HELPING STRUGGLING TEENS AND THEIR FAMILIES FIND HOPE:
THE NEED FOR, AND THE IMPACT OF, SPECIALIZED TREATMENT PROGRAMS

This white paper has been prepared by the National Association of Therapeutic Schools and Programs (NATSAP) Board of Directors and representatives from our membership base. The following important areas will be addressed:

I. PURPOSE AND INTRODUCTION

The intent of this white paper is to educate the public and policymakers of the need for, and the impact of, specialized treatment programs for adolescents, while addressing common myths and concerns about such programs. This paper will also explore the vision, and the role of the National Association of Therapeutic Schools and Programs (NATSAP) in its mission to assist our member programs in providing ethical and quality care for troubled teens and their families. NATSAP membership is comprised of the following types of providers:

Boarding Schools (Emotional Growth, Therapeutic) – These schools generally provide an integrated educational milieu with an appropriate level of structure and supervision for physical, emotional, behavioral, familial, social, intellectual and academic development. These schools grant high school diplomas or award credits that lead to admission to a diploma-granting secondary school. Each school will vary in its approach to the emotional and behavioral needs of the child and we urge parents to review this approach with the professional that has been working with their child to ensure appropriate placement.

Outdoor Behavioral Health (Wilderness Programs and Outdoor Therapeutic Programs) - Most outdoor behavioral health programs subscribe to a variety of treatment models that incorporate a blend of therapeutic modalities, but do so in the context of wilderness environments and backcountry travel. The approach has evolved to include client assessment, development of an individual treatment plan, the use of established psychotherapeutic practice, and the development of aftercare plans. Outdoor behavioral health programs apply wilderness therapy in the field, which contains the following key elements that distinguish it from other approaches found to be effective in working with adolescents: 1) the promotion of self-efficacy and personal autonomy through task accomplishment, 2) a restructuring of the therapist-client relationship through group and communal living facilitated by natural consequences, and 3) the promotion of a therapeutic social group that is inherent in outdoor living arrangements.

Residential Treatment Centers – The focus of these programs is behavioral support. Medication management and medial monitoring is generally available on-site. These facilities treat adolescents with serious psychological and behavior issues. Most are Joint Commission (JCAHO) accredited. These facilities provide group and individual therapy sessions. They are highly structured and offer recreational activities and academics.

Home-Based Residential Treatment Centers – These programs are small, generally serving twelve or fewer participants. The milieu frequently incorporates equestrian, farm or ranch activities. The majority integrate participants in the local public or private schools in the area while others offer home schooling. These programs are excellent for young people that need a highly structured environment.

The length of stay will vary from a few weeks to two years depending on the program and the needs of the child.

II. REASON WHY TREATMENT PROGRAMS ARE DEVELOPED: SIGNIFICANT NEED

Historically, private treatment programs for youth developed for two primary reasons: 1) to address youths' special needs not served through public programs; and 2) to create more effective treatment approaches than were available at that time. Many program founders acted out of concern for the welfare of our youth and a desire to make a difference in their lives, and with relevant experience and education. While financial stability is necessary for a program to continue to provide a specialized service through qualified and credentialed staff, it is concern for our youth, love for the work, and a desire to serve that is the primary motive.

In the past 25 years the level of structure and protection for youth in our society has deteriorated. More than 33% of public high school students drop out of school. Drug use is rampant in junior high and high school, and these drugs are more powerful, addictive, and dangerous. More and more young people have addictions such as cutting, and eating disorders. More are being diagnosed with depression (including bipolar disorder), anxiety, attention deficit disorder, and oppositional defiance. Use of prescription medications to manage emotional and behavioral problems has increased. These facts are symptoms of an adolescent culture that is stressed, overwhelmed, and struggling to cope.

Traditional mental health services also are struggling to cope with the need, and insurance coverage of treatment. Over the past twenty years the length of stay in primary care psychiatric hospitals and residential treatment programs has decreased precipitously. Treatment has shortened and focused on crisis stabilization and medication management in order to manage care and contain costs for insurance companies.

Why do parents place children in our privately funded residential treatment programs? Private treatment programs are a necessary component of an overall continuum of treatment options. They offer a clear, effective solution to real and urgent needs parents and families face today.

