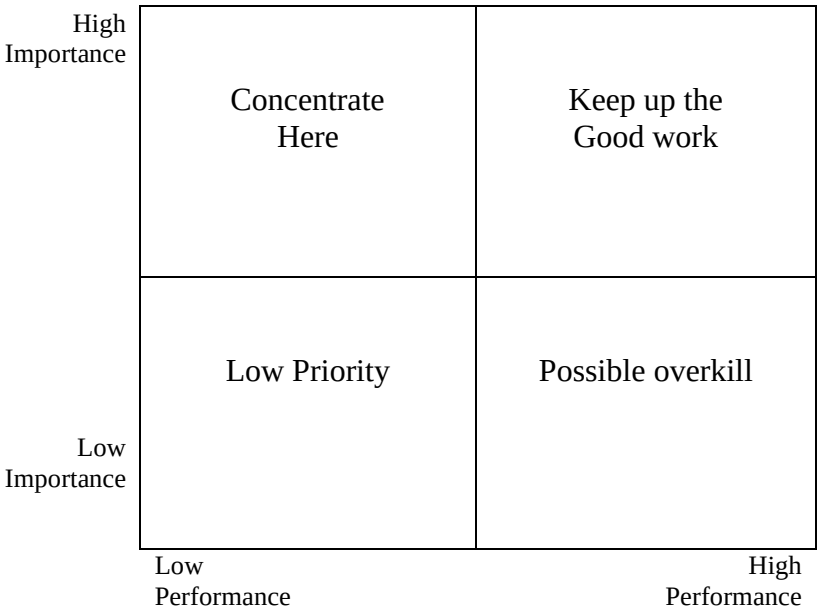

Figure 1. Importance-Performance Matrix

Note: Azzopardi & Nash, 2013

As the importance-performance matrix demonstrates, the unique value of the IPA allows a potentially powerful and valuable visual interpretation (Azzopardi & Nash, 2013; Martilla & James, 1977). Where importance is rated high and performance is rated low, a clear need exists for improvement in services: "Concentrate here" (Martilla & James, 1977, p. 78). Where both importance and performance are high agencies may take comfort in the good work they are doing and ensure they continue the processes they have in place: "Keep up the good work" (p. 78). Where importance is low and performance is low, no need exists to make any changes or improvements: "Low priority" (p. 78). Where importance is low and performance is high, consideration may be given to the time and expense involved, and decisions may be made to reduce efforts in this area to be more efficient: "Possible overkill" (p. 78).

An example of implementation in Wilderness Therapy.

Just over a decade ago a therapeutic program that was already engaged in outcome research decided to also conduct program evaluation research to determine where resources should be targeted to strengthen services and improve outcomes. The Delphi Technique was used to identify the most important outcomes and services to parents and guardians of program participants. The process resulted in the identification of the 21 most important program outcomes and services. Examples of outcomes related items included improvement in parent-child relationship, life coping skills, parent-child communication, confidence/efficacy, and problem behaviors. Examples of service-related items included content around safety, the quality of therapists and field guides, food, weekly emails, and the parent workshop.

A questionnaire was constructed including several demographic items, the therapist's name, and the child's presenting problems. The 21 content areas were then included in the IPA format. For example:

Content area: Relationships

"My relationship with my child improved as a result of his/her participation in the *Agency* program."

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

"Improving your relationship with your child is important to you."

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

Content Area: Therapist

"Your child's therapist is highly competent."

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

"A highly competent therapist is important to you."

Disagree 1 2 3 4 5 6 7 8 9 10 Agree

At the end of the IPA analysis, two general satisfaction questions were included. These items asked if they believed their money was well spent and to rate their overall satisfaction. Although it was not used at the time, we would recommend replacing these two items with a Net Promotor Score (NPS) (Reichheld, 2003). The NPS is an index focusing on the willingness of past customers to recommend the company's services. It has been found to be an effective method to measure overall satisfaction. It is a more robust measure than simply asking how satisfied a customer is with a company's services.

I/P data was collected by an independent researcher over a 10-year period from parents and guardians within one to three weeks after their child was discharged from the program. Each year a report was provided by the researcher to the agency leadership team. Using the matrix IPA, they were able to see areas important to parents and guardians and how the company was performing in each area. They were also able to see areas were importance was high and their performance was low, and where performance was high and importance was low. IPA results led to meaningful discussions as program leadership considered potential responses to the information. They were encouraged to see areas rated highly important by the respondents where they were also performing well. For example, the respondents rated the therapists, staff, and safety as highly important, and performance was also rated high in each of these areas.

Other results were more discouraging. For example, the weekly emails and electronic bridge had little or no value to these parents and guardians, yet performance was high due to substantial resource allocation. They made decisions

around streamlining or eliminating these services. Areas of high importance and low performance also emerged. For example, the analysis revealed academic motivation and performance was important. Yet, the results in this area suggested the parents' and guardians' perceived performance was weak, much lower than importance. The agency recognized they had not developed a strong program to promote educational motivation and provided opportunities for academic growth and preparation to return to school.

The resulting discussions ranged from lowering parents' expectations in this area at admissions and sending a message that this area is not part of the program's objectives, to hiring teachers and instituting a full-blown academic curriculum. Subsequently, an educational specialist was hired, and the academic curriculum was created. They built out some academic programs and therapeutic processes to promote academic interest and motivation base on self-efficacy theory and specific research guiding their process (Widmer, Taniguchi, & Duerden, 2014). They also crafted and began to communicate a clear message about what they were doing in their program and what they were not doing regarding academics to appropriately frame expectations.

Gathering the data over a 10-year period allowed the agency to track changes and monitor organizational progress. During this time, quality improvement initiatives were put into place in key areas. Respondent ratings improved where efforts were focused. The result was clear quality improvement in key areas. The data reflected moderately higher scores (e.g., 12% increase) in logistical and operational areas and substantially higher scores related to therapeutic objectives (e.g., 31% increase). Overall, the agency saw consistent improvement over a period of seven years. Specifically, for example, positive emotional growth and competent therapists were among the most important factors to the parents and guardians (9.9).

As illustrated below in Table 1, in the row "Positive emotional growth" the company's initial rating was 7.5. Five years later it had increased to 9.1. At the end of the seven years, a ceiling effect was reached where scores plateaued and were generally maintained in a range of 8.8-9.5 over the next three years. The data was also used to help other team members on the admissions, clinical and field staff to celebrate areas of great success. The table below provides an example of areas participants identified as most important and how the performance scores improved as the company made changes.

IMPORTANCE-PERFORMANCE ANALYSIS

Table 1

Abbreviated item	Importance	Year 1	Year 2	Year 3	Year 4	Year 5	Improvement from Year 1 to Year 5
Positive emotional growth	9.9	7.5	8.1	8.5	8.6	9.1	1.6
Highly competent therapist	9.9	8.5	8.5	9.3	9.4	9.7	1.2
Moderate problem behaviors	9.7	7.1	7.2	8.1	8.1	9	1.9
Competent staff	9.7	8.8	8.7	9.1	9.3	9.8	1
Developed stronger life coping skills	9.5	7.6	7.7	7.9	7.9	8.6	1
Helpful transition advice from therapist	9.4	7.5	7.5	8.5	8.5	9.2	1.7
Follows high safety standards	9.3	8.5	8.9	9.1	9.5	9.4	0.9
Increased academic motivation	8.4	5.6	5.6	6.6	7	8	2.4
*A=importance rating, 1-5 = year 1-5 performance rating, B=improvement in performance rating.							

Program Improvement

The Delphi and IPA processes provide structure to identify what stakeholders value and quantify performance relative to those values. The processes provide a strong foundation for quality improvement and greater efficiency (Hendricks et al., 2004). Sometimes improvements involve adapting or changing or adding program offerings (Hunt, Scott, & Richardson, 2003). These processes, however, do not provide a framework for analyzing, testing and implementing potential solutions or for evaluating the efficacy of the implemented solution or new offering. In other words, these methods provide information regarding areas in need of improvement but do not provide a method to improve those identified areas. A simple, yet sophisticated, method called the DMAIC model (Define, Measure, Analyze, Improve, Control), (Pande, Neuman, & Cavanagh, 2014) can be used as a framework for process improvement.

The DMAIC model consists of five primary steps of process and quality improvement, including:

1. Define: define the problem
2. Measure: quantify the problem
3. Analyze: identify the cause of the problem
4. Improve: implement and verify the solution
5. Control: maintain the solution

(Pande et al., 2014).

