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Residential Treatment PROGRAMS

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On the cover: Sladic

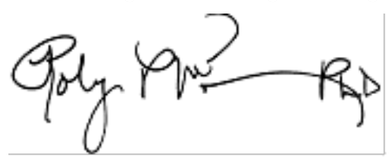
Letter from the Editor

Our Summer issue of the TMP addresses a subject that has been in the news a great deal recently: residential treatment programs for teens. There are numerous programs across the country, all of which offer different treatment options. Our guest editor, Joshua Cohen, PhD, is a consultant who vets these programs in order to help families find the program that best suits their teen's needs. I reached out to Dr. Cohen after a teen I work with returned from one of these wilderness programs with a list of "abusive practices" they experienced while there. This teen's behaviors did improve after they returned home; however, it stemmed from fear of being sent back to the program rather than a true shift in their mental health. The family had vetted the program to the best of their ability. I personally spoke with the therapists working with my client and was really impressed with them. Although this was several years ago, I still struggle to understand what went wrong? How much of what my client reported was factually accurate versus their own interpretation of events? This teen had a history of lying and being manipulative so we did not necessarily believe their account. However, after meeting with them when they returned and subsequently learning more about the program they attended, I fear that I may have done this teen a disservice by not listening to their complaints (or cries for help) during their stay. And yet, Dr. Cohen provides examples of typical letters teens send home to their parents and every sentence could have been written by my client (and probably was). Obviously, not every teen is providing an accurate account and even today, I don't know how I would evaluate their experience differently. I am working with another family right now whose young adult son is in a residential program and is having an entirely different experience. After years of unsuccessful therapy and medication, he is finally feeling better and seems to be making changes in a way that he never has before. I turned to Dr. Cohen for insight about his experiences with residential programs, wondering how he evaluates these programs. He generously shared his thoughts and was so knowledgeable that I turned to him to guest edit this issue.

In the first article, Dr. Cohen discusses the various types of programs ranging from therapeutic boarding schools to wilderness programs, as well as others and explains the difference between them. In the second article he goes on to share in fascinating detail what the consultant process looks like from the time the parents

reach out for help, through their interviews and the transportation process. He debunks some common misconceptions that are prevalent because they have been misrepresented in the media. David Gold, PhD writes about Wilderness programs specifically: what they are and how they aim to nurture change. He asserts that they can be one of the most effective modes of therapy for teens who need more than weekly therapy or even intensive outpatient programs. Unfortunately, there has been a rising awareness of ways in which some programs have taken advantage of these vulnerable teens and their families. Dr. Cohen outlines the numerous ways that consultants try to vet programs as well as ways in which parents can evaluate them. Alec Stone, MA, MPA addresses national efforts that have been made to provide oversight, standardize programs, license or accredit them and regulate best practices for ethical standards within the field.

As a psychologist who works with teens, I am immensely grateful to Dr. Cohen and his colleagues for sharing their insights. I hope that you will be as well!



— Robyn Waxman, PhD

A Note from the "Guest Editor" Regarding The Maryland Psychologists' Summer 2024 Edition

Joshua Cohen, PhD

Dr. Joshua Cohen was born and raised in Michigan, just outside of Detroit. After spending three semesters at Muskingum College in New Concord, Ohio, Dr. Cohen transferred and earned his bachelor's degree in psychology from The American University in Washington, DC. He then earned his master's degree and Ph.D. in Clinical Psychology at Michigan State University and now runs a private practice in Rockville, Maryland. Dr. Cohen specializes in in providing therapy for adolescents and adults in individual and couples treatment, addressing a wide range of challenges including relationship issues, substance abuse, depression, anxiety, ASD, and ADHD.

Additionally, Dr. Cohen is a Therapeutic Placement Consultant, working with families to find higher levels of care for their adolescents or young adults. As a consultant, Dr. Cohen uses his expertise and helps place people into Wilderness Therapy, Residential Treatment, Therapeutic Boarding Schools, or Transitional Living Programs.

In addition to his clinical work, Dr. Cohen has played an active role in the Maryland Psychological Association, serving as Chair of various committees and as President from 2012-2013. His leadership included guiding the association's legislative efforts and overseeing the search for the MPA Executive Director.

It is an honor to have been asked to serve as the "Guest Editor" for the Summer 2024 edition of the TMP. This edition looks at an industry of behavioral health/mental health treatment focused on adolescents and young adults who require more intensive treatment than outpatient therapy can provide. Within this industry there are multiple types of programs and various ways families find the programs. The programs are considered a higher level of care when compared to outpatient therapy or short-term hospitalization. Typically, these programs include Wilderness Therapy Programs, Residential Treatment Programs, Therapeutic Boarding Schools, and Transitional Living Programs. Moreover, within program types, there are different specializations. For instance, there are wilderness programs specializing in treating neurodivergent kids, whereas other wilderness programs work with kids who have a history of trauma.

Finding a program that is a good fit for an individual and for a specific family can be very challenging. Some families choose to look on the internet and find programs that they believe will fit their needs. Others hire a Therapeutic Placement Consultant, meaning a consultant who helps families find a higher level of care for their loved ones. Although some versions of these programs have been around for more than 50 years, surprisingly few mental health professionals are familiar with the programs or aware that there are consultants who are knowledgeable about them.

Beginning with "rehabilitation programs" in the 1950s and CEDU Educational Programs in the 1960s, the industry of treatment programs has at times grown and expanded its reach, and at other times it has shrunk and limited the number of programs available for referrals and treatment. We are currently in a shrinking phase, mostly because of very toxic publicity about programs engaging in abusive behavior and lacking oversight and regulations. Although some reports are accurate, many of them are not only inaccurate but have been direct lies told by people who never actually attended programs. Be that as it may, reports of abuse at programs, both legitimate and illegitimate, have caused a downward spiral in the industry, forcing many programs to close and making it exceedingly difficult to find available help for people in need.

The industry has responded with attempts to increase regulations and oversight to reduce the frequency of abuse in the future. While this approach may sound like an unexpected approach for Therapeutic Placement Consultants and Educational Consultants, it is exactly what we want to see happen. As mental health clinicians, we spend our time helping people who are experiencing mental health crises in their lives. Lobbying for and enacting legislation that would root out bad players and abusive programs and provide guidelines for programs to follow is very desirable because it should lead to healthy, safe programs to whom we can refer. In this edition of the TMP, we are lucky enough to have an article written by Alec Stone, CEO of NATSAP and a licensed lobbyist. This article focuses on challenges in the industry and NATSAP's participation in facilitating legislative initiatives.

One section of the industry that has experienced a disproportionate number of closures is wilderness therapy programs. According to many professionals in the industry, despite the closures and negative publicity, wilderness programs still provide great therapeutic services and arguably have the biggest impact of any type of program in a relatively short time frame. To help clarify and substantiate the positive effects of wilderness therapy, Dr. David Gold, a psychologist with many years of experience as a Therapeutic Placement Consultant, has provided an article for this TMP. Dr. Gold's article focuses on the research showing the effectiveness of

wilderness therapy.

While experiencing a massive overhaul of treatment programs, some truly outstanding programs remain open. Another article in this TMP focuses on the main difference between Therapeutic Placement Consultants and Educational Consultants, the different types of programs that exist in the industry, as well as what a consultant brings to the table. Additionally, the article highlights and demystifies the placement process from the time a call comes in, to gathering information, to the end of formal treatment.

It is my humble opinion that the current state of affairs in the treatment program industry will eventually turn around, and we will once again feel the positive effects of wilderness programs, residential treatment programs, therapeutic boarding schools, and transitional living programs. It is my hope that any program that is shown to act in an abusive or otherwise inappropriate way will be shut down and the people running such programs will be taken to task and punished for their horrific behavior. Moreover, I hope that those programs that have been falsely accused of wrongdoing, and there are many of them, will be resurrected and will once again provide outstanding treatment for those in need.