Parents feel helpless as they watch their children flounder and fail to mature. Despite outpatient therapy, various medications, and occasional brief visits to psychiatric hospitals or youth authorities, some children continue on a downward spiral. In spite of their best efforts, concerned parents can see the situation has become out of control. They are losing their child. Parents realize their child will not graduate from high school, does not handle emotions, shows little or no concern for others, and cannot plan realistically for the future. They wonder if their child might not make it and fear that he or she may even die. The palliative remedies offered by outpatient therapists, and legal and health care institutions often can't address the real needs. They need a specific kind of help, and find it in private treatment programs.

III. ONGOING OUTCOME RESEARCH

NATSAP programs have been committed to internal outcome studies and have participated in two major outcome research studies since 2000. The primary studies were conducted by Dr. Keith Russell, University of Minnesota, who focused on outdoor behavioral healthcare[1] and by Dr. Ellen Behrens, Canyon Research and Consulting that recently completed an outcome study for residential treatment[2].

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[1] www.obhrc.org

[2] www.natsap.org/newsandmedia.asp

Dr. Keith Russell, PhD, University of Minnesota, began conducting an assessment of outcomes in outdoor behavioral healthcare treatment in 2000. Dr. Russell's abstract of the assessment states:

> *Outdoor behavioral healthcare (OBH) is an emerging treatment that utilizes wilderness therapy to help adolescents struggling with behavioral and emotional problems. The approach involves immersion in wilderness or comparable lands, group living with wilderness leaders and peers, and individual and group therapy sessions facilitated by licensed therapists in the field. OBH also offers educational and psychoeducational curriculum designed to reveal and address problem behaviors, foster personal and social responsibility, and enhance the emotional growth of clients. The extant studies on the effectiveness of OBH and wilderness therapy reveal a consistent lack of theoretical basis, methodological shortcomings and results that are difficult to replicate. This publication reports the results of an outcome assessment for adolescent clients who received treatment in seven participating OBH programs that averaged 45 days in length from May 1, 2000 to December 1, 2000. Adolescent client well-being was evaluated utilizing the Youth Outcome Questionnaire (Y-OQ) and the Self Report-Youth Outcome Questionnaire (SR Y-OQ) (Burlingame, Wells, & Lambert, 1995). Complete data sets at admission and discharge were collected for 523 client self-report and 372 parent assessments. Results indicated that at admission clients exhibited presenting symptoms similar to inpatient samples, which were on average significantly reduced at discharge. Follow-up assessments using a random sample of clients found that on average, outcomes had been maintained at 12-months posttreatment.* [3]

Dr. Ellen Behrens, PhD, Canyon Research and Consulting, reported findings from a multi-center study of youth outcomes in private residential treatment at the 2006 American Psychological Association Convention in New Orleans, LA. Dr. Behrens abstract of the findings states:

> *This paper presents the results from the first phase of a longitudinal, multi-center study of outcomes in private residential treatment. It is the first known large-scale attempt at a systematic exploration of client characteristics, treatment outcomes, and discharge predictors in private residential treatment. The sample of nearly 1000 adolescents, from nine private residential programs, was about equally likely to be male or female, from middle or upper socioeconomic backgrounds and predominately white. Ninety-five percent had prior treatment and 85% were treated for multiple presenting problems, the most common of which were disruptive behavior, mood, and substance abuse problems. Parents and adolescents reported significant improvement during treatment on adolescent communication, family relationships, and compliance. Analyses of variance indicated that both adolescents and parents reported a significant reduction in problems from admission to discharge, on each aggregate measure psycho-social functioning (Total Problems Scores, Internalizing Scales, and Externalizing Scales of the Child Behavior CheckList, CBCL, and Youth Self-Report, YSR) and nearly every syndrome (15 of 16 YSR and CBCL Syndrome scales). Only two out of 22 treatment and non-treatment-related variables (Grade Point Average and Mood Disorder) interacted with outcomes. Furthermore, in stepwise regression analyses, testing a wide array of treatment and non-treatment variables, only a handful of variables predicted discharge functioning. Taken together, the analyses suggested that adolescent problems improve significantly during private residential treatment and that, with only a few exceptions, discharge functioning and in-treatment change are relatively similar, regardless of adolescent background, history, problems, and treatment factors. Implications and research recommendations are presented.* [4]

The NATSAP Board of Directors chartered an Outcome Research Committee under the direction of Dr. John Santa, PhD to formulate an outcome study for the NATSAP membership at large. The creation of this study demonstrates NATSAP's commitment to continuing its efforts to appraise the outcomes of the children we serve.

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[3] Keith Russell, Child & Youth Care Forum, 32-60, December 2003 © 2003 Human Services Press, Inc.

