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AN ANALYSIS OF NON-TRADITIONAL INTERVENTION PROGRAMS FOR AT-RISK YOUTH

A Thesis
Presented to
the Graduate School of
Clemson University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
Applied Sociology

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by
Christine Luanne Moore
August 2011

Accepted by:
Dr. William Wentworth, Committee Chair
Dr. Kinly Sturkie
Dr. Marjie Britz

ABSTRACT

Through content analysis, this thesis analyzes relevant wilderness therapy programs and residential treatment centers specifically designed for at-risk youth. More specifically, this study is an applied analysis. The results provide primary care-givers with a guide for assessing programs before their adolescent continues down the path to juvenile incarceration. The study analyzed 20 wilderness therapy programs and 19 residential treatment centers through a series of exploratory questions derived from empirical research concerning the effective and ethically sound treatment of at-risk youth. The five research questions are as follows:

1) What aspects of the program promote and include family involvement?
2) Does the program stress staff competency by providing relevant training and an on-site licensed therapist?
3) What steps are taken to ensure that an aftercare/transitional program is employed after graduation from the program?
4) Is the program accredited under a nationally recognized accrediting body?
5) Does the program engage in outcome studies or track continued progress of former clients after the program is completed?

The study found that wilderness therapy programs demonstrated positive results in the areas of family involvement, staff competency, and accreditation. Additionally, the study found that residential facilities had the highest percentage of positive results in the area of staff competency and highest percentage of negative results in the area of outcome studies. Both types of programs had a high percentage of positive results in the area of family involvement.

DEDICATION

To my sister and best friend, Sharon, who has been my constant source of support and encouragement. You never doubted I could do what I set my mind to do. I aspire to have your generosity, warmth of heart, and perception.

ACKNOWLEDGMENTS

I thank the Sociology Department for sharing their knowledge and insight during my education period. The memories of my experiences and growth here go beyond academic and have proven instrumental in my development as a responsible adult. Specifically, my gratitude extends to my committee members, Dr. William Wentworth, Dr. Kinly Sturkie, and Dr. Margaret Britz for their patience and valuable feedback during this process.

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It would be an oversight not to thank my husband, Wil, who knew when to listen, when to pull me away from this work, and when to leave me alone. Wil, your patience is infinite and your love is my most valuable treasure.

Finally, I would like to offer my sincere gratitude to my friend who I am now obliged to call “Dr.” Maggie, I will never doubt your intelligence despite the story you like to relate, especially after your invaluable insight for your academically-challenged friend during this process. I love the “remember when we….” conversations and if its up to me, we will continue to make memories that leave our cheeks aching upon recollection.

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CHAPTER ONE

INTRODUCTION

Adolescence has been described as a phase of life beginning in biology and ending in society (Petersen, 1988). This period of time can be difficult and frustrating for adolescents and parents alike. While the adolescent struggles to leave behind their childhood and become regarded as an adult, the parent(s) conversely struggle to find the balance between reinforcing authority and supporting autonomy in the decision-making processes. For some adolescents, the need to feel accepted by peers has a stronger influence during this life phase, and may be the primary cause for concern in regard to behavioral choices. For many adolescents, it can be difficult to determine which influences, whether internal (mind and mental state) or external (peers, parents, societal demands and expectations), are having a more significant impact on behavior choices. The confusion created in a developing mind can create the cause and effect of negative behavioral choices. Externally, the need to feel accepted by peers has a stronger influence during this period, and could be regarded as a primary cause for concern and a trigger associated with negative behavioral choices. Whereas, internally, the state of an adolescent's mental health may provide the reasoning for adverse behaviors, which can precipitate action on the part of parents and other authority figures.

Historically, adolescents played a much more prominent role in the family's survival through greater contributions to the familial work load. However, with the rise of urbanization came a dramatic shift in the role of the teenager. School, the place where most of their time is spent, teaches "passive learning, since information flows one way: from the teacher to the student" (Rosol, 2000). Further decay of the expectations of proper moral and ethical behavior is compounded by a media that not only continues to fail to promote decent role models and who blurs the lines regarding the childhood or adulthood roles teenagers should play in family, school, society and in social interactions with the opposite sex.

When parents or primary caregivers are either unavailable or inattentive, adolescents tend to lean more heavily on their peers for guidance and behavioral

examples. In some cases, this deficiency in care will translate into adverse behavior for attention, either negative or positive. Other adolescents suffer from mental health disorders, the prevalence of which will be discussed in subsequent paragraphs. Whether it be related to mental health or parenting practices, adverse behavior in youth can be the source for intense frustration and feelings of helplessness in parents or guardians who seek to redirect their adolescent from an induction into the juvenile justice system. When traditional methods of intervention, such as school counselors, community groups, and counseling services, prove to be ineffective in addressing the problem, out-of-home placement programs could present a viable solution.

There are two distinctive types of out-of-home placement programs. The first involves programs that focus on behavior modification and addressing mental illnesses, such as wilderness therapy and residential treatment. The second involves programs that are designed to regain social control, such as military-style boot camps. While both types of programs were formed with the goal of changing adverse behavior into positive behavior, wilderness therapy programs and residential treatment focus on a personal therapeutic approach to change, while boot camps rely on the use of rigid organization and “tough love” as a means of change.

Statement of Problem

Adolescent involvement in illegal or high-risk behaviors often results in an induction into the juvenile justice or adult justice systems. The debate about incarceration as a means of rehabilitation remains an ongoing and significant debate in our society, and one that will not be addressed in this study except to state that the position of the author is that incarceration is not always the answer for adolescents who break the law since no two events, circumstances or ideologies are identical. In fact, the peer dynamics responsible for negative behavior can be amplified when youths are grouped together, acquire additional harmful tendencies, and express these upon release (Clarke, 1974). Further, the stigma of confinement and subsequent labeling from the community may advance the motivation for delinquent behavior. To avoid this negative effect,

intervention is needed once an adolescent exhibits a pattern of adverse behavior. Various programs are available for concerned parents and families to divert at-risk youth from a detrimental life course. These programs include wilderness therapy, residential facilities, and boot camps.

Parents who are concerned over their adolescents' adverse behavior are likely to seek help outside traditional community resources, such as individual counseling, family counseling, and drug-free community support programs to help their adolescent avoid an induction into the juvenile justice system.

The Internet provides information on a wide variety of subjects and adolescent intervention is no exception. The majority of facilities and programs have websites that tout their programs as the solution. Most provide testimonies from parents concerning the way the program turned their child's life around and testimonies from adolescents who claim the program saved their lives. This information may seem wholly believable to parents who rely on the contents of the websites alone in their quest for a solution.

Purpose of Study

This study provides an analysis of wilderness therapy and residential treatment programs that offer solutions to the frustrations caused by "at-risk" youth. Specifically, the present study examines websites for private intervention programs. Three general questions form the practical basis of this applied research. Are websites a trustworthy source to evaluate program effectiveness? Do websites provide an accurate assessment of program components? Should parents or primary caregivers rely on websites alone to inform themselves accurately about a residential program to which they might relinquish their children?

Research Questions

1) What aspects of the program promote and include family involvement?
2) Does the program stress staff competency by providing relevant training and an on-site licensed therapist?

3) What steps are taken to ensure that an aftercare/transitional program is employed after graduation?
4) Is the program accredited under a nationally recognized accrediting body?
5) Does the program engage in outcome studies or track continued progress of former clients after the program is completed?

Definitions of Terms

"Juvenile delinquents" refers to youths who commit crimes or infractions and are found to be in need of supervision, treatment or confinement. The age which designates a juvenile delinquent varies from state to state. Some states list the minimum age as low as six years of age and the maximum age ranges from sixteen to eighteen (Mason, n.d., "Processing Juvenile Cases," n.d., "The Glossary of Juvenile Justice Terms," n.d.).

"At-risk youth" and "troubled teens" are the terms used for minors who exhibit socially unacceptable behavior, but have not necessarily broken the law. Indeed, most websites that propose to help parents find a tenable solution use similar criteria for designating a youth "at risk." These criteria include poor academic performance, anger, defiance, lack of communication, sexual activity, and experimentation with drugs or alcohol ("Definition of an At-Risk Youth," n.d.).

"Parents" and "primary caregivers" are used interchangeably in this paper. It is not this author's wish to assert that parents must always be present for a child to succeed in life. However, the individual or individuals who provided the primary socialization for the child, filtering their knowledge of the world and impressing their definitions of his or her social situation (Berger and Luckmann, 1966), must continue to embrace their role as part of the family unit to provide the most stable base for the child's personal development.

A "delinquent act" is an act committed by a juvenile that is designated a violation, misdemeanor, or felony offense under the law of a state. Delinquent acts include crimes against persons, crimes against property, drug offenses, crimes against public order or a violation of a municipal ordinance ("Statistical Briefing Book," n.d.).

"Mental health" generally refers to a psychological and emotional state. The term is fluid and is used to discuss a) a positive state of psychological and emotional well-being and the conditions that foster it, b) the absence of mental illness, or c) the presence of mental imbalances that affect overall psychological well-being (Whitlock and Schantz, 2008).

A "status offense" is a non-delinquent or non-criminal offense for juveniles, such as curfew violation, ungovernable, truancy, or underage drinking. These offenses are only attributable to juveniles, as they would not be considered an offense for an adult ("Statistical Briefing Book," n.d.).

What to Expect

Most therapeutic programs that might keep the adolescent from "correctional" incarceration are privately owned. They are growing in number as the demand increases. According to competitive market theory, this growth will eventually create stratified pricing, more diversified service offerings, and wider availability. Growing demand also produces a new marketplace where quality varies considerably. Such diversification makes program choice ever more difficult for parents. Help is not always available from persons of authority because the alternative approaches and their range of options are still relatively new. Furthermore, immersion in the therapeutic process can only have a chance if caregivers and justice authorities grasp that a child's troubles can stem from treatable psychological origins, such as mood disorders, oppositional defiant disorder (ODD), conduct disorder, attention deficit hyperactivity disorder (ADHD) or substance abuse.

Cost

In 2006, the average cost per child in a wilderness therapy program was $14,000 for a two and a half month stay (Szalavitz). This is a cost of $186.67 per day per child or, that is, three times the 2001 average cost ($62.05) of keeping a state inmate in prison (U.S. Department of Justice, 2004). Although most websites will not list their fees, one particular wilderness therapy program, Monarch Center, claimed a cost that was 80 percent less than other programs and listed its fees as $395 per day. Since the average

stay for a client was listed as 60 days and an additional equipment fee was $950, the calculation of admission into this program in Colorado is $24,650 ("Our Wilderness Therapy Program Cost," 2009).

The current situation requires parents to pay for these alternative, immersive treatments. Some insurance providers will pay for portions of this cost. Additionally, some programs provide loan assistance or offer scholarships. Also, some residential treatment programs may be eligible for educational loans.

Clients come from middle-class or above backgrounds. The high cost of treatment means that some parents must use the loan assistance option offered by some programs or, in some cases, re-finance their homes (Cooley, 1998).