The case study described above may illustrate its function as a follow-up to the Delphi and IPA methods. In the previously mentioned case study, the IP analysis revealed a potential area for concentration of Safety (i.e. high importance, low performance): "How important is safety?" "How well did the agency keep your child safe?" We can then apply the DMAIC approach to improving the area of Safety, in a simple example, as follows:

1. Define: define the problem
    a. Safety: In what areas did the agency not keep children safe? Areas identified were incidents of restraints and medication errors.
2. Measure: quantify the problem

   a. Safety: Implement (if not already in practice) methods for tracking the rate of restraints (number, time, location, clients and staff involved, etc.) and medication errors (number, type of error, etc.).
3. Analyze: identify the cause of the problem
   a. Safety: Analyzing the data from Step 2 it was identified that restraints increased on weekends and due to peer-to-peer aggression; and medication errors increased in the last three months and the most common type was a missed medication, rather than wrong does or wrong time.
4. Improve: implement and verify the solution
   a. Safety: Several potential solutions were discussed, and the following were implemented: additional social skills peer-group added to the weekend schedule, as well as additional de-escalation training for weekend staff. Also, additional training for a new nurse who started approximately three months prior, also updated policy and procedure regarding supervision tasks for the nurse manager to oversee the performance of nurses and medication management system.
5. Control: maintain the solution
   a. Safety: Procedure implemented to ensure solutions from Step 4 are successfully implemented and tracking continue. Over time, both restraints and medication errors reduced, thus, demonstrating the efficacy of the implemented solutions. If restraints and medication errors did not reduce, then the team would return to step 1 to repeat the process until improvement is seen.

By improving the content area of Safety, specifically restraints and medication errors, subsequent IPA should reveal the area of Safety moving from the "Concentrate Here" box (i.e. high importance, low performance) to the "Keep up the Good work" box (i.e. high importance, high performance). If restraints and medication errors decrease over time, but the content area Safety does not improve in the IP analysis, then this may suggest either more improvement is needed in restraints and/or medication errors, or perhaps an additional area of Safety needs to be addressed. In either case, efforts should continue until sufficient improvement is made.

Unanticipated benefits

As the data aggregated over time and the agency proactively responded, the staff realized how powerful the data was in communicating to other stakeholders and future clients the success they have achieved in meeting their clients' expectations. And perhaps even more importantly, how they have effectively implemented quality improvement where they needed to strengthen program processes. They were also able to examine internal relationships between service components and outcomes. For example, the data could be analyzed by looking for correlations between individual therapists and outcomes such as emotional growth, coping skills, and problem behaviors. This allowed therapists to see where they were succeeding personally, and areas they may focus on improving based on the perceptions of parents and guardians. In addition, the program's accreditation body required evidence of engaging in research and quality improvement. The program had clear data showing their clients' perceptions of their performance had consistently improved over time due to intentional efforts by the agency.

Conclusion

Professionals working in therapeutic programs and schools face ongoing emotional and physical burdens not found in most professions. It is rewarding, but difficult work. When asked to implement new processes, people often respond with skepticism and resistance. Although engaging some team members in the Delphi, IPA, and DMAIC processes can be difficult initially, when the processes are implemented and people can see the results and implications, attitudes begin to change. Program evaluation research and monitoring of progress can be difficult, and sometimes seem tedious, with little benefit. However, we submit using the process a Delphi Technique to identify key important factors, implementing a study using IPA, and using the DMAIC model to improve, can be beneficial, relatively simple, and less expensive than other processes. For an agency committed to continual improvement, the process can also provide great data for marketing and accreditation.

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Supportive Immersion: The Use of Transformative Cross-Cultural Experiential Learning to Address Social Trends in the 21st Century

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Abstract

In an era of globalization and rapidly evolving cultural changes, traditional support structures are struggling to equip our youth with the necessary competencies for a successful transition into adulthood. A thematic analysis was performed on interviews of participants of a therapeutic gap program providing what is known as "Supportive Immersion," an approach to experiential transformative learning where facilitators and learners co-create experiences of learning. Findings show two main points: 1) participants' articulation of their perceived personal growth and skill development supported the positive impact of heir cross-cultural supportive gap experience, and 2) the five themes identified (PROPS) described characteristics and skill sets of an "integrative learner," which directly relate to preparing young adults for recent changes in societal trends. This study demonstrated the outcomes and effectiveness of guided, supported cross-cultural immersion experiences.

Keywords: Cross-Cultural, Emerging Adults, Supportive Immersion, Gap-Year, Transitions

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SUPPORTIVE IMMERSION

Introduction

Social structures around the world are changing rapidly toward networked societies (Castells, 2004) and globalized cultures (Pieterse, 2015). This has numerous implications for youth development. Parents (Lythcott-Haims, 2015) and schools (Azzam, 2009) are struggling to keep up with the shifts of the new millennium and to equip youth with the necessary competencies for a successful transition into the world of 21st-century adulthood.

Recio and Tracy (2017) compiled different social scientists' analyses of the changing characteristics of industrialized (they use the term "hyper-connected") societies in the 21st-century. The result of the synthesis yielded five interrelated trends, which fundamentally stem from the influence of technological advances (internet and other information technologies) into the very fabric of societal makeup (Castells, 2004; Harari, 2014; Siemens, 2006). The five trends are decentralized power, comfort bias, diffuse identities, self-programmable labor, and agency disparity.

Decentralized Power. Prior to the spread of the use of the internet, societies functioned in hierarchical systems where knowledge and power accumulated at the top and flowed down in a somewhat orderly linear fashion (Castells, 2004). In the 21st-century, systems are rapidly switching to self-organize from the bottom up (Meadows, 2008). Because of this, youth nowadays are less interested in adopting historically established boundaries of nationality, gender, values, power, and equality differentials, and they are less reliant and trusting of those in positions of authority, such as politicians and institutions (Lampert & Çeta, 2014; World Economic Forum, 2017). Access to unfiltered sources of information through technology, as well as increasing access to education, appear to have dismantled the need to rely on hierarchical authorities or experts; therefore, this is deeply transforming the way people relate to power (Nichols, 2017). Decentralized power is perhaps the trend out of which the others originate.

Comfort Bias. Like any other living organism, humans seek homeostasis and safety (Christakis, 2019; Porges, 2004). Human evolution is reaching a moment where the ease of satisfying certain comfort-based needs might be paradoxically producing negative side effects. During recent decades, two unprecedented events in the history of our species took place: 1) most of the world's population live in countries where overweight and obesity kills more people than underweight (World Health Organization, 2018), and 2) for the past 10 years, more people in the world live in urban settings than in rural ones (United Nations, 2009). In theory, it is highly beneficial to satisfy caloric intake and access

the advantages that urban life confers, but death from obesity and the well-known problems of inequality in urban settings reveal the negative side effects suggested above. The sudden rise in the research of topics exposing youth's difficulties with delay of gratification, resilience, agency and meaningful transitions to adulthood (Boin, Comfort, & Demchak, 2010) could be explained by these same societal trends. Trends in parenting styles, such as "helicopter" parenting or "snow-plow" parenting, are meant to protect children from danger and discomfort, but the side effect is that this additional safety and direction prevents the development of resilience and agency, resulting in issues of mental health (Lythcott-Haims, 2015).

Diffuse Identities. The increase in valuing freedom and equality and the decrease in the trust of hierarchical authorities to provide such rights may together lead to a less linear path in identity development. Defining who you are is no longer predetermined by traditional authorities such as family, religion, school, and geography. Jeffrey Arnett (1998) researched these and other social trends that he asserted have led to the rise of a new stage of development in the life span he called "emerging adulthood." One of the characteristics of this life stage is an extended process of identity exploration, which entails "trying out various possibilities for what kind of person to be and what kind of life to live, specifically in the areas of love relationships, work, and ideology" (Arnett et al., 2014, p. 570). The sudden and recent changing landscape in gender identity is a good example of this trend (Burn, 2014). Arnett and coauthors (2014) explained the double-edged sword of the identity exploration process:

> Identity explorations can be exciting but are often daunting and confusing to the person, especially for emerging adults who find themselves unable to make choices about which paths to explore, or who feel the choices they would like to make in love relationships and work are unattainable (p.570).

Arnett (2014) explained that the struggles that come with this process might account for the prevalence of anxiety and depression during emerging adulthood.