— Joshua Cohen, PhD

Classifieds

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Kristen Clarke 208925603

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Understanding the Difference Between Educational Consultants and Therapeutic Placement Consultants, and Exploring Treatment Options Beyond Outpatient Therapy

By Joshua M. Cohen, PhD

Educational Consultant, Therapeutic Placement Consultant, Wilderness Therapy programs, Residential Treatment Center, Therapeutic Boarding School, Transitional Living Programs. These words are familiar to most clinicians, but the majority of mental health professionals do not clearly understand what they mean. What is the difference between an Educational Consultant and a Therapeutic Placement Consultant? Additionally, what are the differences between Wilderness Therapy Programs, Residential Treatment Centers, and Therapeutic Boarding Schools? What distinguishes one Wilderness program from another Wilderness program? These questions and others will be addressed below.

Educational Consultants:
Educational Consultants (EC) come in many different forms, but many of them are parents who entered the consulting field after they placed their child into one or more programs. These individuals went through the process of sifting through hundreds of program websites, had phone calls with many programs to discuss the treatment they provided, the different types of therapies practiced at programs, and learned about the living conditions, the costs, and more. At some point during this massive undertaking, they decided that they could help other families going through similar challenges, by sharing their knowledge and providing consultation. Moreover, if their child had learning differences in addition to mental health challenges, these same parents would also learn about private schools, boarding schools, and therapeutic boarding schools around the country. As these parents began helping other families navigate treatment options, they started to see their ability to help others as a business opportunity and began to formalize their process and create a consultation practice. However, these consultants are still lay people, not professionals with formal training in mental health issues, therapy, diagnostics, and testing.

Therapeutic Placement Consultant:
Therapeutic Placement Consultants are not a clearly defined group either, but generally speaking, they differentiate themselves from Educational Consultants by the fact that they have a clinical degree, and many of them are licensed professionals. They may be psychologists, social workers, counselors, psychiatric nurses, etc. For this group, relying on their clinical training, understanding diagnoses, understanding test data, and knowing the different types of therapy used for different disorders, makes these consultants stand apart from ECs.

Additionally, different consultants focus on different populations. For instance, as a therapeutic placement consultant and also a licensed psychologist, I only work with populations requiring a "clinical focus" and I do not work with families looking for traditional boarding school/academic placements.

Wilderness Therapy Programs:
Wilderness therapy has the most oversite of any of the treatment models discussed here. These programs operate with "field staff" who are with the groups 24/7. All the field staff are aware of what each participant is working on in therapy, and they provide encouragement and support to program participants. They help with journaling assignments, reading assignments, and life skills like cooking and proper care of supplies. There are overnight awake staff in each group as well as primary therapists entering the groups on certain days to have individual therapy, specialized group therapy, etc. I would argue that most wilderness programs provide amazing therapeutic care that any therapist would consider kind, empathetic, and consistent treatment. Moreover, when one enters a wilderness program, one leaves behind all of the distractions of everyday life. There are no cellphones, no tablets, no computers, no gaming systems, and no access to drugs, alcohol, or tobacco. There are no other types of therapy where this level of reset can take place. I freely admit that I am biased and that I believe wilderness treatment is the best short-term therapy available because it has the biggest impact in a limited amount of time (i.e., 8-12 weeks).

There are two approaches to wilderness therapy: The nomadic approach and the base camp approach. The nomadic approach has participants stay in the

"field" throughout their treatment. They hike from campsite to campsite (typically less than 5 miles per day) staying away from people outside their group and staff. Delivery of essentials are brought to them in the field including food, drinks, change of clothes when needed, etc. The nomadic approach is especially good for participants who might try to run from a program, or have trouble transitioning, or for those who have had positive experiences with the outdoors, love hiking, etc.

The base camp model creates a different vibe: these programs have groups go on therapeutic excursions lasting four or five days and then return to base camp for a few days before leaving again for another excursion. Sometimes the excursions have a specific focus such as mountain biking to a mountain summit or rock climbing on a mountainside. These tasks provide an opportunity to accomplish a challenging goal, to ask for help when a task is challenging, and to take controlled risks that are anxiety-producing, require trust in others, and lead to moments of elevated self-esteem. Returning to base camp provides a sense of foundation and a solid reset.

Residential Treatment Centers:

Residential treatment programs are second regarding the amount of oversite of participants provided by programs. Residential programs include different kinds of therapy, teach life skills, have academics as part of the program, and can provide college counseling, and SAT/ACT preparation courses.

Residential programs typically have parameters identifying the populations with whom they work. This could include gender-specific programs for boys, girls, those who identify as non-binary, or those who identify as intersectional, etc. They might also focus on adolescents who have specific diagnoses such as ASD, ADHD, or other neurodiversity, emotional dysregulation, anxiety disorders, primary substance abuse, or dual diagnoses, while others focus on attachment disorders or learning differences.

These programs also offer different types of therapy. These often include DBT/RO-DBT, intensive exposure response prevention (ERP), EMDR, Brain Spotting, equine therapy, canine therapy (using horses or dogs as a therapeutic tool), various types of group therapy, drama therapy, substance abuse groups, and more.

Living conditions are often in a large, modified home that would include an industrial kitchen, multiple bedrooms with bunk beds, bathrooms, and places to store bikes, snowboards, fishing gear, and other gear for weekly outings. Especially if one is coming out of the wilderness, the indoor shower, bed, and flushable toilet are considered luxurious.

Residential programs often last longer than wilderness programs, although the length of time varies for everyone. Length of stay could be anywhere from four months to twelve months or longer.

Therapeutic Boarding School:

Therapeutic boarding schools (TBS) have the least amount of oversight when discussing adolescent treatment programs. These types of treatment programs frequently have students who have come from wilderness programs or RTCs. The participants have been through intensive treatment, and have already started to get back on track, but they still benefit from a therapeutic environment, structured days, and a safe move toward taking on more responsibility.

However, in some instances, RTCs and TBSs look very similar to one another, and the distinction has more to do with how the programs are licensed than the actual level of oversight or the amount of treatment provided. It falls to the consultant to know which programs are called RTC but are more like TBS's and vice versa.

It is also the consultant's responsibility to consider the academic prowess of programs and participants. For instance, if the participant is college-bound, knowing the level of academic rigor in programs is important for making a good match. Checking the historical record of a RTC or TBS, to see where others had applied to college and where they were accepted, becomes important. Many programs can provide such information if requested.

Transitional Living Programs:

These programs are designed for young adults who may have tried college or university but struggled to attend classes, may have stayed in their dorm rooms gaming, lacked sufficient executive function to handle their schedule of classes and homework, etc. Some of these young adults may be on the spectrum, may have a processing disorder, or may have a history of trauma, or something else which limits their ability to shift from an adolescent to a young adult during their college years.

Transitional living programs are designed to provide life skills training, starting with basic tasks such as consistent hygiene practices, improving sleep hygiene, cooking eggs or making one's lunch, doing laundry, and budgeting for going to the grocery store. Other higher-level tasks might include filling out job applications, role-playing interviewing skills, job coaching, handling one's medication, and being responsible when it comes to electronics such as cell phones and computers.

Transitional living programs typically have relationships with therapists in the community or have therapists on staff. Although not all participants will see a therapist, the option is available. The same holds for psychiatric/medication management appointments. Additionally, many transitional living programs offer participants the chance to finish high school credits if they did not graduate before starting the program. Moreover, there are often college or community college campuses near the programs and the program leadership often has relationships with the colleges. This allows young adults to take courses, join a club, go on campus to see a show, and more.

Consulting with Families:

Every consultant has a different way of approaching their process. Some consultants offer a contract that focuses on a certain number of placements. That means that one placement could be a wilderness program, and a second placement for the same participant could be a residential treatment program. At that point, if other decisions needed to be made or if the participant began refusing treatment, the family would either need to sign another contract or attempt to navigate the remaining issues on their own.

Other consultants approach the process differently. They might offer a contract that focuses on time, not the number of placements. For example, some consultants offer a one-year contract that covers all the work that takes place during the twelve months. This could include regularly communicating with the participant's primary therapist at the program to keep track of the participant's progress, setbacks, and periods of stagnation.