Accreditation and Access

National accreditation encourages insurance companies to assist the parents, making the programs available to a wider range of youth (Russell, 2001). Parents are encouraged to seek out accredited programs. Accreditation is afforded to the programs by the Outdoor Behavioral Healthcare Industry Council (OBHIC), the National Association of Therapeutic Schools and Programs (NATSAP), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Association for Experiential Education (AEE) and the Council on Accreditation (COA). These accrediting agencies are responsible for establishing program guidelines and insuring strict adherence to standards.

Mentor Research Institute is a 501 c3 non-profit organization approved by the American Psychological Association for continued education of psychologists. Mentor devotes its services to parents seeking a wilderness therapy program for their children. Mentor is unaffiliated with any of the programs in its listing and requests that parents help them watch and evaluate their various listings of wilderness experience organizations. Only a portion of their listing is for wilderness therapy programs, *per se*. However, their website offers a list of fifty-seven discovery questions for parents when querying a residential therapeutic program. These valuable questions stress child safety, program legitimacy and therapeutic efficacy (see Appendix B). On an affiliated website,

Mentor also issues a warning against sending your child outside the United States and Canada:

> Never send a child with behavioral and emotional problems to a program outside United States or Canada. U.S. law and rights will not protect your child from neglect, abuse or unjustified criminal charges. You may have no rights or ability to hold the program accountable. You may not be able to get your child back if there is a problem ("Outdoor Therapy Practice and Referral," 2007).

Parents thinking of sending their children outside the U.S. should read the specific advice from the U.S. State Department called "Fact Sheet for Behavioral Modification Facilities." The State Department fact sheet information is located in Appendix C.

CHAPTER TWO

LITERATURE REVIEW

History of the Juvenile Justice System

Responding to the rising rate of juvenile crime in the nineties, the juvenile justice system moved away from treatment and rehabilitation toward retribution and punishment. This change translated into longer sentences, lower minimum prosecution age, and more youth transferred to criminal court (Altschuler and Armstrong, 1995). As the system became more focused on trying juvenile offenders as adults, the courts were forced to examine the mental health issues that had been previously restricted to adults. These issues included the constitutional right to mental health treatment (Woolard, Repucci, and Redding, 1992), the applicability of the "not guilty by reason of insanity" defense (Heilbrun, Hawk, and Tate, 1996), and mental competency guidelines (Woolard et al., 1992). Due to the inclusion of such issues in the prosecution of juvenile offenders, researchers and professionals turned toward the assessment and documentation of mental health issues as causes of delinquent behavior.

Juvenile Mental Health

Mental health disorders in adolescents can be caused by biological factors, environmental factors or a combination of both. A young person's behavior, self-esteem, and ability to maintain relationships are damaged by disorders (Boesky 2002). Without appropriate treatment for their mental health disorders, they are at an increased risk for substance abuse, violence, family conflict, and poor academic performance. Normal community resources are limited. For example, studies show that 70 to 80 percent of adolescents with diagnosable mental disorders who receive mental health services are served within the school system, primarily by school guidance counselors (Boesky, 2002). This means that those who primarily provide counseling for mental illness are neither prepared nor certified to recognize mental disorders.

When the problem of mental disorders first surfaced in the criminal courts, extensive research was conducted to determine the extent of the problem. Research revealed that mental health problems affect one in every five young people at any given time (U.S. Department of Health and Human Services, 1999) although the severity of the condition varies.

Within juvenile detention centers, the Coalition for Juvenile Justice (2000) found that between 50 and 75 percent of incarcerated youth have diagnosable mental health problems, such as depression, oppositional defiance disorder (ODD), conduct disorder (CD), attention deficit disorder (ADD), substance abuse (SA), and anxiety and suffered from these problems prior to incarceration. After a yearlong study of post traumatic stress disorder (PTSD) in juvenile detention, researchers concluded that trauma and PTSD are more prevalent among juvenile detainees than in a community sample. About 93 percent of the detainees had been exposed to traumatic experiences capable of initiating PTSD (Abram, Teplin, Charles, Longworth, McClelland, and Dulcan, 2004). Boesky (2002) found that youth in the juvenile justice system suffer from mood disorders at twice the rate of those in the general population and substance abuse disorders at 10 to 20 times the rate the general population. Other research indicates that two-thirds of male juvenile offenders and three-quarters of female juvenile offenders have one or more psychiatric disorders, despite the researchers' exclusion of conduct disorder (Teplin, Abram, McClelland, Dulcan, and Mericle, (2002). This study agrees with recent data provided by an internal survey (reported on the website for the state of Florida Juvenile Justice System) conducted by the Department of Juvenile Justice (DJJ) for juvenile offenders in need of specialized services. The report indicated that 49 percent of youths in the DJJ programs had a diagnosed DSM-IV mental disorder, 14 percent demonstrated behaviors that suggested mental disorder, 35 percent of the youths had a diagnosed DSM-IV substance-related disorder, and 30 percent demonstrated behaviors which suggested substance abuse ("Juvenile Justice Office of Residential Services," 2011).

On the issue of co-morbidity, research indicated an alarming reality: only 17 percent of incarcerated females and 20 percent of incarcerated males had only one mental

disorder, while nearly 57 percent of females and 46 percent of males had two or more mental disorders. These include major depression, dysthymia, mania, psychosis, panic, separation anxiety, overanxious, generalized anxiety, obsessive-compulsive, attention-deficit/hyperactivity, conduct, oppositional defiant, and substance disorders (Abram, Teplin, McClelland, and Dulcan, 2003). The research indicates that mental health disorders have a substantial impact on induction into the juvenile justice system. Armed with this knowledge, rationality dictates addressing those disorders before they translate into criminal behavior. Furthermore, juvenile correctional facilities are by design abusive environments that intensify mental disorders (Boesky, 2002).

Residential treatment and juvenile correctional facilities now provide therapeutic treatment with a focus on altering adverse behavior. But in most cases, these facilities rely on a confinement as a treatment in its own right. Russell (2007) notes that the problem with this approach is that the confined setting makes it difficult for juvenile offenders to link anything they learn through the treatment sessions to real world situations. As a result, what they learn remains in concept form (Bates, English, and Kouidou-Giles, 1997). By contrast, outdoor behavioral health programs focus on establishing a connection between social situations, necessary situational skills and the transfer of those skills to post treatment life. In too many states, mentally ill youth are placed in lockup facilities where they are victims of violence and physical abuse. Subsequently, their condition deteriorates and are released more disturbed and dangerous than when they arrived (Coalition for Juvenile Justice, 2000).

Non-traditional Intervention Programs

Programs such as community programs and individual counseling, offered as alternatives to traditional incarceration techniques, are referred to as “non-traditional” (Russell, Hendee & Phillips-Miller, 1999). The current intervention programs for at-risk youth vary significantly. Their primary purpose is to deter adolescents from involvement in the juvenile justice system and thereby reduce difficulties during adulthood (Russell

and Hendee, 1999). To effectively treat mental and behavioral disorders, these programs require an out-of-home placement.

Celeste Washington is a juvenile court counselor with the North Carolina Juvenile Justice System. She states that all out-of-home placements, residential treatment or wilderness therapy, are utilized either as a "last resort" for youth that have committed "serious or violent offenses." North Carolina has contractual relationships and employs alternative programs on a case-by-case basis. To be assigned, the adolescent is first given a psychological evaluation and a diagnosis. This preparation assists the treatment program with the preparation of an individual care plan. Washington emphasized that neither residential treatment nor wilderness therapy are considered where the adolescent had suicidal tendencies or was assaultive (personal communication, March 1, 2011). Put simply, North Carolina does not use therapeutic programs as a preventative measure.

Residential Treatment Facilities

Defining the term

Residential treatment is an out-of-home placement option that provides therapy for substance abuse, mental health, or other behavioral problems. Within the juvenile justice system, it is referred to as "the most severe sanction that a juvenile court can impose" since it entails the restriction of a juvenile's freedom ("Juvenile Justice Office Residential Services," 2011). Most often, such placement occurs after a youth has been adjudicated for an offense. Juvenile residential facilities within the juvenile justice system range from therapeutic foster homes and youth development centers to sex-offender programs and maximum-security correctional facilities. Some residential facilities are also open to "at-risk" youth who are not yet serving time for offenses within the system.

Existing residential treatment centers (RTC) fit into two distinct characterizations: public and private. Historically, adolescents involved in public residential treatment were generally referred to the center by the juvenile justice system, child protection agencies, or public mental health systems (Curtis, et. al., 2001; Epstein, 2004; Hair, 2005). These programs subsisted through public funding and housed predominantly male adolescents,

the majority of whom were of an ethnic minority (Behrens and Satterfield, 2006). Adolescents involved in private residential treatment, on the other hand, were primarily placed in the facility by their parents or primary caregivers and funded by the same. Though no client demographic information was available for private residential treatment programs due to privacy issues, unofficial observation indicated that the participants, both male and female, were primarily Caucasian and had an upper middle class or upper class socioeconomic status (Behrens and Satterfield, 2006). However, the stereotypical designations no longer fit as statistics show that states are utilizing private residential facilities along with the public, state-run facilities, either at the same rate or at an even higher rate (OJJDP Statistical Briefing Book, 2008). For example, on the website for North Carolina's Department of Juvenile Justice and Delinquency Prevention, the following announcement was made on the homepage:

> The Department of Juvenile Justice and Delinquency Prevention is proud to announce NC ALLIES (A Local Link to Improve Effective Services) a new on-line application process for programs to apply for JCPC funds beginning with the 2011-2012 fiscal year. The North Carolina Department of Juvenile Justice and Delinquency Prevention is seeking qualified providers to deliver high quality, evidence-based services as a dispositional alternative for our court-involved youth.

A link below the announcement provided detailed information on submitting a proposal to become a vendor for statewide residential services as a dispositional alternative. Thus, if the cost of the privately owned and operated residential treatment programs falls within the parameters of the state budget, the court system will use these facilities as residential placements for juvenile delinquents, with some states placing as many as 72 percent in them (OJJDP Statistical Briefing Book, 2008).

Historical background

One predecessor for adolescent residential facilities was established in New York in 1825 as the House of Refuge, which housed any child in the state who had committed

a criminal offense. It was the result of the state's changing attitude towards juvenile crime, which had begun to rise (Roberts, 2004). It also signaled a move away from imprisoning juveniles with hardened adult criminals, a practice that only seemed only to encourage recidivism on the part of the adolescent (Roffe, n.d.).

Although parental authority was historically seen as the first line of defense in discouraging adverse juvenile behavior, the state began to change its viewpoint in regard to its role as a provider of rehabilitation rather than just an exacter of punishment. To this end, the New York State Legislature enacted the Disorderly Child Act in 1865, which stated that if a parent or guardian complained of disorderly conduct, a magistrate or justice of the peace was required to commit the child to the House of Refuge. This Act did not specify that the child have committed a crime, rather a complaint of disorderly conduct was a sufficient reason for admission. (Roffe, n.d.).

As the state became more involved in the lives of children in the area of delinquent behavior, the protection of children's rights turned into an issue of paramount importance. The year 1875 saw the establishment of the Society for Prevention of Cruelty to Children, which subsequently led to the creation of a separate children's court system in 1892. At the beginning of the 20th century, states legally bolstered children's courts, statewide mandates called for a separation of children's cases and records, and conviction of juveniles was limited to misdemeanors, with the exception of capital crimes (Roffe, n.d.).