Self-Programmable Labor. Both sociologist Manuel Castells (2004) and historian Yuval Noah Harari (2014) have warned of the threat of a new class of irrelevant workers. They contended that developments in artificial intelligence and the globalization of the market may lead to the replacement of people who perform generic jobs, either by machines or by cheaper labor in other latitudes. Castells (2004) highlighted the importance of people learning to become self-programmable, which he defined in the following manner:

> Self-programmable labor has the autonomous capacity to focus on the goal assigned to it in the process of production, find the relevant information, recombine it into knowledge, using the available knowledge stock, and apply it in the form of tasks oriented toward the goals of the process (p.26).

Similarly, Harari (2018) believes the most important qualities to develop in the 21st -century are emotional flexibility and self-knowledge in order to be able to constantly reinvent oneself in the face of rapid changes in society.

Agency Disparity. As a summary, Recio and Tracy (2017) added this trend to encompass the consequences of the other four. They reasoned that because of decentralized power, comfort bias, and diffuse identities, there appears to be a gap between the level of agency expected of young adults to become self-programmable labor and the guidance and opportunities to attain it. The expectations of becoming "self-programmable" without a centralized power to follow contrasts with the low resilience of comfort bias and the potential confusion that stems from diffuse identities.

It is important to reiterate that there is data that shows that these trends are less prominent in non-Western cultures and have significantly more impact on people growing up in the 21st-century than on older generations (Lampert & Çeta, 2014). Hence, the question that follows is: how can young people influenced by these trends be supported toward a satisfactory transition to adult life?

In 2016, Recio and Tracy developed an approach to facilitate youth development that responds to the challenges and opportunities provoked by the five societal and cultural trends presented above. This approach is called Supportive Immersion.

Supportive Immersion

Supportive Immersion is an approach to experiential transformative learning where facilitators and learners co-create spaces and experiences of exploration and learning to develop skills in proactivity, resilience, openness, creativity, and self-governance. The learning that Supportive Immersion seeks is integrative, which means that the transformation it intends is systemic, adaptable, and metacognitive in ways that such learning propels further learning. It thus blends approaches that share the goal of integration (Hart, 2014; Siegel, 2007; Perls, Hefferline, & Hoffman, 1951; Maslow, 2013; Wilber, 2000) with approaches that share the method of constructivism, experiential learning, and systemic living (Maturana & Varela, 1987; Varela, Thompson, & Rosch, 2017;

Senge, 2006; Kolb & Kolb, 2009; Freire, 1996; James, 1984; Dewey, 1986; Piaget, 1970; Vygotsky, 1980; Cabrera & Cabrera, 2015; Capra, 1996). Integrative learning–learning that propels further learning–has three fundamental dimensions: systemic, metacognitive, and adaptive.

Systemic. Systemic learning includes and depends on reciprocal relationships with the immediate environment. The African philosophy of *ubuntu* describes this dimension with interconnectedness as its basis and the understanding that one's humanity depends on the quality of interactions with others (Naidoo, Shabalala, & Bawa, 2003; Nussbaum, 2003). This dimension of integrative learning is active when "my learning propels further learning and growth in others and vice versa" (Supportive Immersion Institute, n.d.). Furthermore, systemic learning can be present at any level of a system, such as recognizing that growth in one part of me propels growth in other parts of me, or growth in one part of a community propels growth in other parts of a community.

Metacognitive. Metacognitive learning involves reflecting and developing awareness about the process of one's learning. In order to be intentional about what we learn, understand why we learn, and be able to replicate it, we need to engage in metacognitive processes. Metacognition is the reflection on knowledge, experience, goals, and strategies in the process of learning (Flavell, 1979, as cited in Kolb, 2009, p.5). This dimension of integrative learning is active when "my understanding of how I learn propels me further my own learning" (Supportive Immersion Institute, n.d.).

Adaptive. Adaptive learning is based on the idea that life's demands are forever changing, and a person must meet new challenges with openness and creativity. Dabrowski (1976) asserted that "the course of development passes through the loosening of rigid structures" (p.135). To remain in a "fixed mindset," as coined by Dweck (2008), lowers our ability to learn, grow, and succeed. Integrative learning permits the person to not only use a variety of responses, but to apply those responses, or variations of them, in future situations. This dimension of integrative learning is active when "my learning now with this task propels further learning later and in other tasks" (Supportive Immersion Institute, n.d.).

Supportive Immersion thus co-creates transformative experiential learning spaces where learning propels further learning. These learning spaces are not reduced to classrooms focused on absorbing academic content. Social, experiential, situated, and embodied learning spaces are essential for Supportive Immersion. These include, but are not limited to, cross-cultural encounters,

adventure and nature-connected experiences, psychotherapy, life skills acquisition, and social-emotional learning. Consequently, the integrative learner is someone who embodies the creative energy of an empowered individual and is not only free to act on their own volition or perform tasks without the support of others but is also motivated to invest in finding novel solutions to life problems. Additionally the integrative learner seeks goals and challenges, is a contributor to their surroundings, and is an active participant in perpetuating harmony and congruence in their immediate world.

Cross-cultural Immersion for Integrative Learning

Evidence is building to demonstrate that cross-cultural immersions are providing opportunities for growth and helping people achieve their goals beyond their initial imaginings (Berry, 2005). Studies demonstrated that international immersions can provide participants with numerous benefits, such as increased creativity and integrative complexity (Fee et al., 2013; Maddux & Galinsky, 2009).

Based on this evidence, Recio (2018) proposed that using the Supportive Immersion approach during guided cross-cultural experiences could be an effective avenue to activate integrative learning. Recio (2018) explained that cross-cultural encounters provoke accommodative learning, which means that the stimuli from these experiences is salient or dissonant enough from existing cognitive schemas to require reshaping or the development of entirely new cognitive schemas. Because of this, Recio (2018) hypothesized that such accommodative learning, in conjunction with the empathic connecting, collaborative empowerment, and process-based scaffolding techniques of Supportive Immersion, could effectively elicit learning that propels further learning.

In an evolving global landscape, an integrative learner is needed to best adapt to their ever-changing surroundings. This is vital for the developmental period of the emerging adult, who is trying to find their way in the world. More important is the recognition of agency disparity, where there exists a gap in the level of agency expected of young adults and the appropriate amount of support given to individuals to achieve that agency. Educators, program directors, and mental health specialists need to equip themselves to best support our youth in this transition. To help understand the most effective methods, we must evaluate existing models that are currently trying to achieve this goal. This research study aims to do this by examining the effectiveness of a therapeutic gap-year program that provides supportive cross-cultural immersion.

Method

Participants

There were 10 participants in this study who were males between the ages of 18 and 22. Each participant was a student of the gap-year program, "The Bridge ~ Costa Rica." The Bridge is a therapeutic program blending cultural immersion and therapeutic support for young adult males with mental health needs. Participants were United States citizens that elected to enroll in The Bridge program. The length of stay for each participant ranged from six to nine months. Throughout their stay, participants were culturally immersed through the program's location in Costa Rica, as well as the program's activities emphasizing more in-depth cultural immersion through Spanish learning, homestays, community service, internships, attending the local university and ecological adventures.

Procedure

By the end of the gap year, participants were asked to create a video that summarized their experience. The creation of these videos had two goals: 1) To facilitate the chance for the student to reflect on their experience and narrate what was meaningful and impactful to them; 2) To summarize the experience which would be shared with he student's parents, family and program staff at the program's graduation ceremony. The videos were created with the help of program staff who (as interviewers) used open-ended questions and prompts to explore what experiences of the gap program were most impactful to the participants and how it related to their personal growth. An open-ended approach was used to avoid leading participants to comment directly on the philosophical basis of the experiential immersion gap program itself, which could impact the research's reliability and validity of the data.

After the graduation ceremonies, the videos were archived by the program. Participants gave permission to the program to share the videos as testimonials for marketing and educational research purposes. The videos would become the data for this research study after being shown at a colloquium led by the program director. A third-party member of the colloquium saw this video and felt it contained rich and important data about the impact of cross-cultural immersion on the personal growth of young adults. They approached the program director afterward to discuss this research study using the archived videos.

Therefore, the research question (RQ) that would guide this study was formulated: "What impacts do students perceive in themselves after going through experiential immersion in an international supportive gap experience?"