[4] Ellen Behrens, PhD, Report of Findings from a Multi-Center Study of Youth Outcomes in Private Residential Treatment

IV. A TEAM APPROACH TO CHILD ADVOCACY

Parents seeking treatment for their child can at times feel all alone, but in the area of private adolescent programs, an entire team of professionals is involved in supporting the family and youth in treatment, education and recovery. While some parents will self-refer to a private program, most are guided by the professional expertise of a counselor, psychologist, family doctor, psychiatrist or other professional familiar with the child's emotional, behavioral and educational needs. Educational Consultants are a specialty profession whose focus is providing expert recommendations to parents on appropriate educational, treatment and specialty programs that best fit their child's needs.

Private residential programs for youth take a team approach in working with the educational and health care professionals who are also working with the child and family. A team approach to coordination of services in the program, home, school and community provides an effective and comprehensive care for the child.

Both the Independent Education Consultants Association and NATSAP[5] have deemed the payment or receipt of payments for referrals to programs as unethical, have membership policies stating this position, and have actively educated their membership in the ethics of referral relationships. Concerned parents and families should expect the highest level of professionalism, ethics and standards from every professional on the team helping their child.

V. DIAGNOSIS VS. LABELING: THE BEGINNING OF GOOD AND PROPER TREATMENT

Private treatment programs for youth draw from models of education, experiential education, psychology, psychiatry, social work and family systems theory. We provide a complex milieu of bio-psycho-social-educational treatment that addresses multiple aspects of a child's failure to mature and develop a resilient, adaptive character structure. Each NATSAP program places a unique emphasis on the various aspects of treatment. The result is 170 member programs, each with a somewhat different blend of approaches, but all committed to the same basic principles of ethics and practice in which the value, dignity and safety our children is paramount.

Within a treatment setting, it is important to talk of problems in terms of trends, patterns, or needs and then the consequent strategies for intervention in addressing those needs. That general approach is much more useful than focusing on problems or labels we may use to describe a patient and his or her needs. Caution must be used to understand and help, rather than label, judge, or limit positive expectancies of any child.

The mental health industry has long been criticized for labeling clients through the use of diagnostic terms, in describing problems and designing treatment for adolescents in need. The profession residential treatment for adolescents has also received some criticism in this area of concern. On the opposite side of that coin, some treatment programs, especially some emotional growth schools, have been questioned for not using well-established diagnoses with their codes and delineated clusters of symptoms.

Youth receiving mental health diagnoses need the advantage of matching appropriate treatment to proper diagnosis, and also to be understood and then helped as an individual, rather than as an illness or a problem. Ethical treatment programs, of which there are many, understand and practice both of these principles.

VI. THE ETHIC OF TREATMENT WITHIN THE LEAST RESTRICTIVE ENVIRONMENT

Treatment within the "Least Restrictive Environment" is an ethical principle to which quality mental health, medical health, and education providers subscribe. In the industry of " intensive care" of troubled

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[5] Ethical Principle #5 – Avoid dual or multiple relationships that may impair professional judgment, increase the risk of harm to program participants, or lead to exploitation.

teens, no matter the treatment modality or setting, this ethical principle is widely accepted, and it is the mandate of NATSAP[6] that it be practiced.

Programs gather information about the severity of the problems and the treatment received to determine whether their program's level of restriction is appropriate for each individual child. The historical assessment of treatment is important because it not only tells which treatment approach may be optimal at a particular point in time, but it also tells whether the intensity of services considered is truly appropriate for the youth.

NATSAP programs are committed to this process of screening every potential admission for appropriateness. However, once it is determined that residential care is appropriate, it must also be understood that rapid shifting to lower levels of care or outpatient treatment as symptoms decrease is extremely risky, particularly for troubled adolescents. Rapid shifting to lower levels of care and structure might help control costs, but it is contrary to the needs of most adolescents who are placed in longer-term residential treatment. If they need longer-term residential care, then by definition they need stability of care. The goal of residential treatment is not temporary symptom abatement. The goal is to re-establish a path of development that can lead to success as an adolescent and young adult. Such success requires learning new skills, practice and incorporation of these skills and a new sense of self-efficacy. These tasks take time, consistency, and safe containment for long enough to become incorporated into the adolescent's representation of their family, their world, and themselves.