Increased interest in juvenile reform led to the development of several residential juvenile detention facilities. These facilities were modeled after the House of Refuge and alternately run by the Human Resources Administration and the Department of Probation. The dissimilarity in management led to administrative issues, staff abuse, and overcrowding. In an effort to regulate this environment and to direct the responsibility for juvenile detention through a single channel, the Department of Juvenile Justice (DJJ) was created in 1979 (Roffe, n.d.).

Outdoor Behavioral Health Programs

Defining the term

Wilderness therapy programs, which are the mainstay of outdoor behavioral health pursuits, serve as a non-traditional intervention for adolescents exhibiting emotional, behavioral, and substance abuse issues (Harper, Russell, Cooley, & Cupples, 2007; Conner, 2007). Though primarily referred to as wilderness therapy (WT), this practice has been alternately labeled as wilderness adventure therapy (WAT) and therapeutic wilderness programs (TWP) despite sharing the same basic principles (Tinsley, 1996; Russell, 2003). While a standardized definition of wilderness therapy has yet to be established, researchers and leaders in the industry do not differ but rather overlap in their efforts to provide a sufficient explanation. One such definition is that wilderness therapy is "a systematic experiential group intervention that occurs in a natural setting and employs therapeutic techniques and processes within the context of activities and experiences that contain elements of real or perceived risk (i.e., physical, social, and emotional) to facilitate improvements in the psychological and behavioral functioning of the participant" (Tinsley, 1999). Michael G. Conner of the Mentor Research Institute provided a more concise definition, stating "wilderness therapy, in the purest form, is a positive growth experience where children face natural challenges and adversities that are designed to be therapeutic in nature" (2007). Keith Russell, founder of the Outdoor Behavioral Care Industry Council, noted that wilderness therapy was a "treatment intervention in mental health practice to help adolescents overcome emotional, adjustment, addiction, and psychological problems" (Russell, Hendee & Phillips-Miller, 1999).

Defining the Practice

Wilderness therapy should not be confused with wilderness experience programs (or WEP's) which use the wilderness for education and leadership instruction for a variety of clients. Wilderness therapy programs were specifically developed for juvenile offenders and at-risk youth (Russell, Hendee & Phillips-Miller, 1999). Furthermore, certain program characteristics set them apart. These characteristics include a group

process, a series of challenges which are perceived to be high in risk but are actually low in risk, an unfamiliar wilderness setting, and therapeutic techniques which include individual counseling (Kimball and Bacon, 1993). Other factors unique to wilderness therapy include trained therapeutic staff, individualized treatment plans, and a formal evaluation of treatment effectiveness (Russell, 2001; Davis-Berman and Berman, 1994).

Wilderness therapy treatment includes three stages: "a cleansing phase, which occurs early in the program; a personal and social responsibility phase, a particular focus once the cleansing phase is well underway or complete; and a transition and aftercare phase" (Russell and Handee, 1999). These programs address delinquent behavior by first removing adolescents from their familiar environment, thus leaving behind any negative influences. Within the natural environment, the adolescents are taught a series of challenging activities that serve to boost their self-esteem and establish a pattern of success. Additionally, they are taught to solve problems as a group, establishing interpersonal and social skills (Wilson and Lipsey, 2000; Russell, 2004).

Much effort has been made within the outdoor behavioral health field to distinguish wilderness therapy from other endeavors and provide distinctive standards and characteristics in order to produce accurate outcome data (Russell, 2001). Numerous youth programs within the United States tout themselves as wilderness programs by merely adding a wilderness component, but do not exhibit the characteristics outlined here; thus, they are not included in the subsequent review. Additionally, programs with a distinct religious affiliation have been excluded from this research as well, due to the fact that their philosophy and approach to therapy is evangelistic in nature and yields vastly different evaluations of effectiveness.

Theoretical basis

Although each wilderness therapy program generates their own philosophy and specific procedures, they must reach commonality when clarifying the theory behind the approach. Outdoor behavioral health's lead advocate and researcher, Keith Russell, proposes that the theoretical basis for wilderness therapy includes natural consequences for the adolescent that allows staff the opportunity to withdraw from a conventional

position of authority, “rites of passage experiences practiced by cultures throughout the world,” the consistent use of metaphor, specifically in regard to the family, an educational component that focuses on communication skills, and “traditional educational and pyscho-educational lessons” (2001).

It is imperative that the counselors and mental health professionals who are responsible for guiding at-risk adolescents through the program, initiating interaction with others, assessing behaviors, and recommending future treatment for parents or primary caregivers are both experienced and devoted to developing relationships based on compassion and respect (Russell, Hendee & Phillips-Miller, 1999). This aspect of the theoretical basis serves to promote a mindset that directly contrasts to the boot-camp approach in which adolescents are forced to comply and are essentially broken down with the intention to build them back up and “reshape them” (Krakauer, 1995). This approach will be elaborated on in subsequent paragraphs.

Outcomes

Research concerning the efficacy of wilderness therapy programs in addressing behavioral, substance abuse, and mood disorders was slow to emerge. However, the call for empirical data became more urgent after alarming reports surfaced of youths dying in programs purporting to be wilderness therapy. In 2003, Keith Russell and the Outdoor Behavioral Healthcare Research Cooperative (OBHRC) conducted a thorough investigation, using a large sample of adolescents who were enrolled in various wilderness programs across the United States. Their goal was to determine whether or not participation in a wilderness therapy program precipitated a significant improvement in the adolescents’ psychological functioning and overall behavior and whether those improvements were maintained one year after graduation. They found that the subjects showed significant improvement in both emotional and psychological functioning as a result of their participation in a wilderness program.

Other outcome studies utilized the Youth Outcome Questionnaire (YOQ) which is a 64-item parent report measure of treatment progress for children and adolescents (ages 4

– 17) receiving behavioral and mental health intervention. The YOQ is attributed to social science researchers Burlingame, Wells, and Lambert (1995) and is used to track individual and aggregate outcomes of treatment to better measure quality of services to beneficiaries of behavioral health services. The YOQ-SR is the client self-report version of this questionnaire. Higher scores on the YOQ are an indication of greater behavioral or mental health disorder. A normal range of functioning as established by Burlingame, et al (1995) is a score of 46 and below, while a score of 85 and above indicates a problem in the adolescent's life.

One such study, conducted by the Outdoor Behavioral Research Cooperative, began with a sample of 858 adolescents and their families from seven programs over a twelve-month period. At admission, the adolescents rated themselves at an average score of 71 while parents rated them at an average score of 102. However, at the time of discharge, adolescents rated themselves at an average score of 48 while parents rated them at an average score of 49. Scores from both adolescents and their parents continued to decline and the study concluded with an average score of 32 from the adolescent and 38 from the parents. This indicates that the behavioral and therapeutic gains made by the adolescents as a result of the treatment program were maintained for the duration of one year (Russell, 2002).

A follow-up study published in 2004, measured the results after the adolescents had been away from OBH treatment for two to three years. The results of this study indicated that 80% of parents and 95% of youths viewed the OBH treatment as effective, the majority of adolescents were thriving in school, and family communication had improved. Additionally, they found that aftercare was attended by the majority of the adolescents and perceived as a key component in the transition from the OBH treatment to family and peer situations. OBH treatment was also perceived as being a necessary step in assisting adolescents in addressing and overcoming the emotional and psychological issues that motivated their destructive behavior prior to treatment (Russell, 2004).

A study conducted in 2006 by Keith Russell of the Outdoor Behavioral Industry

Council focused on adolescents with substance abuse and dependency issues. The citation for the entirety of this paragraph is attributed to Russell (2006). The study established that 77 percent of the outdoor behavioral healthcare clients had substance abuse diagnoses and 49 percent had dual diagnoses in mental health as well as substance abuse. After OBH treatment, 20 percent reportedly had not used alcohol in the three months after treatment, and 40 percent reportedly had used alcohol just one to five times during those three months. In follow-up research, conducted within the same year and contributing to the overall study, 42 percent reportedly did not use at all from the fourth to the sixth month following treatment while 30 percent reportedly used only one to five times in those three months. About 8 percent reported 10 or more uses in the fourth to the sixth months after program completion, versus about 23 percent using that frequently pre-treatment. The marijuana use figures were similar, with the number using not at all or infrequently increased from 45 percent to 89 percent, while the number using marijuana regularly dropped from 40 percent to 3 percent (Russell, 2006).

These results suggest that wilderness therapy programs are teaching important emotion regulation skills and that adolescents are continuing to refine their skills after graduation. Overall findings provide considerable support for the use of wilderness therapy in treating adolescents with behavioral, substance abuse, and mood disorders.

Historical background

Outward Bound, founded by German educator Kurt Hahn during World War II, was the forerunner of the wilderness therapy program. Hahn first identified the effectiveness of using the wilderness as an instrument for behavioral modification, based on the principal that the best way to teach people is to let them *do* the lesson instead of simply *listening* to it. According to Kimball and Bacon, his original purpose was to prepare British seamen to survive the difficulties of war (1993). But he understood the difficulties of youth, realized their potential, and advocated a similar setting for struggling teenagers. Further motivating this approach was Hahn’s belief that every person is born with spiritual powers and the means to make good moral judgments, but

that these powers are lost over the course of adolescence due to five declines Hahn identified within society. In an address at the Annual Meeting of the Outward Bound Trust in 1960, he listed these five deficiencies as the following:

> [1] the decline in fitness due to the modern methods of locomotion, [2] the decline in initiative, due to the widespread disease of spectatoritis, [3] the decline in care and skill, due to the weakened tradition of craftsmanship, [4] the decline in self-discipline, due to the ever-present availability of tranquilizers and stimulants, [5] the decline of compassion, due to the unseemly haste with which modern life is conducted (Hahn, 1960).

To combat the effects of these declines, he proposed four antidotes, which are as follows: 1) fitness training, which is to train the discipline and determination of the mind through the body, 2) expeditions, which is to engage in long, challenging endurance tasks, 3) rescue service, which could be surf lifesaving, fire fighting or first aid, and 4) projects involving crafts and manual skills (Neill, 2008).

After the war, Outward Bound came to the United States. The idea of wilderness therapy did not spread, however, until the late eighties and early nineties, years after Kelly and Baer documented the success of Outward Bound programs and demonstrated a reduction in recidivism among participants (1968). The therapeutic origins of this approach were also derived from an additional source. At the beginning of the century, hospital workers experimented with tuberculosis patients, moving the sicker patients into tents outside the hospital to get them away from the healthier patients (Davis-Berman and Berman, 1994). The psychological and physical improvements of the patients placed outside were noted from the experiment and eventually translated into wilderness therapy programs.

Russell, Hendee & Miller identified three aspects of therapy within the wilderness experience in direct regard to juveniles. The first is the environment itself. The natural world provides both a mental and physical healing of the individual. The second aspect entails activities that facilitate personal growth and learning. The third aspect is the community or group with which the at-risk adolescent is interacting, learning social skills

and dealing with difficult situations (1999). This aspect is perhaps the most important, for adolescents who are at a greater risk for delinquency reportedly display difficulty in interacting with peers, acknowledging others' perspectives, dealing with authority, and making proper social decisions (Short & Simeonsonn, 1986). Despite the specific importance of the third, all three aspects build on each other, providing the necessary stimulants for personal growth and development. Russell, Hendee, and Phillips-Miller advocate wilderness therapy as an effective method for juvenile offenders and at-risk youth because it does not draw them out of a familial setting; instead the surroundings facilitate the human instinct to bond with others instead of pitting them against each other as is typical in a hostile setting (1999).