Data Analysis

An inductive thematic analysis, as outlined by Braun & Clark (2006), was used to analyze 10 video testimonials recorded by participants of a young adult, therapeutically supportive gap program. A bottom-up approach was selected by the third-party primary researcher (PR), which would allow for the study to be taken up as an exploratory approach. Thematic analysis was selected as the methodological framework for this study due to the PR's interest in identifying themes related to personal growth through cultural immersion and how the participants narrated this growth in their video testimonials.

The PR's first step was to become familiar with the data by watching the videos and taking note of any impressions that arose. Contrary to the belief that thematic analysis is a "passive" process of allowing data to just "emerge," Braun & Clark (2006) explained that the process is much more of an "active" engagement with the data, where the researcher takes up a self-reflexive position with and through the data.

The second step of the study was to transcribe the videos through which the data could then be combed, which also allowed the PR to become more intimately engaged with the data. With the research question in mind, the PR then began the coding process. Statements of the participants were highlighted and codes labeled based on the statement as it related to the RQ. The codes were then compiled into tables so that they could be viewed together. By placing the codes together, it allowed the PR to see more holistically, an important step prior to thematization.

The third step was to identify the themes across the data sets. At this point of the study, it is important to note how the PR named the themes. The administrators of the gap-year program of this study had been developing the aforementioned theory, Supportive Immersion, which theorizes what elements help facilitate growth while individuals are being supported in cross-cultural immersion and experiential learning settings (Recio, 2018). Going into the study, the PR had no knowledge of SI's theory; but due to dialogue with the administrators after the coding process, the PR ended up becoming more familiarized with the components of SI. It was learned that SI had created terms associated to personal growth, describing the qualities of an individual that is interdependent, self-motivated, goal-driven and resilient. After reviewing these

terms and reviewing the codes, it became very clear that SI's terms could be used as the themes for the codes. Therefore, the PR, who had started the study from a bottom-up inductive method, ended up integrating a top-down deductive thematic analysis to help understand the data that emerged based on the SI theory.

Results

The five themes that both emerged from the coding process and sourced from Supportive Immersion theory are: 1) proactive purposefulness, 2) resilience, 3) open collaboration, 4) problem-solving creativity, and 5) self-governance (hereinafter referred as PROPS when referenced collectively). Supportive Immersion theorizes that PROPS development activates the propelling function (previously called the self-generating function), which "suggests that the energy for problem-solving and learning intentionally initiates within the individual," as well as through the supportive relationships around them (Recio, 2018, p. 178). Recio (2018) cited this to be a necessary activation process for emerging adults to feel a sense of empowerment and agency in driving their own life toward their own goals. This energizing propelling function is also a key characteristic of an integrative learner, who is defined by a motivation to continue to learn and grow through generating personal goals while simultaneously interacting with, adapting to, and contributing to the relational support systems around them. These five themes are foundational to SI theory because PROPS is the desired outcome of characteristics, strategies and skill sets to be developed through supportive immersion learning experiences.

One important dimension of these themes and how they will be discussed in this study is the fact that each theme, while specific and separate from the other themes, are also at the same time integrative meaning that as one theme emerges, it is often correlated to other themes. This will be discussed further in the study.

Theme one: Proactive Purposefulness

Proactive Purposefulness is defined as the ability to intentionally seek out and pursue meaningful goals. Some examples of the codes that were extracted from the data that support this theme are: "feeling awakened," "presence," "living with intention," "create meaning through experience," and "development of values." These all helped define how participants found a sense of purposefulness through their gap-year experience.

In reference to their experience in the program, one participant was quoted: "it makes you think about how to be intentional with the way you live your life … forces you to be present with your decision-making, planning, and the

relationships around you and back at home, and so it's an experience that you come out feeling kind of awakened in a way." Here the participant described a sense of purposefulness through learning to live with intention, being present in relationships and decision-making. Their feeling of being "awakened" was a powerful statement that indicated a prior unconscious living, one that does not facilitate living intentionally or with presence.

This same participant continued to describe what this feeling of being awake and present did for them: "it pushes the idea of 'now is the time' over and over and over and the only way you can fail is when you push that idea away." Here the participant is proposing their new-found motto of "now is the time," which identifies being proactive in their new way of living and that forgetting that will ultimately lead to a possible failure.

Another participant stated that the program and experience in Costa Rica helped "find a way to identify who I am and not who everyone else thinks I am." For this participant, learning to differentiate oneself from what others project onto them was important. This statement identified that this individual cared about discovering their own values and motivations. Discovering one's own driving motivation is a central component to proactive purposefulness.

Theme Two: Resilience

Resilience, as described earlier, is sustaining effort and taking accountability despite adversity and lack of immediate results. Examples of codes in this theme were: "tolerating mistakes," "seeking discomfort for growth," "accountability for actions," "confidence in facing challenges," and "comfort in ambivalence." Through their experiences in the program and cultural immersion, the participants faced many situations that created opportunities for being out of comfort zones. The descriptions of the participants as they relate to resilience showed this to be a fundamental aspect of their experience.

A participant talked about how being out of their comfort zone helped them in "having to deal with some really uncomfortable, not necessarily physically, but emotionally uncomfortable situations really gave me a new perspective on how I need to focus on my priorities and how much the short-term discomforts are worth it in the long term." Similarly, another participant is quoted as saying, "I know it's not going to be easy, or a smooth ride going forward, in the next month, in the next year, [or] in the rest of my entire life. It's never going to be easy, smooth sailing, but I've made it this far and I've done some things I'm very proud of, and I don't see any reason why I can't continue to do so." These were powerfully inspiring quotes. They spoke of resilience as being a mindset of

recognizing that one is going to surely encounter difficulties but that pushing through those difficulties can be a rewarding process.

In addition to learning to feel confident in one's self through resilience, one participant described how resilience created opportunities for more self-awareness, which promoted growth in a different, yet similar, way. They reported:

> I really learned how much being out of my comfort zone made me realize about myself, because once you don't have everything you're used to, you realize how much you depend on certain aspects of your daily life. Being out of my comfort zone has really helped me realize a lot about my personality, like flaws or weaknesses in my behavior, because those are the first things that really appear when I get really uncomfortable.

For this participant, their experience of being in a new environment created a contrasting perspective, which helped them have more insight into themselves and the fact that, prior to their experience, they reverted to maladaptive behaviors to cope with the distress of being out of one's comfort zone. Resilience created an opportunity to grow through the self-reflexivity gained from their experience.

As mentioned prior, these themes are integrative through their interdependence with each other. One theme may not necessarily exist without the correlation to another theme. What stands out in this theme is the fact that resilience was found to be connected to the participants recognizing their own long-term goals and pushing towards those goals for some intentional reason. This highlighted the need for proactive purposefulness to be present in order for resilience to be activated. It would seem that proactive purposefulness, through living with intention and moving towards meaningful goals, helped create the motivation to endure through the difficulties encountered in the participants' lives.

Theme Three: Open Collaboration

Open collaboration identifies the traits of an individual maintaining openness through curiosity and taking in other perspectives, seeking learning and growth across cultures and languages, and engaging in reciprocal relationships and experiences. Through the data, it became clear how much the participants identified their relationships to other peers, staff, members of the community, and the culture as being very integral to their personal growth. Examples of the codes that emerged through the engagement with the data are: "learning a new

language," "open to new people," "sense of family," "impact of homestays," "cooperation," and "supported by others."

First and foremost, it needs to be identified that "learning a new language" was the most identified code and emerged across almost all data sets. Not only was the frequent appearance of this code noteworthy, but the communication of its relevance to their personal growth was significant. For example, one participant stated:

> I didn't learn to speak understandable Spanish for a very long time and I still tried. I was able to go and make more friends than I can say I have in the States. I was able to become a part of a homestay family, and I was able to make some really great relationships in my internships. And it was because I was out of my comfort zone; I was pushing myself to be uncomfortable and learn and adapt.

In this quote, it is identified that learning Spanish not only created a bridge to communicate to others, but that it helped facilitate a successful and meaningful homestay experience and internship opportunity. Additionally, learning a new language was connected to learning to adapt to being out of a comfort zone. Here the theme of resilience is described and shows its correlation to open collaboration. This participant found that resilience created opportunities to be with others that ended up being very meaningful and impactful to them.