In addition to keeping abreast of a participant's progress and setbacks, helping to guide families through the process is another part of the consultant's job. Parents hear all kinds of things from their kids when they are in a program. Letters are written to parents and sent through the program's portal. Some letters say things such as "Everyone in the program has much more severe problems than I have. Please take me out of this program" or "Everyone at this place only stays four weeks. Can you please get me out of here next week, when I reach the four-week mark?" or "I have learned everything they can teach me. Now I understand what I did wrong, and I promise to do better if you just take me home." The most alarming letters include accusations such as "a field staff pushed a member of my group" or "field staff made me hike about 10 miles today because they don't like me and they are punishing me." As one can imagine, parents panic as they read these letters and start questioning the program's safety, the program's therapeutic integrity, and the program's ability to help their child. Under these circumstances, I will contact the program, ask questions to verify what has happened, and then contact parents and share the information. Frequently, the parents have already described themselves as overprotective, and overindulgent, and that they rarely gave consequences for their child's misbehavior. In these cases, the parents must start to learn a different way of parenting, which is part of the programs' expectations of the parents. This is when the consultant gets a call from parents who are panicking and worried that their "child is in a dangerous group," or "that they are not getting the help they need" or something along those lines. The consultant is then tasked to find out what is happening at the program and discuss with parents their child's attempts to manipulate them, trying to get the parents to jump in and save them (this is a common reaction for parents who are enablers).

—Continues on page 28

An Explanation from One Therapeutic Placement Consultant about What He Does and How He Does It

By Joshua M. Cohen, PhD

As a Therapeutic Placement Consultant, I am frequently asked questions such as "How do you determine whether an individual needs to go to a higher level of care?" and "How do you determine which type of program is best for an individual?" The answers to both questions, as well as others, are usually discovered during the first and second stages of my assessment process. Below, I will discuss the process that I have used and honed over the years of my involvement in this work.

At The Beginning:

For me, the process usually starts with a phone call to inquire about the services I offer. The parent who calls provides information about what is happening with their child. As the call goes on, often for an hour or longer, I am listening for descriptions of dangerous behavior, history of other treatments that have been attempted but did not work, as well as other treatment programs that have been attempted, including outpatient therapy and medication management. I listen for clues about substance use, indications that they are questioning their own identity, and problematic behavior outside the family home.

Often one parent is calling, and the other parent is not available, so a second round of phone calls is common. When it comes to the second call I listen for consistency between parents' perceptions of the issues, is one parent more tolerant of the behavioral issues, does one parent minimize the behavior, and do both parents report the same issues? During these initial contacts, I take some basic notes.

For my part, I ask questions for clarification and then explain what the next steps would look like, what things the parents should be prepared for such as the general cost of programs, the fact that much of the expense will mostly be out of pocket, I share what the different types of programs offer, and a basic idea around the average length of stay in each type of program.

Parent Reports and Fears:

During the initial phone calls, many parents share a lot of negative history and information about their adolescent child. Frequently, their list of infractions and serious issues is long and daunting. It can include substance use, car crashes due to reckless driving, physical altercations at school, destruction of property, defying authority, sneaking out at night, falling grades, problematic friend groups, and more. On the other hand, there are also "softer" adolescents who are struggling with anxiety, depression, diagnosis of ASD, learning differences, difficulty making friends, self-harm, suicidal ideation and suicide attempts, hospitalizations, and school refusal. Within these extreme cases, one finds suffering and hardship, as well as family members doing everything they can to reduce the problems that have been taking a toll on the family.

Nevertheless, the parents usually have a lot of anxiety and fear about the possibility of sending their teenager to a treatment program. They sometimes conclude that they are not ready to send their child to a program despite the list of problems that exist, they still hold hope that they can turn the ship, and everything will be okay. This is a highly unlikely outcome, and they often call back and choose the move forward with a placement.

At this point, the parents are sent a copy of the contract. If they sign the contract and pay the fee, the next step is to engage in a clinical intake, either via telehealth or in person. The intake usually lasts 2.5 hours and typically includes the information they have already discussed with me on the phone as well as other information such as academic history, strengths, and weaknesses, history of hospitalizations, history of relationships, releases of information to speak with current therapists, psychiatrists, and whomever else is involved with the participant. Additionally, assessment reports, 504/IEPs, and other information is collected. Once the aforementioned paperwork is read and digested, possible programs are considered.

For adolescent participants, the types of programs considered typically include wilderness programs, residential treatment programs, and therapeutic boarding schools. Wilderness programs with a nomadic approach are typically considered for those who are acting out behaviorally, are engaging in substance use, are bullying other students, and those whose problems include screens, social media, and gaming. For adolescents who fall into the "softer" category, consideration may turn toward a wilderness program using a base camp model, or a residential treatment program. There are also wilderness programs that work specifically with people on the spectrum, and some that work specifically with

trauma, as well as other diagnoses.

As it stands now, data is showing that those who attend wilderness programs before either residential treatment or therapeutic boarding school, do better acclimating, and connecting with others in the milieu in their second program, and finish in a shorter amount of time, when compared with those who go directly from home to a residential treatment program or a therapeutic boarding school. It is assumed that the hard work in wilderness therapy prepares them for subsequent programming.

Differentiating residential treatment centers and therapeutic boarding schools can be difficult because the differences between students is not always evident. The primary difference is that residential treatment centers admit people who have a higher level of acuity than therapeutic boarding schools; residential treatment centers admit students with more emotionally and physically disruptive behaviors, and thus require more oversight and clinical intervention. This translates into licensing regulations for residential treatment centers being required to have a 1:4 ratio of staff to students. Therapeutic boarding school regulations require a 1:6 ratio of staff to students.

When deciding what type of program is appropriate for a therapeutic placement, residential treatment centers fit well for those who have a history of substance use, oppositional behavior, and emotional dysregulation. Alternatively, a therapeutic boarding school would be a better fit for those who struggle with depression, anxiety, and screen addiction and turn their pain inward. Given these differences, one can see why a person who reacts to their issues by using substances, fighting, or getting suspended from school would be considered a good match starting at a wilderness program followed by residential treatment.

Moreover, therapeutic boarding schools are most often used as a first placement when the participant has a specific learning challenge and a tendency to withdraw and isolate when they become emotional. Otherwise, a therapeutic boarding school usually does not have the infrastructure needed to provide the level of support and therapeutic intensity to keep the participant away from screens, substances, or other potential problem areas.

After narrowing the program options, contact is made with a programs admission's department. Information provided to the admission's person includes clinical history, diagnoses, presenting issues, behavioral problems, family background, academic strengths, and weaknesses, and assessment reports. The program can provide the consultant information such as whose group has openings, who is the therapist, and what is the group makeup (i.e., ages, issues, backgrounds, and group cohesion). This information is used to determine goodness of fit. The admissions person will typically take the information to the clinical director/clinical team, share the testing report, and get back to the consultant with either a "Yes, this is our kid" or "We are concerned about XYZ, can you get more information about that issue?"

If the program agrees that the individual is a good fit, the consultant will call the parents to explain the program and the reasons for the goodness of fit. If the parents agree, they will be introduced to the admission's person via email and a call will be scheduled between the parents and the admissions person. If the call goes well and everyone agrees that the program is a good fit for the family, an application is completed, and the remainder of the information is shared with the program (i.e., insurance card, parent's driver's license, immunization records, etc.).

Probably the most daunting part of the process comes when decisions are made about how the participant will get from home to the program. Traveling to the program is the beginning of the therapeutic endeavor and starting it without a big fight with parents is greatly preferred. If the participant has been cooperative with their parents and is willing to get on a plane and travel with them to the program, without begging, promising better behavior, or having a tantrum, then it is an easy decision. If, however, the participant is fighting with their parents, punching holes in the walls, throwing dishes at them, then the consultant discusses using a transport service.