Boot Camps

Defining the term

Teen boot camps, which originated in the juvenile justice system as an alternative to juvenile imprisonment, are most often confused with wilderness therapy programs. They have been used and advocated by authorities in the juvenile justice system because of their similarity to the military and the U.S. Army's historical role in motivating a change in behavior of young men ("OJJDP Fact Sheet," 1996). Their approach is authoritarian, as opposed to authoritative. Juvenile boot camps feature rigorous physical conditioning, activities to bolster self-esteem, confidence, and leadership, and an emphasis upon discipline, usually enforced through a military-like code of rules and regulations ("OJJDP Fact Sheet," 1996). Also included in most programs is a combination of physical labor, drug and psychological treatment, and education initiatives. Participants have typically been convicted of nonviolent crimes. Boot camps are usually intense short-term experiences, rarely lasting longer than six months, after which the troubled adolescent is returned to the community, usually with some kind of intensive supervision and aftercare (Justice Bulletin, 1996).

Historical background

The establishment of these boot camps was more motivated by the idea of a "quick fix" to both the problem of overcrowding in juvenile correctional facilities and the behavioral problems of those living within these facilities and in society (Cowles, Castellano, and Gransky, 1995). Originally, boot camps used facilities that resembled military training compounds. When the private sector moved the program outdoors to cut costs associated with housing, boot camps started to become grouped with wilderness therapy programs. This is due only to the fact that they place juvenile offenders in an outdoor setting in an attempt to modify post-experience behavior. The first juvenile boot camp began in Louisiana in 1985. Since then, several other states followed suit and began operating juvenile boot camps, though most vary in size, admission requirements, and procedure. ("OJDDP Fact Sheet," 1996).

Theoretical basis

The theorized outcome is that the adolescent will supposedly return home a "good soldier" who will obey authority, follow rules, and improve behavior at home and school (Roberts, 2004). Instead of hiring licensed therapists, they use drill sergeant types that push the teens to their limits both physically and mentally. There are no traditional psychological interventions to address underlying emotional or behavioral problems that may have been developing over many years (Muscar, 2008). Instead of correcting emotional and behavioral problems, these boot camps may actually create resentment and hostility towards authority figures (MacKenzie and Souryal, 1995). Fear can be a strong motivator, but it is not the best motivator. Boot camps persuade adolescents to conform to rules for self-preservation (Muscar, 2008). After the experience, adolescents have no more knowledge about working within a family unit or the community than they did at the outset, nor have they built any self-esteem since any communication was likely loud and harsh (Roberts, 2004). They may have learned that breaking the rules brings negative consequences, but their fear of those consequences will diminish once they are back in their old environment.

Outcomes

The recidivism rate of juveniles who attend state-run boot camps has been said to be as high as ninety-four percent and research has concluded that they are no more effective than conventional correctional facilities (Marlette, 1991). That does not say much for the success of this system of rehabilitation. Juvenile delinquents and at-risk youth need therapy, structure, strong guidance, and the discovery of natural consequences of behavior. Researchers indicated that while the therapeutic concept was claimed by most of these boot camps, confusion about the elements of therapy and vague descriptions of actual therapeutic events were rampant (Cowles, et al., 1995).

A Closer Look at the Treatment Programs

As noted in the above research, outdoor behavioral health programs have the potential to provide valid, effective treatment and be instrumental in preventing juvenile incarceration. However, some research has indicated that this industry is fraught with corruption, abuse, and apathy. The most sobering lesson of this revelation was that all programs that herald themselves as the solution for at-risk youth are legitimate, or even safe.

In her book, *Help At Any Cost: How the Troubled-Teen Industry Cons Parents and Hurts Kids*, Maia Szalavitz recounts the stories of the parents who lost their children after trusting the brochures or websites of programs that purported to be a valid source of intervention. Inexperienced staff members, absent therapists, and indifferent program directors contributed to these deaths, but the programs labeled them instead as "accidents." In some cases, the directors who were prosecuted for the crime were not found guilty and were set free to begin another program with the same practices under a different name. She emphasizes the fact that these were not parents who casually turned their children over to an expensive babysitting service, but were convinced by the information that they were given that this program would be their child's savior. (2006).

Since this research came to light, OBH, or outdoor behavioral health, programs came under close scrutiny. This has not gone unnoticed by legitimate advocates and administrators of OBH and much effort has been made to establish standards of practice and to provide accurate assessments of outcomes. The Outdoor Behavioral Health Industry Council's (OBHIC) mission statement reads:

> OBHIC is an organization of behavioral healthcare providers who are committed to the utilization of outdoor modalities to assist young people and their families make positive change. OBHIC's mission is to unite its members to promote the common good of our programs' standards and our industry at large. The mission is accomplished by developing standards of excellence for membership and by sharing information. OBHIC's goal is to be the standard parents and professionals can trust (Council, 1997).

Outdoor behavioral health programs are not the only programs under scrutiny. In a study conducted concerning the success of graduates of residential programs, the majority of the participants indicated that the counselors and staff within their varied residential programs could not make the distinction between "tough love" and compassion and held them back from gaining competency (Mincey, Maldonado, Lacey & Thompson, 2007).

Summary of Literature Review

The current options for at-risk youth are heartening but require knowledge and vigilance. By making the appropriate decisions, the families of these adolescents can assist in rerouting them from a path of destructive or socially inappropriate behaviors. These options are not equal in quality.

The historical events that brought the situation to its current commendable state were initiated by the juvenile justice system itself. As the system realized its own inadequacies in rehabilitating delinquent youth, it turned to processes of punishment instead. This approach led to the recognition of previously unexplored issues within the

delinquent juvenile population: the existence of mental health issues and their relationship to delinquent behavior. Awareness of these issues paved the way to a relatively successful system, which included the incorporation of therapeutic treatment among sentencing alternatives. Additionally, adolescents on the path to enter the juvenile justice system had better prospects for avoiding incarceration when the industry's private sector weighed in.

Private companies offer out-of-home treatment facilities when community efforts and counseling fail to ameliorate adolescent mental health disorders. There are three available options for out-of-home treatment facilities: residential treatment centers, boot camps, and outdoor behavioral health programs.

Residential treatment centers can be both public and private. Historically, the state sent adolescents to public residential programs while upper class clients made use of private residential facilities. However, the general move to privatize the justice system allowed states to employ private facilities as a placement for juveniles. As a result, a wider range of social classes now use this option (OJJDP Statistical Briefing Book 2008). Private facilities still offer admission to youth outside the justice system, though the cost is significant.

The boot camp treatment option is now understood as more detrimental than instrumental in assisting at-risk youth in altering destructive behavioral habits. Boot camps are based on the belief that troubled youth lack discipline and intrinsic control. Modeled roughly after military recruit training, these programs are short, intensive attempts to bully an adolescent into a certain behavioral mindset (Muscar, 2008). While these programs achieve change within their own physical perimeters, research reveals the recidivism rate of graduates to be as high as ninety-four percent (Marlette, 1991).

Outdoor behavioral health (OBH) programs were designed for youth with adverse behavioral tendencies or mental health issues. These programs are more widely used by private clients than by the juvenile justice system. OBH treatment facilities specialize in group processes, wilderness settings, instruction in hard and soft skills, and advancement through three separate treatment stages (Kimball and Bacon, 1993; Russell, 2001; Davis-

Berman and Berman, 1994; Russell and Handee, 1999). Outcomes for OBH have been positive, giving rise to the assertions that OBH programs are imperative for helping adolescents identify and address issues behind their adverse behavior (Russell, 2004).

This literature review has described outdoor behavioral health programs as viable and effective alternatives to traditional intervention programs. However, not all OBH programs are equally effective. A detailed analysis of these programs is vital. The policies, practices and personnel of individual programs should be examined to assess their operational legitimacy. Analysis must also consider the physical and emotional safety of attending youth.

Parents and primary caregivers must understand that programs with ineffective approaches or philosophies can cause as much harm through their neglect of the core issues as do treatment programs that operate outside the guidelines and standards of the industry. Thus, this present study will develop practical guidelines to measure treatment programs according to the components that research has found effective.

The significance of the role that parents and primary caregivers play in these adolescents' lives during and following treatment is clarified in the following chapter.

CHAPTER THREE

THEORETICAL FRAMEWORK

Sociological theories concerning deviance in behavior can essentially be grouped into four categories. The first is social structure theories. These theories contend that delinquency can be attributed to a person's place in the economic structure of society. The second group is social process theories. These assert that delinquent behavior is the result of poor socialization and an adverse upbringing. The third group, social reaction theories, claims that delinquency is a result of social stigma. Finally, the last group, social conflict theories, believes that delinquent behavior is a product of economic inequality.

The two-part theory upon which this paper is based is a derivative of the third group, with a positive twist. This theory was conceived during the sixties when American researchers were increasingly dissatisfied with the social disorganization perspective of criminogenesis. The founder of this theory, Travis Hirschi, proposed an approach for understanding why individuals do or do not conform to conventional norms. His perspective, first termed control theory, and later termed the self-control theory, originated in the 1960's as he observed the widespread re-composition of the American family. He asserted that social relationships, or social bonds as he termed them, were a source for delinquent behavior, rather than an individual's personality (Hirschi, 1969). Thus, he turned the focus from psychology to sociology.

His articulation of this theory suggested four important components in social self-control: attachment, commitment, involvement, and belief.

1. The attachment variable has to do with the extent an individual is attached to social institutions such as parents, peers, and school. Hirschi found that adolescents with strong attachments to parents have a greater propensity to avoid delinquent behavior.
2. Commitment involves the pursuit of conventional activities, such as getting an education and saving for the future.

3. Involvement is defined as participation in conventional activities such as school, sports, and religion.
4. Belief refers to values such as sensitivity to the rights of others and respect for the law.

This early version of Hirshi's work is valid in that these variables are part of the social bonding and behavioral regulation processes. However, Hirschi's later work, in conjunction with Michael Gottfredson, focused on self-control as the determining factor for the likelihood of an individual committing a crime. Children with behavioral problems will tend to grow into juvenile delinquents and eventually into adult offenders (Gottfredson and Hirschi, 1990). Since the course toward or away from crime begins early in life, they asserted that the level of self-control depends on the quality of parenting in a child's early formative years.

The theory purports that parenting is the most important factor that influences an individual's level of self-control. If a child has an abusive or neglectful upbringing, he will tend to be impulsive, insensitive, physical (as opposed to cognitive), and nonverbal, and will tend to engage in deviant acts (Gottfredson and Hirschi, 1990). Children whose parents care about them and supervise and punish their misconduct will tend to develop the self-control needed to resist the temptations offered by crime. Hirschi and Gottfredson accepted race, gender and age within the confines of their theory, purporting that the differences that exist between racial groups were a result of variables of parental supervision (Gottfredson and Hirschi, 1990).