Participants were impacted by their experiences of "Aventuras," the program's name for its ecological, cultural, and service orientated excursions into rural Costa Rican villages. Those that referenced these "Aventuras" in the interviews spoke very highly of their experience. One participant described it in the following manner: "the biggest turning point was through my first Aventura. I kind of developed more of a sense of family and the importance of family and the importance of living in the moment." Another participant also described their experience as:

> Every place here is special to me. Everyone I've met is special in different ways. Being able to realize that I can connect with people and places is really cool and I found happiness in every place I've been, from Aventuras to school. Being able to connect like that is really cool … all the places I've been hold a very special place in my heart because they all have taught me something about myself.

Learning a new language created opportunities for personal growth by getting out of one's comfort zone to communicate with others, which then

facilitated deep, long-lasting connections and then, lastly, helped the participants learn more about themselves in the process. These all contribute to open collaboration as an important aspect of SI's integrative learning.

Theme Four: Problem-Solving Creativity

The theme of Problem-Solving Creativity highlights the trait of an individual that seeks solutions to problems through considering multiple perspectives, uses critical thinking, and is actively looking for alternative solutions with intentional goals in mind. The data showed these characteristics were cultivated through the participants' exposure to naturally occurring problems during their program stay. Examples of codes that were identified in the data are as follows: "expand awareness," "paradigm shift," "perspective taking," "skill acquisition," "confidence in future problem solving."

One participant related their experience in the program and learning to manage problems by saying:

> This place has shown me I can do whatever the heck I want to do because I have the tools, I have the skills, I put it into practice … Sure, I've messed up, everyone does. It's not about not making mistakes; it's about learning from those mistakes and not making the same mistake.

This participant described a sense of confidence in approaching life's difficulties through a few different factors, one being the acquisition of skills and the sense of being able to use those skills to overcome barriers to intentional goals. Additionally, they showed a flexibility and openness to allow mistakes, to give space for mistakes as an inevitable part of life, and to learn from those mistakes.

This participant's statement also showed the correlation to the other themes of resilience and proactive purposefulness. Resilience is shown by the toleration of making mistakes, which is also a form of growth mindset (Dweck, 2008). Proactive purposefulness was seen in the sentence "I can do whatever the heck I want to do," not to be mistaken for a brazen self-focused individual, but instead as the confident statement of someone who knows their goals and is motivated to attain said goals.

Theme Five: Self-Governance

Self-governance describes traits of an individual who sets goals with a sense of empowerment, while monitoring, evaluating, and self-regulating their pursuits. It also shows the flexibility to shift gears and change paths if necessary.

Some of the codes that emerged through the data were: "sense of independence," "shift in life direction," "present-oriented," "sense of power and control" and "personal responsibility."

The data clearly showed the relevance of this theme through the amount of codes that were categorized. Overwhelmingly, this theme contained the most codes. This indicated that their experience had a positive impact on their personal growth through cultivating confidence in managing and directing their own lives. This is an important step for the emerging adult and integrative learner. One participant stated:

> Coming here changed my life. Before I came here, I was in a weird sort of limbo state and when I chose to come here, it was my first step in choosing to take hold of my process and my first step into adulthood.

Similarly, another participant stated succinctly: "I've come to a place where I feel I have control over my future, my actions, towards my goals." As the emerging adult begins the process of identity formation that was once contingent on family origins and values, these types of statements show an empowerment of taking control of one's life, an important position the emerging adult needs to have for a successful transition into adulthood.

Discussion

According to this study, participants articulated areas of growth that are crucial for 21st-century skillsets for emerging adults. Participants (who were previously struggling and therefore enrolled in a supportive gap program) validated their growth; they were able to articulate how these supportive cross-cultural immersion experiences had impacted their perspective and confidence in taking on new challenges that would be presented in the adult world. This gives validation to the growth value and 21st-century skill development that is possible in supportive, international or cross-cultural gap experiences for young adults who need to become integrative learners.

The coded reflections were easily allocated to the five PROPS skill areas promoted by Supportive Immersion theory: proactive purposefulness, resilience, open collaboration, problem-solving creativity, and self-governance. In relation to previous psychological research, these five qualities correspond to the five factors of personality, also known as the five-factor model, or Big Five (DeYoung, Quilty, & Peterson, 2007). Proactive purposefulness corresponds with extraversion because they are about motivation and reward-seeking toward goal completion (DeYoung, 2015) and learning tasks. Resilience corresponds to

neuroticism because they are linked to how people deal with uncertainty and threat (DeYoung, 2015). Open collaboration corresponds to agreeableness because they are connected to how people coordinate and cooperate with others (DeYoung, 2015). Problem-solving creativity corresponds to openness/intellect because they both focus on the ability to generate multiple and unusual solutions to problems (DeYoung, 2015). Finally, self-governance corresponds to conscientiousness as they both are about being able to prioritize, plan, and govern behavior across long time spans (DeYoung, 2015). The value of using PROPS, as opposed to the Big Five, is found in that PROPS are purposefully articulated in their strengths-based form (no matter what one's natural personality tendencies) to show the path toward integrative learning, in contrast with the Big Five, which includes a dimension in its negative pole, such as neuroticism. Furthermore, the five PROPS are terms that are more easily understood outside of psychology and academia.

Given the current societal desire for strengths-based and positive approaches to mental health, PROPS skill development offers an alternative to previous theories such as the Big Five. Rather than focusing on what might be lacking in our youth, PROPS offers an alternative that highlights which skill sets will be beneficial to thrive in the 21st-century. As noted previously, the five PROPS skills directly relate to five interrelated trends that are changing the way that youth engage with and interact with the world today thanks to the influence of information-age developments in 21st-century society. PROPS skills effectively articulate an answer to the question of how youth can navigate the world of decentralized power, comfort bias, diffuse identities, self-programmable labor, and agency disparity.

The degree to which any, or all, of the five PROPS skills are activated will determine the level of integrative learning occurring in a person at any given moment. These five skills, separately or together, appear in the literature for which integration is an important goal (Hart, 2014; Siegel, 2007; Perls, Hefferline, & Hoffman, 1951; Maslow, 2013; Wilber, 2000). Becoming an "integrated learner"–a learner that knows how to propel further learning, or perhaps in colloquial terms, a life-long learner–is the over-arching goal of a 21st-century adult. In other words, an integrated learner is one that can take on the quickly changing dynamics of a globalized information-age that requires a self-programmable adult with agency to implement PROPS skills in order to resiliently solve problems in a collaborative and purposeful way.

Conclusion

The participants' articulation of the perceived impact of their gap program experience supported the assertion that supportive cross-cultural immersion experiences help equip emerging adults with the attitudes, habits, and skills to productively engage in 21st-century adulthood. Data from this initial research confirmed SI's theory in regard to PROPS as a useful framework for skill development for emerging adults in the 21st century. The desired outcome of the PROPS skillset integrates characteristics that foster personal development and growth as an integrative learner who can generate opportunities to propel further learning. As a developing integrative learner with PROPS skills, these young adults perceived themselves as more confident in and capable of engaging with, adapting to, and problem-solving within their emerging adult environments.

Further research is warranted to continue to tease out the specific beneficial elements of and methods to facilitate immersive growth opportunities for emerging young adults, as well as the driving factors that promote integrative learning most effectively and efficiently. Future research will continue to enrich this data and will also focus on participants' perceptions of the support they receive from peers, staff, community members, and environments through experiential activities. Through these enrichments, research will explore the effectiveness of the three pillars of the Supportive Immersion theory: empathic connection, collaborative empowerment, and process-based scaffolding hypothesized to support the development of the five themes identified in this study.

Limitations

The origins of the datasets themselves present some possible limitations to the study. As mentioned, the data comes from videos created by participants of the gap-year, with the help of staff prompts for the purpose of sharing at a graduation ceremony. This presents two considerations related to bias: 1) the videos were created with the help of staff, which requires consideration of how the language used in the videos could have some bias that speaks to a possible allegiance to the program, specifically in how the language could represent the program philosophy and culture, and 2) the data was in part to be presented at a graduation ceremony, so it could indicate a one-sidedness that may be reflective of the participants trying to express their experiences in a positive light for family members, as well as program staff. These potential forms of bias were considered by the PR during the analysis of the data but are still worthy of note.

SUPPORTIVE IMMERSION

Lastly, two of the authors are developers of The Bridge program, as well as the Supportive Immersion theory; therefore, there is some inherent potential for bias in the articulation of this article. Nevertheless, the self-perceived areas of growth are articulated in the words of the participants themselves at a point where the program staff had no power over any future decisions directly related to the participants' lives, and the video interviews were coded by a third-party researcher. Therefore, there is value in validating how the participants perceived their own growth in experience thanks to a supportive, cross-cultural, gap program experience.