Transport Services:

Transport services have a bad reputation and often become the most challenging sticking point for parents to get past. It is assumed that big, burly men with handcuffs show up at the house, scare people half to death, threaten the participant to get them to comply, or else... and then kidnap the participant, all of which is carried out in the early hours of the morning. Fortunately, this description makes for fun TV, but it is not accurate.

So, what really happens with transport? The transport company is contacted by the consultant and basic clinical, personality, and demographic information about the participant is provided. If the participant is a 14-year-old female with paralyzing social anxiety and depression, with a history of suicide attempts, the transporters need to know this information. In this case, the transport company will send a female as the lead transporter. The lead transporter will ride in the backseat with the participant, provide support in the car and on the flight, and will be able to escort the participant to the restroom as needed.

If, however, that participant has a history of substance abuse, and aggression, has been in fights at school, and is a large man himself, the transporters need to know this too. Under these circumstances, the transport company might send three transporters instead of two. All transporters are trained in methods of de-escalation, will sit and talk with the participant before leaving for the airport, and the transporters will explain what is happening and how it will unfold, providing the participant with information to include them in the process.

The transporters do arrive in the early morning hours, usually between four and five o'clock. There are a few reasons for this: first, they travel into town from wherever they live and must meet at the airport, pick up a rental car, and drive to the home of the participant. If they are transporting from the East Coast to the Western United States, they need time, and the timetable is set by the program, as they have a deadline since the participant must arrive at the program no later than 2:00 PM. Thus, if an 8:00 am flight is leaving BWI to Salt Lake City, Utah, and the family lives in Northern VA, they will need to leave the participant's home very early.

Before leaving for the airport, the transporters need time to talk with the participants and try to create rapport. It will often take about 1.5 hours to get to the airport, and they must arrive at the airport 1.5 hours before the flight takes off. One transporter returns the rental car at the airport while the other waits with the participant. Once inside the airport, they must go through security, and they will always offer to get breakfast for the participant. The flight is 4-4.5 hours long, landing around 12:00 pm EST/10 am MST. Then, they rent a car at the airport and drive to the program, often stopping for lunch. This explains the timing if everything goes according to plan, without any unforeseen interruptions, and still leaving some leeway just in case. I hope that this explanation debunks the reason for fear of using the transport services and the need for an early morning arrival. Finally, this is nothing like kidnapping. The way to approach transport services that work best for most families is for the parents to wake up their adolescent and tell them that they decided that they will benefit from going to a program, that they will be safe, and that they love their child. The transporters are introduced as the people who will take them to treatment. This is very different from a kidnapper's approach. Having used transport services many times, I can say that I have never had a transport go sideways. No one has run away, fought the transport team, refused to comply with directions, or any other scenario one can imagine.

The transportation team keeps all interested parties abreast of their transitions and destinations. They text and email the parents, the consultant, and the program. Updates happen when they have left the house with the participant. They share any issues that took place such as "initially, the participant was resistant to leave with the team, but we talked, and they decided to leave with us" or "they cried when leaving but then slept in the car on the way to the airport." These types of texts are shared when leaving the house, arriving at the airport, boarding the plane, landing, and being handed off to the program. When the participant arrives at the program, the consultant gets notified and updated throughout the first 24-48 hours. The consultant is also contacted by the program's primary therapist to update about the transition, to ask questions about the parents and the family dynamics, and to schedule future calls. Parents are also contacted by the primary therapist within the first 24-48 hours to touch base, let them know how the participant is adjusting, and schedule the weekly calls.

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Wilderness Therapy: What It Is and What It Is Not

By David Gold, PhD

I earned my BA from Yale University and my Ph.D. in clinical psychology from New York University. I am a former adjunct professor of developmental psychology at Johns Hopkins University and was a member of the research psychiatry faculty at Johns Hopkins School of Medicine. In addition to working as a school psychologist for the Baltimore City public school system, I have worked full time in private practice at Crossroads Psychological Associates since 1995, and became a partner in 2006.

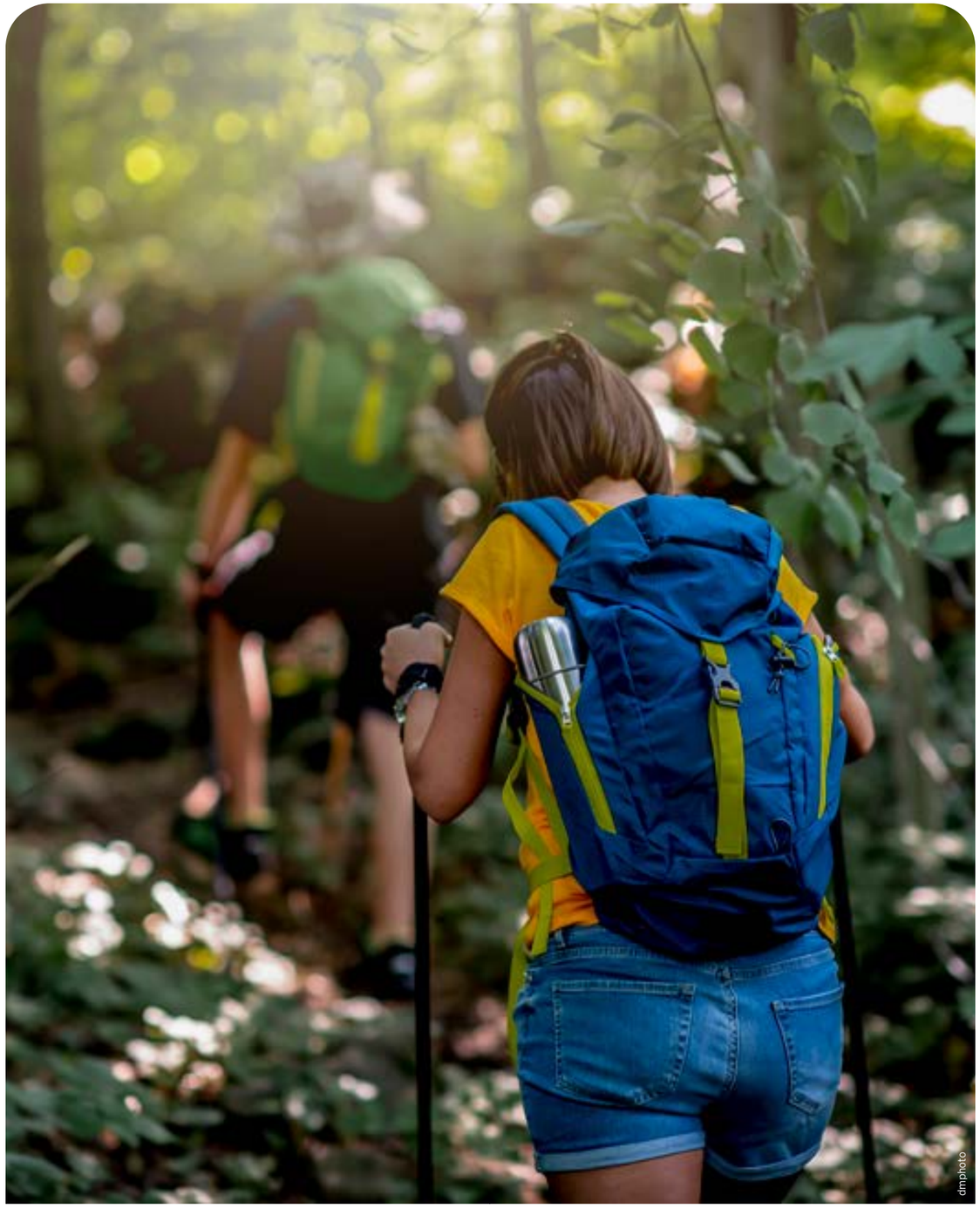
Although I work with all ages, children through adults, I specialize in working with teenagers and families. In addition, as a therapeutic placement consultant, I match teenagers and young adults who need more than what can be provided on an outpatient basis, with the appropriate therapeutic residential school, wilderness program or residential treatment center.