Parents or primary caregivers who have a vested interest in their adolescent's well being and seek to divert them from a path of deviant behavior, which could lead to incarceration, will benefit from the information presented in this research. Indeed, this research will only benefit those who attempt to find a solution directly after it has become apparent that their adolescent is "at-risk"; parents whose adolescents have already entered the juvenile justice system will find that the DJJ holds principal authority on their placement.

The following chapter examines the methodology by which the research was conducted as well as justification for the research questions that have been used to analyze each treatment program in this study. These questions represent vital elements within any treatment program and can be applied to future non-traditional treatment programs that are established after this study has been concluded.

CHAPTER FOUR

METHODOLOGY AND RESEARCH PROCEDURES

Content Analysis

Content analysis is a qualitative type of research that allows the researcher to evaluate written or recorded communication. Harold Kassarjian critiqued the methods used in 128 studies on consumer behavior which employed content analysis. His intent was to improve research conducted under this method. Subsequently, his work set the standard for producing valid and reliable research through content analysis and will be adhered to throughout this research project (1977).

For the purpose of this study, content analysis was considered the best method of research because it focuses on a single element of communication (Kolbe and Burnett, 1991); in this case, that single element is the website of the individual programs. Furthermore, content analysis offers the chance for an unobtrusive review of the written communication since a bias undoubtedly would be involved if interviews were employed (Kolbe and Burnett, 1991). For the purpose of this research, it will prove to be a valuable method for evaluating and analyzing the written content of websites.

Website Content Analysis

Websites can be an excellent source of information. They are relatively easy to access and can be a timely resource for parents searching for an intervention program. Thus, I have employed website content analysis in an effort to provide a simple and relevant method of evaluating and comparing wilderness therapy programs online. One of the most important aspects of website content analysis is the use of unitizing. This process is defined by Dr. Klaus Krippendorff as "a systematic distinguishing of segments of text - images, voices, and other observables that are of interest to the analysis" (2003). Thus, the focus turns to the collection of units, rather than the relationship between them. In the case of this study, the prevalence of image and text references to family or parental involvement is of more importance than the relationship between the specific words used.

The websites to be analyzed are private residential facilities in the form of non-traditional intervention programs within the outdoor behavioral healthcare industry to which families of at-risk youth have access. They were located using Internet search engines because that is the primary method used by parents or caregivers seeking resources. The search engines used were www.ask.com and www.google.com. The keywords used in the search were "wilderness therapy for at-risk youth," "wilderness therapy for troubled teens," “residential facilities for at-risk youth,” “residential facilities for troubled teens,” “therapeutic boarding schools,” and “alternatives for troubled teens.” "Adventure therapy" and "wilderness programs" were not used as search strings because they identified a variety of general camp-style programs specializing in teamwork or leadership. These programs are useful in their own right, but do not target adolescents with behavioral or emotional problems. Through the keyword search, the programs listed below were identified as wilderness therapy programs, residential facilities, and therapeutic boarding schools established strictly for adolescents with behavioral and emotional problems. Those listed below represent a sample of the established programs as identified through the keyword searches. Boot camps were not included in the evaluation as the search for specific websites established under that category yielded a single result of an internet form to be completed for additional information. This result is not surprising due to the negative media that surrounds this form of treatment.

The intent of this research is purely applied. Using the literature, I developed content analytic criteria in the form of five areas if inquiry that should be applied to each website to identify which programs are worthy of further examination. These areas of inquiry were 1) family involvement, 2) staff competency 3) aftercare or transitional resources 4) accreditation, and 5) outcome studies. Within the literature review, these were potential problem areas that could offset any progress an at-risk youth could be making during the rehabilitation process. Additionally, with the exception of outcome studies, the overhead costs of the service provider are greatly reduced in the absence of these critical elements. Thus, an absence may be the signal that the program is driven monetarily rather than compassionately or efficaciously.

During the research no calls were made to program staff and no interviews were conducted with program staff either by email or in person. Instead, their primary information source, their website, was analyzed and the results reported below.

Explanation of Methods

This research was conducted to determine whether or not websites are a valid source for identifying legitimate, safe, and effective programs. To that end, I have used the strengths and limitations derived from the relevant literature to identify five important areas of inquiry for the use of parents and/or caregivers who are seeking help for their at-risk youth. These five inquiries were posed during the analysis of each website and will provide a basis for identifying the presence or absence of important components of the program in question. They can be applied to each program during an investigation of the available resources, especially if more wilderness therapy and residential programs are established after the date of this research. They are useful as an initial means of filtering during the process of selecting a valid and effective wilderness therapy program or residential facility.

Website Content Analysis: Family Involvement

Family factors play a pivotal role in delinquent behavior. A stable family and good parental monitoring are vital for a successful adolescence. Poor parental discipline or supervision skills lead to conflict concerning the role of the adolescent. In her research in conjunction with the Strengthening America's Families project, Karol Kumpfer pinpointed four major family risk factors: family history, family management problems, family conflicts, and family poverty (1999). Family history refers to poor socialization habits and physical or sexual abuse. Family management problems include ineffective responses to a difficult child. Family conflicts are a product of marital discord or verbal abuse. Family poverty addresses the disadvantage that low-income or single parents face when trying to provide for their children financially and maintain consistent supervision (Kumpfer, 1999). Often, these risk factors are a product of a lack of knowledge

concerning parenting skills. To reduce the presence of these factors, family involvement is vital throughout the adolescents' treatment process. Three separate aspects identified the component of family involvement within the analysis.

The first aspect was the existence or absence of a secure website offering progress updates for parents or families. Keeping the parents or family informed of their child's progress allows them to stay involved during the treatment process and provides additional assurance of the child's safety, given the exposure of unethical practices concerning the treatment of children within these programs (Reese, Vera, Simon, & Ikeda, 2000). Additionally, Harper and Russell noted that lack of family involvement was a common element in programs in which child maltreatment occurred (2008).

The second aspect follows on the heels of the first and demonstrates a greater capacity for parental monitoring of and participation in the program. This aspect determines whether or not the program offered the option of physical interaction of the family and adolescent during the program through occasional parental visits on-site. This would allow parents or primary caregivers to better understand their role in the life of the adolescent and prepare for the imminent post-treatment phase (Nickerson, Brooks, Colby, Rickert, & Salamone, 2006).

The third aspect of family involvement was whether or not the program offered family therapy sessions. Effective parenting programs have sought to educate families regarding the proper environment for an adolescent. In their comprehensive review of these programs, Kumpfer and Alvarado identified key components for effective family-oriented therapy. These include establishing rapport with the program therapist, locating support services, and addressing the problems of the adolescent at multiple levels and dimensions (1998). When wilderness therapy programs and residential facilities incorporate these components, their effectiveness is increased because they address the behavioral problems of the adolescent along with any potential parental issues. Research has shown that treatment methods that focus on rebuilding a child's family structure along with providing the child with intensive therapy have reduced recidivism by as much as 80 percent (Coalition for Juvenile Justice, 2000). Studies suggest that one reason for

delinquent behavior may be child abuse or neglect in the home. Programs should be planned to meet the developmental needs of the adolescent, but should also consider the parents' need to change their parenting style and social behavior (Kumpfer and Alvarado, 1998), thus therapy sessions involving the entire family are more effective than counseling sessions for the adolescent alone (Robinson et al., 2005).

Website Content Analysis: Staff Competency

> By March 29, Aaron was so sickly that he could walk no further. The other campers carried him back to base camp. He vomited all over them, babbling incoherently about seeing purple stars in a purple sky. Again, he asked for medical attention and again, despite obvious evidence to the contrary, he was called a faker by program staff (Szalavitz, 2006).

The preceding paragraph references a situation in which a male adolescent in a wilderness therapy program suffered and eventually died after being denied care from ignorant staff members. When a program takes short cuts to acquire staff members, problems are rampant. At-risk youth are dealing with issues such as drug addiction, borderline personality traits (BPT), anxiety, and eating disorders (Szalavitz, 2006). Without the background or experience to deal with these issues, staff can easily misinterpret symptoms or behaviors to the detriment of the participant. Thus, to ensure the safety of the adolescents, the first indicator of the staff competency component is the continual presence of a staff member with medical training, such as a wilderness first responder (WFR) or an emergency medical technician (EMT).

As this lucrative industry grows, the need for employees increases as well. Szalavitz warns that when the focus shifts to money, the consequences may be a relaxed scrutiny and lower standards in the area of qualified staff and a greater focus on program expansion at the expense of the entrants and their hopeful parents (2006). The primary responsibility of staff is to guide the adolescents through the program. Thus, those who facilitate the transformation in at-risk youth should possess the proper skills for their undertaking. For, if counselors do not understand the issues the adolescents are facing,

they are more inclined to believe, like the rest of society, that they are dealing with a "bad kid" (Roberts, 2004). In regard to wilderness therapy programs, three distinct sets of skills have been identified through the research as vital to an outdoor staff leader. The first set is technical skills, which includes map reading and fire building (Curtis, 1994; Crisp, 1998; Bartley, 1989). The second set is termed “soft,” such as communication, interpersonal, and listening skills (Bartley, 1989). The third set is advanced skills; this includes counseling, psychotherapy, crisis intervention (Davis-Berman & Berman, 1994). With the exception of the first set, these skill sets can be attributed to residential treatment staff as well. Thus, the second aspect of the staff competency component is identified through the provision of initial comprehensive training for staff before involvement with the at-risk youth.

Although primary staff should be aware of the existence of any mental health diagnoses and the specific ramifications that accompany the diagnosis, the responsibility of addressing those issues falls on the shoulders of a therapist with at least a master’s degree in the mental health field, licensure in the mental health field, education in crisis intervention, and experience working with adolescents on a daily basis (Roberts, 2004). Since the specific benefits of sessions with a licensed therapist with experience in individual and family therapy has been addressed previously, suffice to say that the third aspect of the staff competency component is the identification of a licensed therapist.

Website Content Analysis: Accreditation

One of the most important aspects in the operation of a program designed to provide care for teenagers is accreditation. Accreditation is provided by national organizations that promote and, in some cases, fund valid healthcare programs. Those that promote outdoor behavior therapy through schools, programs, and research are the following:

ACA (American Correction Institute)

AEE (Association of Experiential Education)

COA (Council on Accreditation of Services for Families and Children, Inc)

JCAHO (Joint Commission on Accreditations of Healthcare Organizations)

NAADAC (National Association of Alcoholism and Drug Abuse Counselors)

NATWC (National Association of Therapeutic Wilderness Camp)

NATSAP (National Association of Therapeutic Schools and Programs)

OEREC (Outdoor Education: Research and Evaluation Center)

OBHIC (Outdoor Behavioral Health Industry Council)

OBHRC (Outdoor Behavioral Health Research Council)

SACS (Southern Association of Colleges and Schools)

WEA (Wilderness Education Association)

WRC (Wilderness Research Center)

As a result of careful practices, the JCAHO remains the dominant accrediting agency from the previous list. Established in 1951, the agency continues to be the nation's leading accrediting body for setting standards in healthcare. They serve to improve the safety and quality of care provided through healthcare organizations, including wilderness therapy programs. Additionally, JCAHO accreditation may allow many families to receive reimbursement for their teen's treatment through their health insurance, depending on the insurance provider. In a document entitled '2008 Accreditation Decision Rules For All Programs,' located on their website, the JCAHO explicitly states that accreditation will be withheld if it is determined that "an immediate threat to patient/public health or safety exists within the organization (2008).