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IEP Placement: Funding Private Residential Schools

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Abstract

Children who suffer with behavioral and/or emotional disorders are eligible for special education services under Individuals with Disability Education Act (IDEA). Parents can seek specialized instruction and services through their child's Individual Education Plan (IEP) and, in most cases, public schools are able to appropriately manage the services required for their child. However, because of limited funding and resources, many public schools are not able to provide the type of wrap-around services to meet the needs of students with disabilities, which ultimately affects their ability to learn and function in life. The majority of alternative educational settings have been in existence since the 1970's and serve students who need a more specialized learning environment. On the Least Restrictive Environment (LRE) continuum of placement, residential treatment centers are at the top of the pyramid, being the most restrictive environment. If a student's disability warrants placement in the most restrictive environment and public schools are not able to provide services, then residential care should be considered and, per the IEP, the school may be responsible to pay for the residential placement. This paper will look at the history, laws and research around this topic of private residential school placement for students with disabilities. Opposing views will be discussed as well as the "gray area" for making placement decisions based on federal court proceedings, family decisions, and school district policies. Real life case studies will be presented, followed by a summary of the impact of placement for a child with disabilities.

Keywords: behavioral needs, emotional disturbance, FAPE, mental health, placement, residential, IEP

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Jack's parents were in despair. Despite their best efforts in trying to obtain funding to help their son with his mental health issues, every door was being shut. The costs were astronomical to pay for treatment for a family with limited financial resources. They had tried insurance, to no avail. They tried obtaining a second mortgage, which provided some funds, but not enough. Finally, they turned to their school district. Under IDEA, Jack qualified to received services for an emotional disturbance. They knew the services their school offered were not enough to keep Jack safe from his own mental demons. Placement in a private residential treatment school which specialized in emotional and behavioral disorders was their only option.

Jack's parents are not alone. Parents of children with disabilities want what's "best" for their child (Wright, 2016). Some parents are dissatisfied with services offered at public schools and seek for funding to support their choice of residential placement. Residential schools can provide students with much needed therapeutic support along with structure and consistency not available in other settings. Residential placements are very restrictive settings, as well as extremely expensive, and take the child out of the home (Advocates, 2009). Residential placement is a serious consideration for an IEP team. This paper will explore the controversial issues surrounding residential placement as it relates to educational laws and special education rules, both for the families and school districts.

Research and Literature Foundation

Definitions and Overview

Residential placement is a facility in which the student lives full-time and is under 24-hour custody. Residential placement provides a therapeutic component to address a student's mental health along with an educational component to provide academic curriculum (Advocates, 2009). Residential placement is considered one of the highest restrictive placements on the Least Restrictive Environment (LRE) continuum (Morin, n.d.). LRE is part of the Individuals with Disabilities Education Act (IDEA), which states that children who receive special education services should learn in the least restrictive environment, as appropriate, with their peers who do not receive special education (Morin, n.d.). Private residential programs are specialized programs outside of a school district and should only be considered if the child's disability under IDEA is so severe that supplementary aids and services cannot provide an appropriate education within the school district. Students who benefit from residential care include: those with extreme behavioral difficulties, those who are unable to

generalize learned behaviors across settings, those who require intensive 24-hour supervision and interventions to address aggressive, assaultive, destructive or self-injurious behaviors, those who have significant mental health issues which impact their ability to attend and function within the school environment, and those who have not made progress in their emotional and behavioral goals in a less restrictive setting (Advocates, 2009).

Private School Placements by LEAs must be accordance with the student's IEP and at no cost to the parent. Consistent with the rules in many states, the Utah State Board of Education (rule 300.104) states:

> If placement in a public or private residential program is necessary to provide special education and related services to a student with a disability, the program, including non-medical care and room and board, must be at no cost to the parent(s) of the student or adult student" (Dickson, 2016, p. 115).

Free Appropriate Public Education (FAPE) is an educational right of all children in the United States that is guaranteed by the Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (IDEA). Private school placement falls under Free Appropriate Public Education (FAPE). FAPE is defined as an educational program that is individualized to a specific child, meets the grade-level standards established by the state, and from which the child receives educational benefit. FAPE is provided at the public's expense, without charge to the parents (Common Special Education Terms and Definitions, 2016, p. 2).

Unilateral Placement occurs when a parent enrolls the student with disabilities in private, including religious, schools or facilities that meet the definition of elementary school or secondary school under IDEA (Dickson, 2016). When FAPE is an issue, parents may seek financial reimbursement for the private school placement. Parents are entitled to due process procedures under IDEA. According to Special Education Rules from Utah State Board of Education (USBD, rule 300.148):

> If the parent(s) of a student with a disability or adult student, who previously received special education and related services under the authority of an LEA or USBD, enroll the student in a private preschool, elementary school, or secondary school without the consent of or referral by the LEA or USDB, a court or a hearing officer may require the LEA or

> USDB to reimburse the parent(s) or adult student for the cost of that enrollment if the court or hearing officer finds that the LEA or USDB had not made a FAPE available to the student in a timely manner prior to that enrollment and that the private placement is appropriate. A parental placement may be found to be appropriate by a hearing officer or a court even it if does not meet the State standards that apply to education provided by the USBE and LEAs" (Dickson, 2016, p. 126).

Controversy and Legal Cases Surrounding Residential Private School Placement

The decision to place a child in a private, residential setting tends to be highly controversial between parents and school district personnel. School districts have limited funds, and as such, do not wish those funds to leave the public-school system. As recent as August 2017, The Illinois Alliance of Administrators of Special Education (IAASE) publicly wrote a letter in opposition to any public funds used to support private education. The Illinois special education administrators make a compelling argument stating that not all students with disabilities have equal access to private schools based on the school's entrance policies and some private schools significantly lack accountability for progress due to lack of reporting requirements and research-based outcome data. The letter further states that students with disabilities and their families are not guaranteed basic due process rights afforded under the Individuals with Disabilities Education Act (IDEA) when a parent makes a unilateral decision for placement. Finally, the Illinois special education administrators end with an indisputable point by stating that "use of public dollars to pay for private education decreases the funding available to ensure a strong public-school system, which is essential to quality educational opportunities for students with disabilities" (IAASE, 2017). Understandably, residential schools are expensive, and school districts have limited budgets for non-public settings. School district personnel aggressively seek to keep funding within their own schools and special education programs.

However, if residential care is deemed the most appropriate setting for a student with disabilities, then the school district is obligated to pay the private school tuition and related expenses, especially when the district fails to offer an appropriate special education program. Under IDEA, if a school district determines that an eligible child cannot receive FAPE from the programs that the public agency conducts. Therefore, according to the IAASE:

> If placement in a public or private residential program is necessary to provide special education and related services to a child with a disability, the program, including nonmedical care and room and board, must be at no cost to the parents of the child (IAASE, 2017).

In the case of *U.S. Supreme Court vs Burlington*, a father became dissatisfied with his third-grade son's lack of progress in a Massachusetts public school system. A new IEP was developed which placed the child in another public school in the district. Upon advice of specialists at Massachusetts General Hospital, the father unilaterally withdrew his son from the public school and placed him in a state approved private facility to better address his son's learning disabilities. He then sought reimbursement for tuition and travel. The state Board of Special Education Appeals (BSEA) ruled that the proposed IEP placement was not sufficient, and the private school was appropriate based on his son's disabilities. The BSEA ordered the school to reimburse the father, which the school appealed to the federal courts, saying that the parents had violated the "status quo provision of the Education of the Handicapped Act (EHA) by enrolling their child in the private school without approval" (Essex, 2016, p. 139). The U.S. Court of Appeals, First Circuit, reversed the district court's ruling and the case was appealed to the U.S. Supreme Court. The Supreme Court ruled in favor of the father based on the inappropriate IEP placement of the public school (Essex, 2016).

The legal cases surrounding reimbursement under IDEA for private residential schools is as split in the courts as it is within individual school districts. The one caveat that courts use to distinguish entitlement to reimbursement is the question: "is the learning process impacted?" In the case of *Shaw v. Weast* in the Fourth Circuit Court, a student with learning disabilities and emotional disturbance displayed suicidal tendencies, depression, and self-injurious behaviors. The parents placed her in a residential school to keep her safe, even though the IEP team had recommended a therapeutic day school. The parents sought reimbursement but were denied because their placement was based on safety, rather than for educational purposes. The court also ruled that the residential school was not the least restrictive environment, as the student was making progress academically in the therapeutic day school (Essex, 2016). In summary, if a student's academic needs are being met and progress is shown by the least restrictive environment, the courts may deem the lateral placement by a parent not necessary.