VII. THERE IS GREATER RISK WITHOUT TREATMENT

Risk in treatment has recently been the focus of a new legislative proposal. Representative George Miller-CA has introduced federal legislation (HR 1738 III X Miller, 2005) " *To End Institutional Abuse Against Children.*" It is not the purpose of this paper to address concern about this well intended proposal. However, we feel compelled to point out that the very title of the bill creates a negative bias. The word "Institutional" implies that programs are "warehousing" students or patients and infers a cold or inhuman approach to caring for those in need. It also implies that all programs are similar and not individualized.

NATSAP agrees that institutional treatment approaches are not in the best interest of youth. NATSAP programs are not institutional in their approach but rather seek to provide individualized and nurturing care in their therapeutic and educational programs. We have seen and experienced first hand that NATSAP programs are guided and staffed by credentialed individuals, and that the programs are so varied that they are more individualized than institutional. It is precisely this creativity, individualization, and variability in treatment programs, along with the help of those who know the programs well, that enhance the possibility of finding a "good fit" between each student and the selected treatment program. Many NATSAP programs provide an environment that is rich in staff-student interaction and affection within the context of a communal environment that fosters mutual respect and trust. There is a sense of a vibrant community in which all members, staff and students alike, affect each other and contribute to a greater good. In many cases, programs foster a family-like atmosphere that places great emphasis on the balance of nurturance and recognition with appropriate limits and structure. Providing a safe and supportive forum for kids, free from the varied stresses, stimulations and distractions of their home lives, allows for maturation to resume and security and confidence to blossom.

Sadly, tragic incidents of abuse or even death during treatment have occurred. The premature death of any child should attract attention. It is a universal desire to ensure the protection of our children. There is great grief and sadness when the life of even one child is lost.

Even NATSAP programs who aspire to the best practice standards have experienced tragedies. Despite these rare, yet sad, experiences we must consider the alternative.

We must realistically acknowledge that, by definition, our clients are at high risk for negative, even fatal outcomes. Without treatment the risk of death or serious injury is much greater. In the case of

[6] Ethical Principle #1 – Be conscious of, and responsive to, the dignity, welfare, and worth of our program participants.

troubled youth, far more lives are lost to suicide, alcohol poisoning, accidents while driving under the influence, drug overdose, or death in the act of a crime of violence. Sometimes, failure to treat illness and addiction in our children can be a stance which passively endangers our youth.

Failure to treat has many consequences, and as a community it is the responsibility of each of us to do whatever we can to support the goal of treating those in need. Even though our clients, youth at risk, are truly a minority of the adolescent population, they contribute in a measurable way to the social and community costs and consequences to which negative behaviors lead.

VIII. FOLLOWING STANDARDS OF CARE AND PROPER REGULATION

Treatment programs which are members of NATSAP and other reputable programs as well (which together make up the majority of programs) actively seek opportunities to assure safety, improve outcomes, and live by principles of ethics and standards of best practice to guide both business and treatment decisions. This is evidenced by a significant number of programs which have sought licensure even when it was not legally required for business operation, and a significant number of programs which have voluntarily achieved accreditation by Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other accrediting bodies.

As part of the foundation of NATSAP, Ethical Principles were developed in 2000 and Principles of Good Practice for clinical treatment were delineated. In 2004, Principles of Good Practice in Education and Behavioral Management Guidelines were implemented. See Appendices I, II, III and IV. Member programs have been educated in these Principles and must adhere to them in order to gain and maintain membership in NATSAP.

Not only has NATSAP developed and promoted widely the value and importance of such principles, NATSAP has also actively sought out local and state licensing bodies and legislative quorums to develop, implement, and enforce standards of care to guide programs towards excellence in care, and to protect our youth in treatment.

For example, NATSAP was the driving force in Idaho, Utah and Oregon to help state licensing officials delineate regulations and guidelines for licensure for therapeutic programs in those states. It should be noted that Utah had no guidelines for therapeutic boarding schools until NATSAP members in those states (the leaders of treatment programs), approached state officials, requesting oversight and offering help in the interest of creating and maintaining a reputable industry, and more importantly, in monitoring the welfare of children from many states who were being served within Utah and Oregon.

NATSAP and its leaders within treatment programs are in favor of realistic and proper regulation. As with any complex profession, we ask that regulation be deft, well informed and of intelligent design. We ask that regulators consider input from those who understand the profession, and that the regulation recognize the unique qualities of our programs. NATSAP also believes that regulation is generally most effective at the level of state governments who are able to write regulations that take into account the needs of children and families, as well as the unique qualities of each treatment setting.