The organizations that provide accreditation act as a governing body to ensure that the practices of these programs are safe and legitimate. When these strict regulations

and meticulous supervision are lacking, these programs can and do practice unsafe and ineffective methods (Szalavitz, 2006). Accreditation granted by a nationally recognized accrediting agency means credibility for the program and an assurance for the parents or primary caregivers that regulations are in place to prevent unethical or harmful practices. Thus, the component of accreditation was identified by the existence or absence of a national accreditation.

The other type of supervision is in the form of licensure provided through the individual states where the program is located. However, national accreditation carries more weight because some states have historically been lenient when initially granting the license and monitoring the program's daily practices (Roberts, 2004). Also, since some states do not require a license to operate, the presence or absence of state licensure was not analyzed as part of the accreditation component.

Website Content Analysis: Aftercare Considerations

Improving parenting skills can be the key component in maintaining positive family dynamics over time (Kumpfer and Alvarado, 1998). Support for the parents and the adolescent during the transition period back into society is vital to establish patterns of behavior from all members of the family. The transition from the program to the old environment can be challenging. Intensive aftercare programs prevent teens from relapsing into their former, negative behavior (Ferguson, 2009).

Aftercare programs are vital for the success of the rehabilitation. According to Roberts, these programs serve to 1) prepare youth for progressively increased responsibility and freedom in the community, 2) facilitate youth-community interaction and involvement, 3) develop new resources and supports where needed, and 4) monitor and test the youth and the community on their ability to deal with each other productively (2004). In short, they are a combination of control measures and treatment interventions to address specific and individual needs (Altschuler and Armstrong, 1996). This component is identified by the provision of a transitional phase after the completion of the program.

Website Content Analysis: Outcome Studies

Within outdoor behavioral health research, the most accepted definition of outcome is the change or difference in the client between the beginning and the end of the program (Stumbo & Peterson, 2004; Wade, 1999). Outcome measurement is significant to accrediting agencies, the consumer, and the financier. Accrediting agencies need valid documentation to justify their support of a particular program. The consumer, or parent, should have knowledge that program practices are not simply based on an idealogical perspective. The financier, who can be either the parent or an insurance company, needs more than the word of a program director to justify their provision of funds.

Blankertz and Cook noted several additional benefits including improvements in both quality of performance and staff morale through feedback (1998). When accountability rather than good faith is employed, the results can be exceptional. Programs who engage in outcome studies, whether self-based or independent, are demonstrating their commitment to efficacious practice by subjecting their operations to outside scrutiny.

In regard to outdoor behavioral health, outcome studies have proven social and emotional gains by participants, as reported in the literature review.

There are two ways to measure the component of outcome studies in content analysis. The first is through testimonials from participants and their parents or caregivers. Usually programs illustrate their efficacy by posting pictures of smiling, confident teenagers and letters from pleased parents on their websites. Since the publishing of testimonials can be subject to manipulation by the program to stimulate a positive impression, the second, more valid measure was employed for the purpose of this study. To reliably evaluate a program by its practices, the relevant data must be subjected to thorough analysis; thus, the second measure of whether or not a program is concerned with its own efficacy is through reported involvement in an outcome evaluation.

CHAPTER FIVE

RESULTS

This section will present the results of the content analysis. The first section will present the results from the analysis of each variable within both types of programs, wilderness therapy and residential treatment facilities. The second section will separate and compare the results and examine the specific strengths and weaknesses of each.

Part One: Analysis of Variables

Family Involvement

Thirty-nine programs were analyzed by applying the research questions derived from the literature. The first research question was 'What aspects of the program promote and include family involvement?' Since family involvement was shown to be important in preventing the adverse behavior in adolescents and is vital in thwarting maltreatment, this question was relevant for any program providing treatment, whether in a residential or a wilderness setting.

This question was measured by three separate considerations within the realm of family involvement. The first was the existence of a secure website by which parents or families could log in and receive regular updates of their adolescents' progress. As Table 1 demonstrates, only 18% of the programs utilized this relatively simple technological tool. Instead, analysis revealed that the majority of the programs relied on weekly phone calls from the adolescents' therapist to provide progress updates. This was a very simple measure to assess, since it was not subject to obfuscatory terms or ambiguous phrasing; thus the designation of "not clear" was unnecessary.

The second consideration used to measure the component of family involvement was whether or not the program offered periods of physical interaction between the adolescent and family members during the course of treatment. Analysis revealed that programs that encouraged interaction in the form of family weekends and family therapy sessions that involved both the adolescents and the parents were slightly more prevalent

than programs that did not. In very few cases, occasions of family interaction was not specified and, thus earned a ‘not clear’ designation.

While similar to the second measure, the third measure gained its distinction by denoting whether or not family therapy was offered or required. Analysis of this component showed that in some cases, family therapy sessions were utilized by the family alone and the adolescent undertook group or individualized therapy within the treatment process, although programs which included the adolescent in family therapy sessions outnumbered those which did not.

Table 1: Percentage of Programs, the Prominence of Family Involvement

	Yes	**No**	**Not Clear**	**Total**
Progress Updates	18%	82%	0%	100%
Family Interaction	54%	36%	10%	100%
Family Therapy	72%	23%	5%	100%

Staff Competency

The second research question posed in this study was ‘Does the program stress staff competency by providing relevant training and employing an on-site licensed therapist?’ According to Table 2, the relevancy of competent and educated staff was indeed a primary consideration with the exception of on-site staff training. The analysis of this question involved three separate measurements. The first measurement was whether or not the presence of medical personnel was required during the treatment process. A rather significant number of the programs received a ‘not clear’ designation due to the fact that they did not specify whether or not they required their staff to have a Wilderness First Responder (WFR) or Emergency Medical Technician (EMT) certification. Especially in regard to wilderness therapy programs, treatment of mentally ill adolescents carries a substantial amount of risk. Additionally, as noted in the justification of this measurement in the Methodology section, staff should be trained to recognize and treat symptoms before a condition worsens and should be able to recognize the difference between a serious situation and an adolescent faking a condition to avoid

an aspect of the treatment. The significance of the 'not clear' designation in Table 2 is due to the fact that some websites did not specify staff requirements in that area or provide definitive safety measures.

The second measurement of the component of staff competency was whether or not staff training was offered through the program before interaction with at-risk youth. As programs continue to be scrutinized because of reports of unethical treatment, it seems that more programs are hiring staff with full qualifications and experience. However, the programs that did offer staff training emphasized the necessity for ongoing training for the duration of the employment period.

While the second measure is vital to the success of the treatment process, the third measure reaches further into the realm of efficacy. Since therapy is being conducted with at-risk youth, whether in a residential or wilderness setting, a licensed therapist must be retained on staff for that very purpose. It is both reassuring and commendable to note the high percentage of treatment programs that demonstrated their commitment to a valid therapeutic approach by employing a licensed therapist (see Table 2). To further clarify this analysis, the small percentage of programs in Table 2 that were designated as being 'not clear' on this measure did not provide a staff list or credentials of their staff although they reported a therapeutic approach.

Table 2: Percentage of Programs, the Significance of Staff Competency

	Yes	**No**	**Not Clear**	**Total**
Medical Staff	54%	8%	38%	100%
Staff Training	38%	44%	18%	100%
Licensed Therapist	95%	0%	5%	100%

<u>Accreditation</u>

Noted as being a form of supervision for programs conducting treatment for at-risk youth, accreditation also strives to support best practice and establish standards within the industry. The research question posed is simply whether or not the program is accredited under a nationally recognized accrediting organization, a list of which was

provided in the Methodology section. In Table 3 it can be noted that a significant percentage of programs were found to be without accreditation. Analysis revealed that the majority of these unaccredited programs had received state licensing.

Table 3: Percentage of Programs, the Existence of Accreditation

	Yes	**No**	**Not Clear**	**Total**
National Accrediting Organization	62%	33%	5%	100%

Aftercare Considerations

The transition period between therapeutic treatment and a previous environment can be momentous for an adolescent as he or she tests new skills and readjusts to society. As noted in the Methodology section, aftercare is essential in providing continued support and preventing a relapse. The research question that was applied to programs to determine their commitment to aftercare was "What steps are taken to ensure that an aftercare/transitional program is employed after graduation from the program?" Despite research proving the necessity of aftercare programs, analysis showed that only twenty percent provided an aftercare or transitional phase, according to Table 4. Some programs breached this gap by providing workshops to prepare parents prior to graduation and assisting the family in locating mental health professionals for continued care. A small number or programs encouraged the youth and their families to use the program as resource for any questions or further therapeutic support.

Table 4: Percentage of Programs, the Occurrence of Aftercare

	Yes	**No**	**Not Clear**	**Total**
Program Sponsored	20%	62%	18%	100%

Outcome Studies

The final research question posed in this study was whether or not the therapeutic program engaged in any outcome studies or tracked continued progress of former clients after the program is completed. Given the surprisingly low percentage of programs that

do participate in outcome studies according to Table 5, this author asserts that it is entirely possible that some programs do track the progress of youth after graduation without broadcasting that fact on their website as participation in outcome studies is voluntary. However, outcome evaluation is the primary method of proving efficacy and should be pursued more rigorously.

Table 5: Percentage of Programs, the Prevalence of Outcome Studies

	Yes	No	Not Clear	Total
Program Sponsored	23%	77%	0%	100%
Independent Study	15%	85%	0%	100%

Part Two: Comparing and Contrasting the Results

Positive Results

While serving the same population of at-risk youth, wilderness therapy and residential treatment facilities have different approaches in some aspects of the therapeutic treatment process. This section will compare the positive and negative results of the specific variables without breaking down the specific methods of measurement as did the previous section.

With the exception of one variable, Table 6 shows that wilderness therapy programs have a higher level of attentiveness towards matters relating to efficacy and safety. However, the margin for family involvement when compared to the family involvement variable for residential treatment is not significant.

Table 6: Percentage of Programs, Positive Results

	Family Involvement	Staff Competency	Accreditation	Aftercare Considerations	Outcome Studies
Wilderness Therapy	50%	72%	80%	20%	33%
Residential Treatment	49%	53%	42%	21%	5%

Both wilderness therapy programs and residential treatment facilities have a high level of considerations for staffing, though wilderness therapy programs' assessment is significantly higher. Additionally, Table 6 shows a large percentage of wilderness therapy programs adhere to the strict standards of national accrediting organizations. The top two organizations that offer accreditation to wilderness therapy programs who comply with their standards are JCAHO, a leader in health care, and NATSAP, a leader in outdoor behavioral health care.

Negative Results

In regard to the negative results of the analysis, or the measure of programs in both arenas reporting non-involvement according to their website, the significant margins are in the areas of accreditation, aftercare programs, and outcome studies, per Table 7. The high percentage of residential programs that did not acquire accreditation is, in most cases, due to the fact that the program was licensed by the state instead. Additionally, according to their website, programs which did not provide aftercare or transitional phases would offer assistance in orchestrating a smooth transition by communicating with mental health professionals or providing a "treatment plan summary."