Wilderness therapy combines rigorous clinical work with an experiential component in a way that is qualitatively different from both outpatient psychotherapy and other types of residential therapy. It is an evidence-based treatment backed by over 20 years of research. And despite how they are portrayed on social media and in the newspapers, wilderness therapy programs have been shown to be safe and non-punitive.

Wilderness therapy is a clinical intervention for both adolescents and young adults. It can be used to address not just behavioral difficulties and substance abuse, but social, emotional and relational difficulties as well. According to the *Manual of Accreditation Standards for Outdoor Behavioral Healthcare Programs,* wilderness therapy is "the prescriptive use of wilderness experiences by licensed mental health professionals to meet the therapeutic needs of clients". Most wilderness therapies may be characterized as including

> (a) Extended backcountry travel and wilderness living experiences long enough to allow for clinical assessment, establishment of treatment goals, and a reasonable course of treatment not to exceed the productive impact of the experience.
> (b) Active and direct use of clients' participation and responsibility in their therapeutic process.
> (c) Continuous group living and regular formal group therapy sessions to foster teamwork and social interactions (excluding solo experiences).
> (d) Individual therapy sessions, which may be supported by the inclusion of family therapy.
> (e) Adventure experiences utilized to appropriately enhance treatment by fostering the development of eustress (i.e., the positive use of stress) as a beneficial element in the therapeutic experience.
> (f) The use of nature in reality as well as a metaphor within the therapeutic process.
> (g) A strong ethic of care and support throughout the therapeutic experience (DeMille et al., 2018, pp. 242-243).

Wilderness therapy can be thought of as an extended group backpacking and camping trip, with licensed clinicians and field staff (i.e., paraprofessionals). It allows the clinicians to see patterns and behaviors as they come up organically in the milieu, and to



be able to address them experientially in the moment, in addition to processing them verbally.

Wilderness therapy is an evidence based treatment. It is supported by a considerable amount of research published in peer reviewed journals. One meta-analysis reviewed 36 outcome studies totaling 2399 students who participated in wilderness therapy. This analysis found "medium effect sizes for all six constructs assessed: self-esteem (g = 0.49), locus of control (g = 0.55), behavioral observations (g = 0.75), personal effectiveness (g = 0.46), clinical measures (g = 0.50) and interpersonal measures (g = 0.54)" (Bettman et al. 2016). And these changes appear to be long-lasting and stable over time. One longitudinal study found that "adolescents make significant changes during outdoor behavioral healthcare" and that these participants maintained these gains 6 months and 18 months after leaving the programs (Combs et al. 2016).

Additionally, wilderness therapy has been shown to improve teenagers' functioning when compared with a control group of adolescents participating in other forms of treatment. DeMille et al. (2018) compared 60 participants in wilderness therapy with a comparison group of 60 matched adolescents whose parents inquired about participating in a wilderness therapy program but chose to seek treatment within their community. Their results indicate that "the gains in the (wilderness therapy) group were significantly greater than the (treatment in their community) comparison group, almost three times larger in fact." (DeMille et al. 2018).

Wilderness therapy programs typically involve some participation in somewhat challenging and risky activities and helping students move out of their comfort zone. Programs necessarily have a responsibility to keep their students safe.

> The universal duty of care, popularly described, is to avoid causing harm to others from unreasonable risks. In relationships of trust and reliance-such as those you enjoy with...participants-that duty is expanded: You are expected to protect your participants from unreasonable risks or , not simply refrain from creating such risks (Gregg 2021)

"However, making physical and emotional safety paramount in outdoor recreation, education, and therapy does not negate the need for, or even the value of positive risk taking...as a mechanism of personal growth" (Norton, 2021). Interestingly, data collected from wilderness programs show that despite the risks that are inherent in some of these activities, wilderness programs are actually quite safe. In fact, students enrolled in therapeutic wilderness programs were three times less likely to go to a medical emergency room than adolescents living at home. Further, teenagers were 140 times more likely to be injured playing high school football than participating in a wilderness program. Both the frequency of illness and the frequency of physical restraint and therapeutic holds decreased each year from 2006 – 2011. "The average adolescent in US inpatient mental health services was about four and a half times as likely to be restrained as (a wilderness therapy) client in 2010" (Gass et al. 2012).

As is the case for most areas of medical and psychiatric care, wilderness therapy seeks to improve as the field continues to develop. Towards this end, this year the National Association of Therapeutic Schools and Programs (NATSAP) has submitted legislation to congress that outlines federal guidelines intended to improve both the safety and effectiveness of residential therapeutic programs including therapeutic wilderness programs. This proposed legislation includes

(i) Child abuse and neglect shall be prohibited, including any acts of physical, emotional or mental abuse:
(ii) All parts of the covered program must ensure the safety of the children in their care:
(iii) Adequate furnishings at the covered program shall be provided for each child in their care:
(iv) The covered program must maintain and environment that ensures safety for program staff and children in care for the following safety areas-(I) Food service risk and assessment, (II) Drinking water or wastewater assessment; and (III) Hazardous material management, including handling and storage...
(v) The covered program must obtain all private health record information referred to in this Act in a manner that complies with federal law and applicable regulations.
(vi) The covered program must have policies and procedures that cover all prescription and non-prescription medication ...
(vii) staff at the covered program must be provided with orientation training prior to or within 30 days of hire. The orientation must include training on the following – (I) Discipline and behavior management protocols including de-escalation skills training, crisis prevention skills, positive behavior management, and discipline techniques that are non-punitive in nature and are focused on helping children in care build positive personal relationships and self-control; and (II) Training may not include any emotional, mental or abusive protocols.
(viii) ratios of staff to children in care must be established and maintained that will provide adequate supervision, safety and protection for children in care.

Wilderness therapy has been used to help teenagers and young adults for decades. It has been shown to be a useful and effective treatment when other modalities have not been successful. Is it 100% effective? No. Is an extended backpacking trip (whether as part of a wilderness therapy program or just for recreation) sometimes uncomfortable? Absolutely. Do backpackers sometimes find themselves cold or hungry or dirty? Yes. Has it been shown to be safe? A review of the literature confirms that these programs are, in fact, quite safe. Were/are there some poor quality programs out there? Unfortunately, yes. Did the industry need to grow, develop, improve and tighten up its procedures over the past 25 years? Yes. Have surgical procedures, chemotherapy and most other medical procedures grown and improved over this same time span? Of course. Is wilderness therapy a panacea? No. But it can be an extremely good and useful option when it is a good fit and other treatments have not been successful.

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Navigating the Treatment Industry and Knowing What to Look for When Choosing a Program

By Joshua M. Cohen, PhD

As you may be aware, there has been a lot of negative publicity surrounding the youth therapeutic treatment industry. The negative press has included a mix of honest statements put forth by people who have suffered tremendously at programs where abuse was commonplace, as well as bad actors who have gained employment at upstanding programs, and these individuals preyed on vulnerable populations. Moreover, there have been a couple of highly publicized documentaries, most notably one in which Parris Hilton, the famous heiress to the Hilton hotel chain, talked about abuses she suffered while in adolescent treatment programs in the 1990s. Additionally, Parris Hilton gained access to state and federal legislators and has spent time lobbying and testifying before state legislators and the United States Congress. Over time, many people have come forward claiming abuse and the amount of negative publicity has grown into a movement of its own known as "unsilenced."

Unfortunately, there have also been bad actors in the "unsilenced" anti-youth-treatment industry. These bad actors seem to come in two different forms: The first is the person who was in treatment with someone who claims they were abused. To provide support for their friend, the bad actor makes public statements saying they too were abused or witnessed abuse at a program. In some instances, a third person who was also in treatment with the bad actor questions them about their claim. Not infrequently, the bad actors have responded that they were not abused, but they want to support the people who have claimed they were abused. The second form of bad actors claim they were at a program and suffered abuse, but they were never actually at the program. In these instances, the program investigated the claim and found that no one with the name of the complainant was ever in the identified program.