The Seventh Circuit in the United States Court of Appeals have stated the rule that parents are not entitled to reimbursement for their placement when the

"placement …. was in response to medication, social, or emotional problems that [were] necessary quite apart from the learning process". This rule came into play with the case of *Dale M v. Board of Education of Bradley-Bourbonnais High School District No. 307, 237 F.3d 813* (IAASE, n.d.). The Court was presented with a student with dyslexia, substance abuse, and behavioral difficulties that resulted in several arrests. The parents appealed to the court for reimbursement after unilaterally placing their son, Dale, in a boarding school for troubled youth. The Seventh Court applied the rule to determine if the residential placement was reimbursable: "The essential distinction is between services primarily oriented toward enabling a disabled child to obtain an education and services oriented more toward enabling the child to engage in non-educational activities" (Robbins, Schwartz, Nicholas, Lifton & Taylor, 2014, p. 4). By applying the following rule, Dale's parents were not entitled to reimbursement because the placement was due to confinement, which is a non-educational problem, not a "related service" under IDEA.

In a land-mark case in 2012, *Jefferson County School District v. Elizabeth E*, the U.S. Court of Appeals for the 10th Circuit in Denver, ruled 3-0 in favor of the parents of a girl who suffered from severe emotional and mental health issues (Jefferson County vs. Elizabeth E, 2011). The parents placed their daughter in a residential boarding school in Idaho which cost over $9,800 a month. The parents sought reimbursement from Jefferson County district. The district denied the request, stating the girl was out-of-state and therefore not the responsibility of the district. The school district appealed to the 10th Circuit Court and was joined by School Boards from Colorado, Kansas, New Mexico, Oklahoma, and Utah.

The premise for the appeal stated, "School districts should not be responsible for unilateral residential placements made for medical purposes. Such responsibility is not only beyond the range of their competence and funding but also exceeds the requirements of IDEA" (Walsh, 2012, p. 1). The parents drew support from the Obama administration, the U.S. Department of Justice, and the U.S. Department of Education. The 10th District Court upheld the appeal on behalf of the parents, noting the private residential placement was a fully accredited school, and the student's educational needs were being met. Services for her mental-health issues were necessary in order for her to benefit from her academic instruction, and as such, the tuition was reimbursable as "related services" under the federal special education law. The court also denied the school district statement that it had no obligation because the student was not physically present in Colorado. The court denied this statement, saying IDEA

makes no allowance for such a condition. The law is federal, not state-based (Walsh, 2012).

Case Study

The date of Jack's (Jack is a pseudonym) IEP meeting was held in August, prior to school starting. In attendance from the school at the Residential Treatment Center was Jack's special education teacher, the school administrator, and Jack's therapist. On the conference call from the district were Jack's parents, the special education director, the school psychologist, the general education teacher, and the special education teacher. Also joined on the line was an independent clinical psychologist the parents had hired to do a psych evaluation which was independent of the school district's reports.

The meeting began with the district's school psychologist report. The school psychologist met with Jack two days after he arrived in the residential program. She found Jack personable, polite, and engaging. Jack had recently completed two months in a wilderness program and was enrolled in the school as per parent placement because (according to mom), Jack was refusing to do things he previously enjoyed, he was struggling to fulfill responsibilities, he refused to go to school for four weeks, and was playing video games 10 hours per day. The school psychologist summed up her report, and based on her assessments, Jack had ADHD and needed accommodations in school to address his focus and attention issues.

The licensed psychologist had a much different report based on his assessment of Jack, which was completed at the residential program. The licensed psychologist did an in-depth assessment which included interviews with both of Jack's parents, a case review by Jack's therapist, and a case review from Jack's wilderness therapist, along with seven clinical ratings and assessments, which included an autism rating scales, personality inventory (Minnesota Multiphasic Personality Inventory-Adolescent, MMPI-A), clinical inventory (Million Adolescent Clinical Inventory, MACI), and a depression inventory (Beck Depression Inventory, BDI-II). According to the findings of the assessments and interviews, the licensed psychologist diagnosed Jack with the following DSM-V classifications:

- Autism Spectrum Disorder, requiring support, without intellectual impairment
- Generalized Anxiety Disorder
- Persistent Depressive Disorder

- Unspecified Impulse Control Disorder, and
- Attention-Deficit/Hyperactivity Disorder.

Based on his findings, the licensed psychologist recommended that Jack continue his treatment at the residential center and successfully complete the program. The licensed psychologist commented in his report that if he (Jack) did not continue in residential treatment, the potential for these problems would become significantly worse. The psychologist discussed Jack's lack of insight into effectively managing his difficulties and daily responsibilities, which would leave him highly vulnerable into falling back into self-destructive patterns of behavior should he return home. The report concluded that Jack will need to be in a therapeutic environment that can provide services for his unique learning, developmental, and emotional needs. Jack's parents, the school administrator, Jack's therapist and the special education teacher at the residential program confirmed the licensed psychologist's report based on their own observation, data, and experiences with Jack.

The school district proceeded to outline Jack's IEP goals, and at the end of the meeting, denied the parents' request for placement at a residential setting. Their conclusion was that Jack could be appropriately served in a public-school setting with accommodations for ADHD. In response, the parents are embroiled in a battle with the school district. They have hired a special education attorney who is aggressively contesting the school district's summary, stating that Jack's depression is situational and that he was overwhelmed by all that was going on outside of school, which caused his challenges, not the presence of a lifelong disability that interferes with his ability to access his education. The attorney will use experts to show that Jack's grades were propped up by thousands of dollars of tutoring, and his challenges have been life-long. His social, mental, and developmental challenges have impacted his ability to learn. The case will most likely be headed to a hearing unless the two sides can agree upon a settlement.

Theory to Practice

Over the course of 18 years, the school administrator at the residential program has been involved in approximately 50 cases such as Jack's. Several of these cases have reached the courts in which the administrator has been called upon as a witness for the family's defense. During the court session, the administrator has been asked to describe the student's inability to function in the general public educational setting, along with the need for a more specialized residential setting with mental health support so the student can access the

academic curriculum. The school administrator has consulted many parents in her career on the process of the IEP, specifically when they have placed their student unilaterally and the rights of the parents under IDEA. However, having worked in the public schools for 16 years, the school administrator is aware of the financial burden of these placements. Public schools are struggling to stay financially solvent, and out-of-district private residential placement takes a toll on an already limited budget and resources.

Surprisingly, many parents win their case with their school districts. In the school administrator's career, only approximately 15 of the 50 cases have not been in favor of the parents. Most school districts will initially deny the placement, but with an attorney, the parents can present a strong case on why the disability affects the academic progress of their child. Since most school districts do not have the intense supports these students need in order to deal with their severe emotional and behavioral difficulties, residential placement becomes a very real possibility. However, the schools must first recommend services and placements to the parents, which are often within their district or local region.

Schools are required to offer a continuum of placements from regular education classes with supplementary services and supports to other options, such as special education classes and special education schools. The parents are part of the IEP team, and while they need to explore each option for suitability, they can base their decisions on their child's unique and individual needs. Under IDEA, parents have the right to deny the IEP team's recommended educational placement. If the case becomes conflictual with attorneys present on both sides, a school district will often propose a settlement. Costs increase exponentially the further within the legal system the case is appealed, so often a settlement is the best option financially for a school district and the parents.

Practice Guidelines

As a school administrator, whether in private or public setting, it is vitally important to understand the rules and laws for children with disabilities and IDEA. An administrator must follow the professional standards which directly align with the National Policy Board for Educational Administration (NPBEA), Professional Standards for Educational Leaders (PSELs), the Utah Educational Leadership Standards (UELS), and topics covered on the Praxis Educational Leadership: Administration and Supervision Exam. Most notably are the following standards which relate to laws and rules for children with disabilities and the financial responsibility to manage funding for a child with disabilities.

IEP PLACEMENT

Professional Standards for Educational Leaders (PSELs) (NPBEA, 2017)

Standard 2: Ethics and Professional Norms

2a: Act ethically and professionally in personal conduct, relationships with others, decision-making, stewardship of the school's resources, and all aspects of school leadership.