Table 7: Percentage of Programs, Negative Results

	Family Involvement	**Staff Competency**	**Accreditation**	**Aftercare Considerations**	**Outcome Studies**
Wilderness Therapy	45%	10%	10%	45%	65%
Residential Treatment	47%	23%	58%	79%	95%

Outcome studies were seldom mentioned within the websites of the residential treatment programs. Their claims for successful rehabilitation were rarely supported by the data. In regard to the wilderness therapy programs, several websites highlighted outcome studies that placed the programs in a positive light. These studies were conducted by independent researchers and had been discovered by the author in relevant

literature; however, the studies had been conducted on other programs with "similar practices and philosophy" and had not directly evaluated the program in question. Thus, these programs were given a negative designation on the measurement although they had referenced outcome studies. Additionally, wilderness therapy programs that did participate in outcome studies tended to continue that trend, year after year, while other programs did not report any outcome evaluations at all.

Unclear Results

For the sake of this analysis, an unclear designation simply means that the information was not presented in a discernible manner. Some programs received a 'not clear' designation because an assumption could be made, but no facts were evident. For example, Outward Bound has several outcome evaluation studies within academic literature; however, since they did not reference these studies on their website, they were given an unclear designation as neither "yes" or "no" would suffice in this situation.

According to Table 8, the second highest designation of unclear information was found in the area of staff competency. Due to the prevalence of unethical and cruel treatment in this industry due to a lack of understanding or education, programs that offer any kind of out-of-home placement for adolescents should provide specific details about the requirements for staff and the level of training they must undertake.

Table 8: Percentage of Programs, Unclear Results

	Family Involvement	**Staff Competency**	**Accreditation**	**Aftercare Considerations**	**Outcome Studies**
Wilderness Therapy	5%	18%	10%	35%	2%
Residential Treatment	4%	2%	0%	0%	0%

Aftercare considerations within wilderness therapy programs remains the highest designation of unclear information presented in the website, according to Table 8. This may be the most significant area of weakness, as this treatment method requires a

removal of an adolescent from a familiar environment and an intense experience in the wilderness, followed by a return to that same environment after a relatively short time. If the transition phase is not handled gently and considerately by those now familiar to the adolescent, the re-entry may be abrupt and result in a relapse.

CHAPTER SIX

DISCUSSION AND CONCLUSION

The purpose of this research was to analyze residential treatment and wilderness therapy programs through the use of website content analysis. More specifically, the study utilized five research questions derived from relevant literature to determine whether or not the programs were efficacious and ethically sound. The research questions covered the areas of family involvement, staff competency, accreditation, aftercare, and outcome studies. This study serves to educate and inform parents or primary care-givers of the important aspects to consider when pursuing a out-of-home placement for their at-risk youth.

Results from the literature review reveal that there is a strong connection between mental health and adverse social behaviors within the juvenile population, specifically, at-risk youth. Thus, addressing these issues should be a primary concern among treatment programs. The types of treatment programs in existence for at-risk youth were highlighted by an examination of their history, approach, and outcome studies, where applicable. Additionally, the literature review was consistent in revealing several areas of consideration for increased effectiveness of these treatment programs. These areas were further examined and delineated in the subsequent methodology section for the purpose of analysis. These areas of concern were developed to form of the following research questions:

1) What aspects of the program promote and include family involvement?

2) Does the program stress staff competency by providing relevant training and employing an on-site licensed therapist?

3) What steps are taken to ensure that an aftercare/transitional program is employed after graduation?

4) Is the program accredited under a nationally recognized accrediting body?

5) Does the program engage in outcome studies or track continued progress of former clients after the program is completed?

Concerning family involvement, analysis revealed that family therapy played a predominant role in measuring this component as 72% of the programs offered collaborative therapy as a resource for strengthening the family relationship. Following relatively closely behind was the element of family interaction during the course of treatment, with a utilization percentage of fifty-four. Progress updates as a measure of family involvement brought up the rear, revealing that only 18% of the treatment programs offered immediate updates via the Internet.

Regarding analysis in the area of staff competency, results suggest that retaining a licensed therapist on staff was considered to be paramount since 95% of the treatment programs listed or referenced the presence of a licensed therapist. Additional results in this area suggest that employing staff with some form of medical training did not meet the same level of criticality, since only 54% of the programs definitively demonstrated having staff with medical credentials, even at the most basic level. This finding leads into the final measure of this component, which revealed that forty-four percent of the programs did not offer initial or ongoing staff training. This lapse may be a result of the demand for fully qualified personnel at the initial point of employment; however, the prevalence of diverse and challenging situations necessitates ongoing training to avoid a trend of attaching habitual approaches with unfamiliar scenarios with only a hope that those approaches will be effective.

In the matter of accreditation, only one measure was applied to the analysis. That measure was simply whether or not the treatment program held a membership with a nationally recognized accrediting agency. Analysis demonstrated that 62% of the programs held an accreditation, while 33% did not. The majority of those holding state licensing were residential treatment programs, rather than wilderness therapy programs. However, the majority of the unaccredited treatment programs had received licensing through the state and the low level of attention these programs placed on accreditation

can likely be attributed to the fact that state licensing is more significant for residential facilities, though perusal of relevant research did not bring this fact to light.

Results suggest that providing a transitional or aftercare phase for youth after the program was the primary weakness for wilderness therapy and residential treatment programs alike. In fact, only 20% of the analyzed programs provided any kind transitional element and very few programs encouraged families to continue to utilize them as a resource for questions or encouragement following the completion of the program.

Outcome studies proved to be another weakness within both types of programs. Analysis revealed that only 23% conducted a program-sponsored outcome study, and only 15% contracted an independent company to acquire outcome results. Since this is the primary method by which efficacy can be determined, this lapse in practice is a serious one.

Overall results from the analysis of wilderness therapy websites suggest that in all areas except aftercare, wilderness therapy programs place a strong emphasis on aspects of the treatment process that have been shown to be the most effective in precipitating a transformation of behavior in at-risk youth. Additionally, results from the residential treatment websites suggest that these programs value family involvement and staff competency at a higher rate than other aspects of the treatment program.

Summary

Through researching this topic, I have gained an appreciation for the nuances within the programs in regard to approach, despite their similar objectives. These programs provide individualized treatment plans as well as individualized approaches. From the arts to equine therapy to the utilization of nature, the diversity of approaches can only yield an improved and more functional effort in diverting at-risk youth from juvenile incarceration.

Wilderness therapy programs and residential facilities, when utilized correctly, can be a rewarding method for addressing issues of trust, control, destructive thinking

patterns, and low self-esteem in adolescents. Through working cooperatively with others, at-risk youth can learn social skills. Through mastering difficult challenges, they can gain a sense of self-confidence. Through facing the responsibility of ensuring their own survival, they can develop self-respect. While gaining a better understanding of themselves, they also learn how to cope with difficult situations, how to control their anger, and how to work with others to achieve harmony. If these changes do occur within the treatment process, then the program was successful. The adolescent, formerly known as the "at-risk youth," can be welcomed back into society and live a healthy, happy, crime-free life.

Additionally, these programs can function as a stabilizer during a life phase that resembles an emotional roller coaster. Such confusion and mental instability can generate a gravitation toward negative influences simply because those influences are peers who are better able to relate than the most well-intentioned parents. During this precarious phase, program staff can guide the adolescent in sloughing negatively influenced behaviors by providing the opportunity to learn naturally, rather than being taught, that the real benefits of positive behavior in a civilized society can lead to greater rewards in life and help to avoid pitfalls such as incarceration.

In regard to the safety of these programs, this research has been heartening. Reports of abuse and negligence within the industry led to an increased scrutiny of policies and procedures. Additionally, the outcry drove staff of legitimate programs and like-minded researchers to take action in order to avoid being grouped in with the "bad apples." Thus, they not only become more vigilant in the communication of the philosophy and core principles, but also advocated and, in some cases, led the effort for an establishment of standards of best practice.

By applying these research questions, which represent the presence of critical program elements as established in the literature review, parents and primary care-givers can be assured that their child will not only be physically and mentally safe, but will also be given the best treatment for their behavioral or mental needs if their condition precipitates an out-of-home placement. The chapter outlining the theoretical framework

of this research emphasizes the need for parents to be involved during the developmental phases in their child's life. Thus, their utilization of outside resources and subsequent involvement during the course of treatment could prove to be the manner in which they achieve a solution.

Implications for Further Research

This study shows that residential treatment facilities and wilderness therapy programs do not differ widely in their therapeutic approach to at-risk youth. However, certain distinctions do set them apart. If an at-risk youth must experience at out-of-home placement, future research could demonstrate how the differentiation in the programs could benefit certain personality types or specific mental health issues. Also, future research could examine the rate at which graduates of these programs return as adults to facilitate the same transformation they underwent. Program participants may respond more positively to persons to whom they feel they can relate (Ferguson, 2009).

Additional research could examine the value of implementing more aftercare programs versus the ensuing cost. Also, since this study drew attention to the lack of outcome studies in regard to residential treatment facilities, further research could be conducted to demonstrate the success of such facilities as a non-traditional approach to intervention.

APPENDICES

Appendix A

Coding Sheet

Website:_____________
Date Accessed:_____________
Name of Program:______________

Type of Program: (circle one)
Wilderness Therapy
Residential Treatment Facility
Boot Camp

Family Involvement: Progress Updates
Is there a secure website offered for parental or family progress updates?

Yes
No
Not Clear

Family Involvement: Family Interactions
Are there any periods of physical interaction between family and teen during the treatment process?

Yes
No
Not Clear

Family Involvement: Family Therapy
Are family therapy sessions offered by the program?

Yes
No
Not Clear

Staff Competency: Medically Trained Staff
Was the constant presence of medical personnel required during the treatment process?

Yes
No
Not Clear

Staff Competency: Staff Training
Was staff training offered through the program before interaction with at-risk youth?

Yes
No
Not Clear

Staff Competency: Licensed Therapist
Was a therapist with state licensure included on the staff list?

Yes
No
Not Clear

Accreditation: National Accrediting Body
Was the program a member of a national accreditation organization?

Yes
No
Not Clear

Aftercare Considerations: Program Sponsored
Was an aftercare program offered through the program itself?

Yes
No
Not Clear

Outcome: Program Sponsored
Did the program conduct an outcome study with their own data?

Yes
No
Not Clear

Outcome: Independent Study
Did the program participate in an outcome study conducted by an unaffiliated organization?