With all the negative publicity, and the intolerable risk of choosing a program where abuse is a real concern, how do parents who have exhausted their local resources, find safe and effective treatment for their adolescent? What should they look for in a program? How do they know who they can trust? Below are a few options that can help families make safe choices for their children.

One option is to use a Therapeutic Placement Consultant. It is important to know that consultants do not have financial connections to any programs and therefore are independent and likely to choose programs that best fit the individual. Additionally, consultants regularly travel and visit programs. They meet with the program leadership, the clinical staff, the educational staff, and with participants. When meeting with participants, most consultants want to meet without program employees present, reducing the pressure that a staff person is hearing a participant's response to a question or concern. Being able to ask questions about the program's strengths and weaknesses, about the therapists, about individual and group therapy, as well as questions about residential staff and programming staff, provides useful information about how the program operates.

Another option is for parents to visit the program before making a final decision. If parents tour a program, meet the staff, therapists, teachers, and participants, and see the facilities, they typically feel more confident in their decisions. Frequently, a couple of program participants give the campus tour to parents, providing time to talk and see how the kids interact. The participants are typically open to sharing their history and journey. As a result, parents often get a sense of the participant's personality and their challenges. Parents often draw comparisons between participants and their child. When the program and the family are a good fit, the parents can see their child in the participant who is touring them, they find comfort in the connection and can see the participant's growth, which instills hope in the parents.

Alternatively, the consultant can encourage families to ask the program leadership to explain online reviews or newspaper articles written about the program. In response, the program should feel comfortable being candid and transparent. If there was a bad actor-employee whose name came up in a review, the leadership should be clear about what happened, their response when they learned of the problem, the outcome, and the impact on the program. It is remarkable how a candid response can give families the comfort and trust they need to feel good about choosing a given program. For example, in one such instance, a program had hired a therapist who was a bad actor. The therapist was accused of having a sexual relationship with a minor who was also their client at a program. When the program became aware of the allegations, the therapist was terminated, the program fully cooperated with the police investiga-

tion, and all participant families and consultants were notified. The therapist was tried, convicted, and sent to prison. When the program was subsequently asked by potential participant families about these events, they shared the information openly and honestly. They added that none of the families who had a child enrolled at the time of the events took their child out of the program, not even the family whose child was sexually abused. Furthermore, no lawsuits were filed against the program. It is assumed that families with children at the program when the sexual abuse took place, saw the issue as horrible behavior by an individual and not a systemic problem of the program.

Another avenue used to increase a family's comfort level when pursuing information about a program, is for parents of potential participants should be able to contact the parents of other participants who had child who previously attended the program. Of course, the program is going to provide names of previous family participants who were happy with the program and outcomes. Still, through non-scientific observation, it seems that parents who have had kids in treatment programs understand the hardship and are willing to share their experiences with other parents traveling through a similar landscape. During these interactions, stories of "household terrorists," (kids who hold the family hostage and blow up the family environment) are exchanged, poor grades earned by smart students, calls to the police in the middle of the night, repeated hospitalizations for suicidal ideation, school refusal, and substance abuse, are shared between parents. "You're not alone" is the transmitted message, and "hope can be found in the program you are considering."

Alternatively, some parents will say that their partner feels one way about the program, and they have had a different experience of the program. They may report that the program was not helpful because family therapy session times were always changing, the therapist often forgot the Zoom calls, the participant, while on a home visit, reported bullying. When they returned home, they reported that a person snuck a vape pen of THC into the program. Even worse, they may report hearing about inappropriate staff behavior. When this happens, the potential family is typically going to go in a different direction and other programs will be considered.

Another way to investigate programs is to look for those that are accredited by outside, independent organizations such as CARF, CoA, JCAHO, or AEE. These organizations provide independent oversite of programs and maintain the highest standards in the industry. Moreover, programs that are members of NATSAP must be accredited by one or more independent accrediting organizations.

Kids Say the Darndest Things:

When kids go to wilderness therapy programs, the most frequent form of communication is through letter writing. The participant writes letters that are assigned by their therapist; "write a letter to your parents and tell them what you have been doing and how things are going." Often the letters read as follows:

> "Mom and Dad,
> I'm so sorry for all the problems I've put you through. I'll change I promise.
> I'll do everything you ask, and I won't complain.
> This place is horrible, and you've made a huge mistake. All the other kids here have much worse problems than I have. They are all drug users, some were in juvie, and some have really bad mental illness and always talk like they want to fight. I'm scared. Please, please, please, take me home. The staff doesn't do anything. We need to cook our own food and if we don't gather enough firewood, we can't build a fire and there is no way to stay warm. They don't listen to us if we complain about something. They said if we keep complaining, they will make our backpacks heavier by filling them with rocks. Please take me home. I can't live like this.

When parents receive these types of letters they are typically upset and concerned. The feelings of insecurity and fear that they experienced before sending their child to treatment return quickly, and they are at a loss about what they should do. Usually, they contact me, the therapist, or the admissions director and ask about the letter. They ask if what "Jimmy" is reporting is true. Usually, the therapist provides the bulk of the explanation. They explain the issues described in the letter, and usually, the parent's anxiety returns to baseline. The parents will learn

from the therapist that someone in the group encouraged them to write this type of letter because it taps into the anxiety that most parents feel, and they claim they saw someone go home early after this type of letter was received by parents. The more serious issues such as "the staff said they will put rocks in our backpacks" quickly shift to "someone said that they heard from their neighbor at home that they put rocks in backpacks."

Frequently, the letters get worse before they get better. The begging for early discharge turns into threatening statements such as "If you don't take me out of here, I'll never talk to you again." These interactions often become "grist for the therapeutic mill"; previously, the adolescent made many of the decisions at home because the parents were afraid their child would be angry with them or would hate them forever if the parents did not comply with their demands.

Finally, when something bad has happened or a serious issue has arisen, the program typically calls the consultant and then the parents. The program often wants to notify the consultant first so they can be helpful to the parents once they are notified. This happened frequently during the COVID-19 pandemic if someone in the program was exposed or got sick, or if there was a significant change in staff. And of course, it happens when there is a tragedy such as a suicide or a suicide attempt, and It also happens if there is an accusation made about a therapist or a staff person. Most often, the appropriateness of being informed is appreciated and is received by parents as a comforting measure, not an anxiety-producing event (this assumes the issue is not related directly to their child). But in general, the big issues, those that make the hair on the back of your neck stand up are not communicated in letters home.

Licensed Professionals and Paraprofessionals:

All staff, licensed and unlicensed, receive training while working at programs. Whether it is conflict resolution, therapeutic interventions, safety holds, wilderness first responder, or wilderness first aid, the training is important to the daily needs of the program. Additionally, licensed clinicians may receive additional training in DBT, CBT, therapy techniques for substance abuse treatment, and so on. However, in most wilderness programs, the primary therapist is only in the field with the participants one or two days a week. However, there are always paraprofessionals with the groups. In wilderness programs, the paraprofessionals are called field staff, in residential treatment centers and boarding schools they are called residential staff or teacher aids. These are non-licensed individuals who help carry out the day-to-day therapy program or school assignments for each participant. These paraprofessionals are with the participants on a rotating schedule such as eight (8) days on, and six (6) days off. In wilderness programs, they are with the group while they are hiking, when they are building a fire, and when participants sleep, the field staff check on each group member throughout the night to be sure everyone is present, safe, and sleeping. The field staff are aware of each participant's therapy goals and assignments, they are aware of the emotional state of each member of the group. They are a source of information, consistency, support, and comfort, and serve as a solid sounding board when someone is having a hard time. Most participants find themselves connected to one or two field staff and they look forward to their next shift with the group. Field staff also are in frequent contact with the primary therapist. They often text important information to the therapist, share concerns, or ask the clinician for clarification about an assignment.