We are in favor of a partnership between caregivers and governmental agencies, so that regulation and policies are realistic, practical, workable, and truly therapeutic for children. We hope for measures that are developed in cooperation and in our shared commitment to help troubled youth gain back their lives and find hope.

We actively seek open dialogue between different parties with differing views and who are looking for collaboration and cooperation. There is no room for programs who have little interest in providing excellent care, who seek to avoid accountability.

IX. PUNISHMENT: AN INEFFECTIVE METHOD FOR LONG-TERM POSITIVE CHANGE

The few programs in the country that continue to employ the outdated, ineffective, and sometimes damaging negative treatment methods, using terms such as "tough love", or are otherwise employing a model of punishment to mold or reform behavior, have created controversy and generated negative media.

Most of these programs are self-described as “boot camps”, or behavioral, but not therapeutic and professional programs.

NATSAP programs do not employ these methods. The NATSAP Principles insist that programs operate with the utmost concern for human dignity and specifically prohibit any behavioral management procedures that involve sexual, physical, or emotional abuse[7], or that deny a nutritionally adequate diet[8] for our participants. All programs must also have a clear written statement of participants’ rights openly disclosed to both participants and parents.

Reputable programs recognize the need for two primary factors needed in the creation of an environment for positive change for adolescents who are attempting to change maladaptive or addictive patterns of responding to life's stresses and choices. Those two elements are Structure and Nurturing. Successful parents, teachers, or counselors know that an imbalance of these two core elements, on either side, undermines the very foundation and environment in which internal and personal change take place for developing youth. We have observed that most professionals in this industry of helping youth are both intelligent and caring enough to make constant efforts at keeping this balance. For those who are not, we join the effort to assure that needed changes will occur.

X. NEGATIVE MEDIA CONCEALS POSITIVES ABOUT ADOLESCENT TREATMENT

In recent years, there has been increasing interest in, and media coverage of, private programs for helping struggling teens. In particular, there has been interest on the part of the general public, regulatory bodies, and the legislative community. Scrutiny has been primarily focused on the general programs for helping “acting out" and other difficult to manage adolescents, as well as hundreds of programs, some very small and specialized, to address the special needs of particular populations. Just a few of these clientele include: the learning disabled, autistic, diabetic, oppositional defiant, clinically obese, or drug dependent youth.

The increased attention on these programs has, fortunately, increased awareness among families looking for help, among consumer advocates in their attempts to protect families from unethical programs and practices, and among public policymakers.

Unfortunately, when a tragic event occurs the media coverage may be highly emotional and may inappropriately generalize a specific, rare incident to the profession of treating teens as a whole. The result increases the fear of families struggling with their struggling children and generates well-intended but perhaps not well-informed public and legislative response. This does not lessen the pain and anguish of a family who suffers the loss and even more so if caused by unethical or poor quality care. While tragedies do occur, and must be addressed, they are not pervasive or representative.

XI. IN CONCLUSION: NATSAP IS PASSIONATE ABOUT GOOD TREATMENT

NATSAP honors, respects, and joins those whose efforts are in the cause of protecting children, and their frightened, overwhelmed, and sometimes desperate parents, from unnecessary, unethical, or otherwise

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[7] Behavioral Support Management Guidelines – Principle 3.4 – (the following interventions are prohibited) Physically abusive punishment; any behavior support management that is contrary to local, state and/or national licensing or accrediting bodies

[8] Behavioral Support Management Guidelines – Principle 3.4.1 – (the following are prohibited) procedures that deny a nutritionally adequate diet

poor treatment. What we do not embrace are methods, in the name of consumer protection, which damage not only reputable and effective treatment programs, but families as well.

Rumors, fear and conflicting information about treatment undermine trust that families must have in order to commit to high quality and effective care that is truly needed by their child. They contribute to feelings of insecurity and self-doubt, feelings of discouragement, aloneness, and hopelessness, and damages the foundation of a trusting relationship, which is so important in the effective treatment of youth.

NATSAP believes that in our collective strength, advocates for youth and their care will have more success in helping our youth. Independent professionals, parents, youth, private programs, schools, policymakers and other child advocates must work together toward common understanding, better public education and highest standards of care to lay the cornerstones for building protection, safety and a bright future for our youth.

APPENDIX

Appendix I	NATSAP Ethical Principles
Appendix II	NATSAP Principles of Good Practice
Appendix III	NATSAP Supplemental Principles of Good Practice
Appendix IV	NATSAP Behavior Support Management in Therapeutic Schools, Therapeutic Programs and Outdoor Behavioral Health Programs.

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