2c: Place children at the center of education and accept responsibility for each student's academic success and well-being.

Standard 9: Operations and Management

9h: Know, comply with, and help the school community understand local, state, and federal laws, rights, policies, and regulations so as to promote student success (NPBEA, 2015).

Utah Educational Leadership Standards (UELS) (UELS, 2019).

Standard 6: System Leadership – An educational leader promotes the success of every student by understanding, responding to, and influencing the interrelated systems of political, social, economic, legal, policy, and cultural contexts affecting education.

6B1: Operates consistently to uphold and influence federal, state, and local laws, policies, regulations, and statutory requirements in support of learning for all students.

Praxis (0411 or 5411) Topics (ELAS, 2019)

III. Managing Operational Systems and Safety – Aligning and obtaining fiscal and human resources

An educational leader:

1. Allocates funds based on student needs within the framework of local, state, and federal regulations (Praxis, 2016).

IV. Collaborate with families and other community members

An educational leader:

2. Involves families in decision making about their children's education (Praxis, 2016).

Following the standards is critical, but an administrator must also stay up to date on laws impacting educational policies and rules. Following case studies in school law helps prepare a school administrator to best serve her or his school and make decisions which impact the welfare of all students and the school community, both academically and fiscally.

Conclusion

Mental health issues are on the rise in the United States. Daily, the news and social media highlight the plight and danger of untreated individuals who are dealing with severe emotional disturbance and the resulting maladaptive behaviors. The cost of treatment is astronomical for an adult and is a burden on government social services. The costs can often be mitigated by treating individuals in their youth, as children and adolescents are more malleable and open to change. Public schools, under Individual with Disabilities Act (IDEA), have the responsibility to identify and help children who suffer from all kinds of disabilities, which include emotional disturbance, and offer appropriate educational services that allow them to receive equal educational opportunities. Special education services under FAPE provide free and appropriate public education consistent with a student's individual needs.

Sometimes, the services offered in a public school are not enough if the needs of a student exceed the services being offered. Residential care becomes an option at the top of the Least Restrictive Environment (LRE) alternative continuum. Residential care has 24/7 supervision and care, which neither the parent or school has the ability to sustain. Where there is sufficient evidence, IDEA allows for residential placement to provide special education and related services to the child with disabilities. If residential placement is determined to be the best option for a child through his or her IEP, then the school district may be obligated to cover the costs related to the placement if and only if academic progress is not being met due to the disability.

However, some parents take matters into their own hands and unilaterally place their child in a residential setting, which is often a private institution. Because the placement relates back to their child's disability, they may seek reimbursement from their school district. Refusal on the part of a school district to pay for a residential school can move into due process on the part of the parents. Sometimes these cases can be solved quickly through amending an IEP, but often these cases are controversial, conflictual, and expensive. School administrators need to be fully aware of the laws surrounding placement and make

decisions as part of the IEP team to best manage their budget, provide resources and expertise, and support families within their community.

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Questions may be directed to:

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Salt Lake City, UT 84105
(801)832-2427 • ebehrens@westminstercollege.edu

Manuscript Topics

The *Journal of Therapeutic Schools and Programs* (JTSP) is published by the National Association of Therapeutic Schools and Programs and publishes articles that assist readers in providing comprehensive care for adolescents, young adults, and families receiving services from residential, wilderness/outdoor behavioral healthcare, and transition treatment programs. The editors welcome manuscripts that are the original work of the author(s), have been approved by an Institutional Review Board when data was collected, and follow APA style as presented in the sixth edition of the *Publication Manual of the American Psychological Association*. Manuscripts may include, but are not limited to, case studies, topical clinical articles, literature reviews, qualitative research and empirical research. Submissions are encouraged that relate relevant theory to clinical practice or provide original research relating to program or treatment effectiveness.

Submitting the Manuscript

Electronic submission is required at www.natsap.org. **Author/s must submit an abstract, keywords, and author bio/s along with the manuscript.** Authors are required to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test procedure, funding provided by program) when their manuscript is submitted. Contact Dr. Ellen Behrens at ebehrens@westminstercollege.edu with questions.

Manuscript Evaluation

Submitted manuscripts will initially be reviewed and evaluated by Dr. Ellen Behrens or a Guest Editor. After the initial evaluation, manuscripts will be sent to a Review Board who will forward their recommendations to Dr. Behrens or the Guest Editor. The JTSP management team reserves the right to edit or to require editing of content, format, or style, or to make other revisions before accepting a

manuscript for publication. Dr. Behrens will make final decisions regarding publication status.

Manuscript Format
All manuscripts should be submitted in a form that allows blind refereeing (see *APA guidelines – 6th edition*). The author's name and any identifying information must be visible only on a detachable front page. Manuscripts will be retained by the JTSP Editorial Board and will not be returned to the author(s).

Manuscripts should be formatted to 8 1/2" x 11" paper as follows:

- Font to be used is "Times New Roman – Size 12"
- Italics and Underline are accepted
- Document must be in black text only
- 1-inch margins are required on all sides
- Double line spacing is required
- Pages are to be numbered in the top right-hand corner
- Submit manuscripts in the following order: 1) Title Page (de-identified), 2) Abstract (no more than 100 words) and keywords, 3) Text, 4) References, 5) Figures (Tables, Charts, Graphs).

Total manuscript length including abstract, tables, and references should ordinarily not exceed 25 pages. The entire manuscript including footnotes, references, and quoted material and figures/illustrations should conform to the style specified in *The Publication Manual of the American Psychological Association – 6th Edition.*

Images depicting aspects of the contribution are strongly encouraged. Insertion notations for figures, tables, and images should be included in their preferred place within the document though the actual figures, tables, and images along with appropriate captions should be appended to the end of the submitted manuscript. Please attach original camera-ready art or jpeg/gif files for figures and images.

Journal Management
The National Association of Therapeutic Schools and Programs (NATSAP) Board of Directors has engaged Ellen Behrens, Ph.D. for the editorial and managerial responsibilities for the *Journal of Therapeutic Schools and Programs* (JTSP).

Publication Ethics and Publication Malpractice Statement

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Authors may be asked to provide the raw data in connection with a paper for editorial review and should be prepared to provide public access to such data (consistent with the ALPSP-STM Statement on Data and Databases), if practicable, and should in any event be prepared to retain such data for a reasonable time after publication.

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The authors should ensure that they have written entirely original works, and if the authors have used the work and/or words of others that this has been appropriately cited or quoted.

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The National Association of Therapeutic Schools and Programs
Ethical Principles

Members of the National Association of Therapeutic Schools and Programs (NATSAP) provide residential, therapeutic, and/or education services to children, adolescents, and young adults entrusted to them by parents and guardians. The common mission of NATSAP members is to promote the healthy growth, learning, motivation, and personal well-being of our program participants. The objective of all our therapeutic and educational programs is to provide excellent treatment for our program participants; treatment that is rooted in good-hearted concern for their well-being and growth; respect for them as human beings; and sensitivity to their individual needs and integrity.

When applying to become or continue as a member of The National Association of Therapeutic Schools and Programs, the program / school Executive signs the Ethical Principles stating that *our organization supports and follows the NATSAP Ethical Principles*.

1. Be conscious of, and responsive to, the dignity, welfare, and worth of our program participants.

2. Honestly and accurately represent ownership, competence, experience, and scope of activities related to our program, and to not exploit potential clients' fears and vulnerabilities.

3. Respect the privacy, confidentiality, and autonomy of program participants within the context of our facilities and programs.

4. Be aware and respectful of cultural, familial, and societal backgrounds of our program participants.

5. Avoid dual or multiple relationships that may impair professional judgment, increase the risk of harm to program participants, or lead to exploitation.

6. Take reasonable steps to ensure a safe environment that addresses the emotional, spiritual, educational, and physical needs of our program participants.

7. Aspire to maintain high standards of competence in our areas of expertise and to be mindful of our limitations.

8. Value continuous professional development, research, and scholarship.

9. Place primary emphasis on the welfare of our program participants in the development and implementation of our business practices.

10. Manage our finances to ensure that there are adequate resources to accomplish our mission.

11. Fully disclose to prospective candidates the nature of services, benefits, risks, and costs.

12. Provide informed, professional referrals when appropriate or if we are unable to continue service.

13. NATSAP members agree to not facilitate or practice reparative therapy.

National Association of
Therapeutic Schools and Programs
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