The Bottom Line:

When therapy programs are being considered for one's teenage child, the family has often gone through so many alternatives that they feel they have no other options available to them. Still, as one would expect, they are not willing to send their child to a program that puts them in harm's way. As discussed in Alec Stone's article in this edition of TMP, the industry agrees that programs engaged in abuse, violence toward participants, and/or other unethical approaches to treatment, must be shut down. Everyone who is on the right side of this argument agrees that there is no place in the youth therapeutic treatment industry for unethical, destructive, abusive behavior. Every industry has experienced bad actors and needs to resolve incomprehensible behavior committed by these individuals. This has included clergy from all religions,

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Embracing Change: Transforming Therapeutic Schools and Programs for Patient Centered Care

By Alec Stone, MA, MPA, Executive Director
National Association of Therapeutic Schools and Programs

Alec Stone, Executive Director, National Association of Therapeutic Schools and Programs, has been a leader in national nonprofit management for more than two decades. With an expertise in biomedical research and healthcare advocacy, Mr. Stone has worked with premiere organizations such as the Oncology Nursing Society, American Cancer Society, American Medical Association, American Dental Association, and the Federation of American Societies for Experimental Biology. His corporate partnerships have included GlaxoSmithKline, Procter & Gamble Company, Jansen, Merck, and Pfizer. As a public policy professional, Mr. Stone has extensive experience with Congress, NIH, FDA, CMS, HHS, and other federal agencies. He has created two Congressional health caucuses, drafted report language, held legislative briefings, written Congressional testimony, provided information for the Congressional Record, and set up annual meetings between advocates and their federal representatives. Mr. Stone has worked with local, state, and federal candidates and elected officials. From campaign management to media development, Mr. Stone has worked with multiple White House Administrations and for several members of Congress. He continues to consult for elected officials in the Washington, DC metropolitan area. Mr. Stone holds a BA in history from Memphis State University, a Master's in Public Administration from Southern Illinois University's Graduate School of Public Affairs, and a Master's in Political Management from The George Washington University's Graduate School of Political Management. Mr. Stone has been recognized with numerous awards and is a member of several civic and community boards and committees. He and his wife, Lisa, have four children.

Introduction

The world has changed dramatically these last four years. A global pandemic. An economic breakdown. A divisive political environment. Add the technological advancements that are outpacing traditional understanding of communication, information sharing, privacy, and safety, and it is little wonder that adolescents and young adults are feeling anxious, conflicted, lost, and confused. Now, perhaps more than ever, it is incumbent upon the mental and behavioral health community to raise awareness and provide guidance for the next generation. An excellent and proven sector within the larger environment though are the fully accredited therapeutic schools and programs.

While science, medicine, and health are under assault, documentarians are using techniques to bring to light some heinous activities perpetrated on students and patients, dating back 30 years. These very real and lasting abuses stem from misguided people who thought their interpretation of tough love was to demean, distance, demoralize, and

degrade adolescents. Most of those programs were not overseen by professional mental and behavioral clinicians. Many were operated by businesses, diligently working to mask their operations as therapy. For parents and guardians seeking what they perceived as last resorts for their children in desperate need, the marketing of such programs belied an achievable salvation.

Today, there are hundreds of therapeutic programs and schools. They range from wilderness and adventure to residential treatment centers and day schools. There are equine-assisted treatments and psychiatric hospitals. Acuity ranges from depression and ADHD to sexual abuse and suicidality. The trauma and life-long paths to recovery and a balanced existence are different for each patient. Therapeutic programs are now designed to adhere to specific categories, meeting the person where they are to achieve the desired outcomes that work for the individual.

NATSAP Establishes a Professional Society

Helping to guide the way—and in fact that is the motto—is the National Association of Therapeutic Schools and Programs (www.natsap.org) mission. NATSAP serves as an advocate and resource for innovative organizations that devote themselves to society's need for the effective care and education of struggling young people and their families. The vision is for a nation of healthy children. The Association is the voice that inspires, nurtures, and advances the courageous work of these schools and programs.

Incorporated in 1999, NATSAP has itself evolved in the last two decades. Its members include therapeutic schools, residential treatment programs, wilderness programs, outdoor therapeutic programs, young adult programs, and home-based residential programs working with struggling teens and troubled adolescents. All are working through NATSAP to make sure the field provides the highest

quality services to the young people and families each serves.

The common pursuit of NATSAP members is to promote the healthy growth, learning, motivation, and personal well-being of program participants. The objective of member therapeutic and educational programs is to provide excellent treatment rooted in deep-seated concern for the individual's well-being and growth, respect for them as human beings, and sensitivity to their own needs and integrity. NATSAP is proactive in improving ethical standards and practices within the field.

Therapeutic schools and programs, like other professions, are part of an ever-changing and evolving field, and NATSAP has grown with the times. The Association is the largest not-for-profit membership society in the U.S. dedicated to residential treatment centers, therapeutic boarding schools, and wilderness therapy programs. The member programs are devoted to providing effective care to thousands of people experiencing a range of mental and behavioral difficulties. That care is regulated by state licensing departments and national accrediting bodies.

Standardizing the Field

Beginning in 2023, all NATSAP Member Programs must be licensed by an approved national therapeutic accrediting body. NATSAP is not, itself, one of those licensing or accrediting bodies, or authorized or established to monitor schools or programs. That arm's length distance is another layer of ethical standards that makes the Association a stronger professional home for the community.

Before NATSAP was formed and a call for accreditation convened, few programs and schools were held to formal standards, and none were recognized at a national level. Limited organized and purposeful field-wide collaborations with the intent to share ideas, information, or innovation were nonexistent. Since NATSAP began, it has offered frequent opportunities for collaboration between members through the national annual conference, the Leadership Summit and Academic Conference, various regional meetings, a Washington DC Advocacy Day, and numerous webinars and educational sessions.

In NATSAP's first years, the founders launched the annual National Conference as an event to share industry principles, best practices, ethics, and studies. These collaborative initiatives are essential in uniting high-standing psychologists, therapists, educational consultants, schools, and programs. Many of the standards that existed within the therapeutic field before NATSAP was created were only outlined by individual programs and schools. Unified guidelines did not exist or were not enforced by the associations that drafted them.

Standards for ethical practice were the priority at NATSAP's start. The Ethics and Standards Committee and the original NATSAP Board of Directors composed 13 ethical principles that have since been embedded in the fabric of membership. These specifications are reviewed frequently. NATSAP's Best Practices Committee fields questions and concerns. If a program is engaging in unethical behavior, this committee can ask for a suspension of membership until the issue is rectified or for a specified length of time or can recommend the program be removed from membership.

Previously there was no requirement for licensed therapists or clinicians to oversee treatment in therapeutic schools and programs. NATSAP changed that and currently, therapeutic services are required to be overseen by a qualified clinician. All clinicians and therapists employed at NATSAP programs must be licensed. A program that employs only non-licensed therapists/clinicians is ineligible for NATSAP membership. Each student within a NATSAP Program must have a written treatment plan overseen by the licensed clinician. This requirement has elevated the therapeutic field, strengthening the community and adherence to patient-centered care. As the desire of programs to become a member of the Association grows, so does the desire of programs to increase their own standards to match those of the Association.

Additionally, NATSAP members are required to be either state licensed or nationally accredited. NATSAP has called for state and local licensing boards and legislative bodies to develop, implement, and enforce standards of care to guide programs toward excellence and to protect our youth in treatment. To maintain state licensure or national

accreditation, a program is required to meet approved standards of care, report incidents, and be subject to periodic, often unannounced, on-site reviews and audits. As the therapeutic field grows closer to the desired ethical and credential oversight as the standard practice, more programs are seeking this additional oversight.

Data-Driven, Evidence-Based

Since NATSAP was founded, the Association has been committed to demonstrating effective treatment through outcome studies. In recent years, more than 60 NATSAP members contribute annually to the University of New Hampshire Therapeutic Schools and Programs study. The data collected through 2019, when the last demographic surveys were updated, yield impressive statistics. More than 14,000 adolescents have consented to sharing information about their experiences, with 80% reporting clinically significant improvements at the end of their treatment modality. Along with the UNH study, some member programs have worked with Cornell and Stanford; others have long-running research collaborations with their local universities.

To further the data-driven approach to demonstrating positive outcomes, NATSAP has launched the Research Designated Program (RDP). The RDP status recognizes programs that supply data to evaluate a school or program's effectiveness and increases understanding of the positive impact of schools and programs. NATSAP helped fund the Golden Thread, a software package that allows members to follow a client through treatment. As a secondary benefit, the software allows educational consultants, who refer families to schools and programs, to collect data on those who initially seek services, but ultimately, choose not to attend a therapeutic program.

The therapeutic program community faces a challenge in facilitating randomized controlled studies of treatment outcomes, both RDP and the Golden Thread research initiatives provide valuable data in the face of this challenge.

Regulatory Oversight Advances Through Advocacy

Before NATSAP's insistence, scant federal or state legislation regarding funding, regulations, protection, or oversight for individuals with disabilities or programs treating those individuals were codified. The adoption of solidified therapeutic and ethical standards allows NATSAP a unified and credible position to advocate to legislative offices. NATSAP is continuously advocating with state and federal representatives on bills that can improve oversight and protection to individuals with disabilities-specifically those with mental health issues-therapeutic programs, school regulation for students with mental health issues, funding, and workforce development.

NATSAP continuously monitors legislation, engages in conversation with public offices and organizes policy briefings between administrators and therapists to meet face-to-face with legislators on relevant legislation. NATSAP also provides various resources for members to monitor state bills and acts, to facilitate a stronger relationship between decision-makers and mental health professionals.

Conclusion

When a child, adolescent, or young adult is in need of mental and behavioral health treatment, families are in turmoil. It is an emotional, exhausting, and expensive time. As formal intervention becomes necessary, parents and guardians are often lost in the morass of misinformation and contrary recommendations. For too long, and for too many people, attending an unaccredited therapeutic program only exacerbated an already tenuous situation. NATSAP was formed to end unscrupulous practices and direct patients to treatments that benefit the individual.

What we understand today about the person and the process is much better than was previously known. From depression to addiction, treating the whole person is now the standard of care. This in and of itself is a relatively new approach to health. Without these schools as a viable option, many people would be hospitalized, imprisoned, or would die from their condition. A stark realization of the need for therapeutic programs.

But therapeutic schools, far from being the last resort, should be viewed as part of the continuum of care. They are "safety net programs" that have

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Under these circumstances, discussions become more therapeutic, and the parents are starting to learn and recognize in themselves, how to feel their feelings but avoid the impulse to "save" their child. Instead, the consultant and the program try to encourage and support as the parents learn to tolerate their child's discomfort. Sometimes, however, things go in unexpected directions.

Real Examples of Bad Parenting Decisions:
Parents may make decisions that are not in the best interest of their child, but because they feel they know their child best, or because they want to satisfy their own needs, they carry out bad decisions. For instance, parents might decide that they are going to remove the participant from a program so that their child will not miss a family vacation, even after discussing this with the program's therapist and psychiatrist, and both professionals advised against taking this person out of the program. In one case, a father took his private jet, picked the child up, and the family went on vacation. In another example, parents decided to take their minor child off campus for a family visit, which was approved by the program, and allow them to have an alcoholic beverage at lunch, which was not acceptable. As a final example, parents decided to listen to their adolescent son's request and when they left the program for a day off campus, the parents purchased pornography for him and allowed him to bring it back to the program where it was confiscated by staff.

In other instances, many parents admit to having a parenting style that is overprotective, and overindulgent, and rarely give consequences for their child's misbehavior. In these cases, the parents must start to learn different ways of parenting, which is part of the programs' expectations of the parents. This can mean that parents learn about setting appropriate boundaries, and sticking to their decision even when their child reacts negatively to the boundary. Some parents learn about setting boundaries without yelling or respecting their spouse by not interrupting them. All of these topics are either introduced or reinforced by the consultant.

As you can probably tell, there is a tremendous amount of information to learn and to think through when engaging in a therapeutic placement process. Learning about the individual family members who are involved in the process, understanding which type of program would be best for their issues, which specific programs have availability, which therapists have an opening at the program, plus other factors all become part of the process that consultants provide. And this is all taking place before the participant arrives at a program.

In another article in this edition of the TMP, I share the actual steps I take when I am the therapeutic placement consultant helping a family find a placement for their loved one.

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Once at the Program:
At this point, the consultant's job shifts away from the initial information-gathering and transport process and moves toward the therapeutic realm. Weekly communication with the primary therapist is established to discuss the participant's challenges and progress. Additionally, once the family therapy sessions have started, discussions will include the parent's reactions to their child being in treatment outside the home, their level of understanding about their child and the treatment they will receive, their willingness or resistance to doing their work, whether it is reading a relevant book or writing an initial letter to their child (the letter has a specific rubric), is shared with the consultant.

Around the 6th week of wilderness treatment, the primary therapist and the consultant start discussing "next steps." This includes whether the participant would benefit from going to a second program such as a residential treatment center or a therapeutic boarding school. At this point, the consultant is talking with parents about the next steps and starting to locate appropriate options. All the steps taken in the initial placement are happening again sans the intake interview.

Learning About Programs:
To learn about different programs, consultants travel to visit programs. Often, consultants pick an area of the country and try to visit several programs in the region. For instance, Utah has a tremendous number of programs. A consultant might pick "Northern Utah" or "Southern Utah" and tour programs in those regions. Similarly, one could choose "Southeastern Montana and Northwest, Idaho." When going to these regions, one could visit 12-15 programs in five days. Currently, most regions have a consortium that will set up the tours according to the types of programs a consultant wants to visit (adolescent, young adult, wilderness, residential treatment, therapeutic boarding, transitional living). One person in the consortium coordinates the trip itinerary including meetings with programs, hotels, travel schedules, dinner with programs, rental car, and flights. The consortium divides the cost amongst the participating programs and each program probably spends less than $300.00 total.

Another way to meet with program leadership is at conferences. People set up meetings before big conferences to meet with consultants and share the highlights of their program. Whether the conference sponsor is the National Association of Therapeutic Schools and Programs (NATSAP), the Therapeutic Consultant Association (TCA), or the Autism Symposium, the opportunity to meet with programs and learn about their niche, is a simple approach to connecting with treatment programs.

Conclusions:
Not only does Therapeutic Placement Consultation provide a change of pace from providing therapy, but it also provides an opportunity to help families who are stuck in the midst of a crisis. Whether it is an attempted suicide, and the client will be discharged from the hospital in two days without a treatment plan, or a frightening episode of threats and aggression towards a parent, consultation work can be exciting and rewarding. Moreover, touring programs and visiting with others who share a passion to be helpful to those in need, but use different treatment modalities, is an invigorating way to recharge my batteries.

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OBGYNs at Johns Hopkins in Baltimore, MD, primary care doctors, police officers, dentists, and more. These industries have rules and regulations that govern their fields and guide the responses to infractions. Unfortunately, the youth therapeutic treatment industry has had few regulations established to guide them. Furthermore, many of the regulations that do exist were created by legislators who are unfamiliar with the treatment industry and in many instances created unhelpful laws or harmful laws. Repeated requests to have legislators visit treatment programs and spend a day or a weekend in the field with participants at wilderness therapy programs, were met with an unwillingness by legislators to learn about the programs through direct experience. Still, the industry continues to call for oversight that will provide appropriate guidance to helpful programs and those that are above board in their practices. Hopefully, the legislative efforts would also shut down the programs that are abusive and do damage to participants, families, and the industry.

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a demonstrated history of success, helping the individual reach the next progressive stage of life. Countless graduates testify to the benefits of their experiences, without which they share a potentially dark future without hope. Therapeutic schools and programs continue to provide a positive change for thousands of people every day.

As the field of therapeutic programs evolves, NATSAP will be there "guiding the way," changing with the times, and continuing to be the voice for inspiring, nurturing, and advancing the courageous work of the Association's elite members.