Yes
No
Not Clear

Appendix B

List of Analyzed Websites: Wilderness Therapy Programs

Adirondack Leadership Expeditions
adirondackleadership.com

Anasazi
www.anasazi.org

Aspen Achievement Academy
www.aspenacademy.com

Catherine Freer Wilderness Therapy Programs
www.cfreer.com

Eckerd Youth Alternative (EYA)
www.eckerd.org

Four Circles Recovery Center
fourcirclesrecovery.com

Monarch Center
monarchcentercolorado.com

Mountain Homes Youth Ranch
mhyr.com

Odyssey Wilderness Programs
www.odysseynw.com

Open Sky Wilderness
www.openskywilderness.com

Outback
www.outbacktreatment.com

Outward Bound
www.outwardboundwilderness.org

Phoenix Outdoor
www.phoenixoutdoor.com

RedCliff Ascent
www.redcliffascent.com

Red Top Meadows Residential Program
www.redtopmeadows.org

Second Nature Wilderness Programs (SNWP)
www.snwp.com

Soltreks
www.soltreks.com

SUWS
www.suws.com

Wilderness Quest
www.wildernessquest.com

Wilderness Treatment Center
www.wilderness-therapy-program.com

Appendix C

List of Analyzed Websites: Residential Treatment Facilities

Discovery Ranch
discoveryranch.net

Falcon Ridge Ranch
www.falconridgeranch.com

Harborcreek Youth Services
www.hys-erie.org

Inner Harbor
youthvillages.org

Kolob Canyon Residential Treatment Center
kolobcanyonrtc.com

La Europa Academy
laeuropaacademy.com

Moonridge Academy
moonridgeacademy.com

New Beginnings
sequeltsi.com

New Haven Residential Treatment Center
newhavenrtc.com

Project Patch
www.projectpatch.org

Red Rock Canyon School
www.rrrtc.com

Summit Achievement
summitachievementcom

Sunrise Residential Treatment Center
sunrisertc.com

The Keys of Carolina

keysofcarolina.com

The Village
acadiavillage.org

Three Springs New Directions
sequeltsi.com

Tipton Academy
www.tiptonacademy.com

Willow Springs Center
www.willowspringcenter.com

Youth Care Inc
www.youthcare.com

Appendix D

List of General Questions to Ask a Program

1. What is the name and position of the person you are talking with? Where are they physically located? Are they located at the program?
2. Is the person you are talking with a licensed counselor, medical or mental health professional?
3. How long has this person worked in this program? What jobs have they had in the program? Have they ever worked as an instructor, guide or therapist?
4. How long has the program existed?
5. Has there ever been an injury or death of student that resulted in a criminal or civil action against the program. If Yes, ask for the name of the newspaper that covered the story. (This is not confidential information because it should be a matter of public record.)
6. Has the program undergone a change in ownership in the past 2 years? Who owns the program? Ask for information necessary to contact the owners.
7. Who is the program director? How long have they been there? What is their experience? Are they licensed?
8. Is the program licensed or accredited and with what organization or agency? What is the contact information for that organization or agency?
9. Is there a licensed professional in your program who will be directly responsible for your child's safety and well-being? Who is specifically and ultimately responsible for your child?
10. Is the program co-ed? How are boys and girls supervised?
11. What is the staff to student ratio?
12. How may students have graduated or completed your program?
13. How many students graduate each month? When are graduations normally?
14. Who is responsible and supervises the various departments in the program? What are their qualifications and are they licensed?

15. Who supervises the program's therapists/counselors? Is the supervisor licensed at the appropriate level?
16. What type of students are accepted in the program?
    - drug and alcohol problems?
    - psychiatric medications?
    - criminal background?
    - violence or assault?
    - sexual assault or rape?
17. Can they provide you with a written copy summarizing the program's policies and procedures? Insist on a written copy of anything they tell you before you admit your child.
18. What are the qualifications of the field staff?
    - college education
    - trained in CPR and first aid?
    - training as a wilderness first responder?
    - trained in search and rescue?
    - crisis intervention?
    - licensed as a mental health professional?
19. How are new staff trained before they start working with students?
20. How much experience do staff need to have before they assume a lead, senior staff or supervisory leadership role?
21. Are new staff background checks completed and verified before the staff starts work?
22. Are all the counselors and therapists licensed in the state they are working? Can they send you a copy of the assigned therapist license and the means to contact their licensing agency?
23. What are the qualifications for the counselor and therapist your child will be working with?

24. Is there a licensed psychologist who works with staff and students in the program?
25. Is there a consulting psychiatrist or psychiatric nurse practitioner who consults with the program? Or a physician experienced with psychiatric medications?
26. Is there a nurse on staff who can consult with staff or see students in the field if necessary?
27. Who is responsible for dispensing and monitoring medications?
28. Are medical policies and procedures under the direction of a licensed medical health care provider who is on staff or is at least affiliated with your program?
29. Will they give you a copy of the medical procedures in the case of injury, illness or other health problems?
30. Is there a handout that describes the emergency procedures that are followed in the event of accident or serious injury?
31. How much and how often do students receive professional counseling or therapy?
32. Are the counselors and therapist's required to follow the ethical standards required under their license?
33. Do they have a handout that describes the program's therapeutic model for supervising, educating and counseling students?
34. Is there a handout that describes the program's educational and written requirements that students must complete as part of their program?
35. Does the program have an educational component and is the educational program fully accredited with transferable credits? How are credits achieved?
36. How do they handle students with learning disabilities?
37. Ask them to describe the psychological and social structure of program?
38. Ask why do students change within the program structure they provide?
39. What recreational opportunities are provided? When and how often?
40. What is the minimum length of stay in the program?
41. What is the average length of stay for a student?

42. What is the longest stay?
43. Is there some estimate of how long a child like yours will need to be in the program to succeed?
44. How many of the graduates go home and how many go to other programs? Why?
45. How can you communicate with your child if your need to? Under what circumstances?
46. What support services or trainings do they offer parents?
47. What involvement is necessary from parents?
48. How do they handle misbehavior? Runaways? Combative behavior?
49. What is the programs philosophy on medication and the use of medications in the program?
50. How is communication handled between incoming and outgoing staff members?
51. What educational services do they offer for students with unique learning styles?
52. What is the minimum level of experience for a staff person in order to lead a group, be a head instructor or senior guide?
53. How does the program keep their staff from "burning out"?
54. Who is directly responsible to monitor the behavior of staff and their interactions with students?
55. Who is ultimately responsible for your child's health, safety and well-being and what is their experience and qualifications?
56. Has the program had any complaints filled by parents with public authorities that were sustained?
57. Has the program's permit, license or accreditation been suspended or revoked?

Source: http://www.wildernessprograms.org/InterviewQuestions.html

Appendix E

Fact Sheet: Behavior Modification Facilities

In almost every region of the world, there are facilities for the treatment of minor children with drug/alcohol and/or discipline problems. These private and state-owned overseas treatment centers can often be characterized as "Behavior Modification Facilities."

Parents/guardians enroll their minor children in these facilities in the hope they will improve their problematic behavior. Some facilities request parents/guardians to sign a contract for their minor child's treatment authorizing its staff to act as their agents. These contracts purport to give staff very broad authority to take any actions deemed necessary, in the staff's judgment, for the health, welfare and progress in the child's program. The facilities can be located in relatively remote areas, restrict the minor child's contact with the outside world, and employ a system of graduated levels of earned privileges and punishments to stimulate behavior change. The minor child's communication privileges may also be limited.

The Department of State has no authority to regulate these entities, whether they are private or state-owned, and does not maintain information about their corporate or legal structures or their relationships to each other or to organizations in the United States. The host country where the facility is located is solely responsible for compliance with any local safety, health, sanitation, and educational laws and regulations, including all licensing requirements of the staff in that country. These standards may not be strictly enforced or meet the standards of similar facilities in the United States. The Department of State has, at various times, received complaints about nutrition, housing, education, health issues, and methods of punishment used at some facilities.

Prior to enrolling their minor children in such overseas "Behavior Modification Facilities," the Department of State strongly recommends parents/guardians visit the facility and thoroughly inform themselves about both the facility and the host country's rules governing it and its employees. The Department of State also encourages parents/guardians and facility administrators to ensure that all U.S. citizen enrollees are

registered with the nearest U.S. Embassy/Consulate in case emergency consular services are needed.

U.S. consular officials are not qualified to determine whether the programs offered by the facilities are of therapeutic benefit to the enrollees. When aware of such facilities, U.S. consular officials conduct periodic facility visits, sometimes accompanied by host country officials, to monitor the general welfare of the U.S. citizen enrollees. Inquiries into the welfare and whereabouts of U.S. citizen enrollees may be initiated by contacting the closest U.S. Embassy/Consulate in the host country or the Department of State's Overseas Citizens Services (OCS) office at the below telephone number. Also, parents may contact the closest U.S. Embassy/Consulate in the host country to inquire about the facility or speak to the Department of State's Bureau of Consular Affairs" OCS Specialist for that country (Tel.: 202-647-5226 or, for after hours emergencies, 202-647-5225).

The Federal Privacy Act protects U.S. citizens, including minor children, from the unauthorized disclosure of information that the U.S. Government has collected and maintained about them unless the U.S. citizen has consented in writing to the release of the information or one of the Privacy Act"s "conditions of disclosure" permits the U.S. Government to release the otherwise protected information.

While parents/guardians may at times act in loco parentis for their minor children and obtain information that is otherwise protected by the Privacy Act, it must also be noted that minor children"s explicit wishes must be respected. Thus, a U.S. consular officer who has been advised by a minor child that s/he does not want any information released to an inquiring parent/guardian should honor those wishes absent the presence of circumstances affecting the health or safety of the minor child (i.e., one of the "conditions of disclosure"). Parents/guardians should be aware that U.S. citizens 14 years of age and older have the right to apply for a passport without their parents"/guardian"s permission. In extreme emergency situations, they may also request repatriation assistance from the U.S. Government without parental consent.

Source: http://www.travel.state.gov/travel/tips/brochures/brochures_1220.html

Appendix F

NATSAP: Principles of Good Practice

The following principles of good practice have been unanimously adopted by the board of directors and membership of the National Association of Therapeutic Schools and Programs as basic principles of practice ascribed to by member programs and schools. Full members certify compliance with the practice principles while associate members aspire to these principles, but are not yet in full compliance. The intent of this statement of practice principles is to raise the general level of operating practice within therapeutic programs and schools. These guidelines refer to therapeutic programs and emotional growth schools as "program/schools" and refer to client/students as "program participants."

1.0 ADHERENCE TO STATE AND FEDERAL LAWS

The program/school shall adhere to all applicable state and federal laws in conducting the operation, including administration, hiring and employee practices, observance of safety regulations, and the care of program participants.

2.0 ADMINISTRATIVE PRACTICES AND PROCEDURES

The program/school has a responsibility and duty to strive to provide its program participants with appropriate ethical and professional service in all areas of operations.

2.1 The program/school will have a written plan for governance, program administration, and professional services. The Plan includes the following elements.

2.1.1 Introduction and history of the program/school.

2.1.2 A delineation of the responsibility of the governing body including, policy development, responsibility for implementation, compliance, amendment, and oversight of the policies.

2.1.3 Mission Statement.

2.1.4 Philosophy of the program/school.

2.1.5 Description of the population the program/school serves, including admission, non-admission and discharge criteria.
2.1.6 Description of services provided.
2.1.7 Organizational Structure including an organizational chart.
2.1.8 Tuition / Fee statement including all ancillary cost, and refund policy.
2.1.9 A plan for self-evaluation and program/school improvement.
2.2 The program/school shall have proof of general liability, professional liability, fire, and vehicle insurance coverage as appropriate.
2.3 The program/school will follow accepted accounting practices.
2.4 Member schools/programs will:
2.4.1 Not offer or accept payment for referrals.
2.4.2 Represent facts truthfully to program participants and third-party payers.
2.4.3 Disclose fully all costs and fees for service.
2.4.4 Respect copyrights, trade authorship, and proprietary information, and will not plagiarize or use materials, documents, or resources from other sources or programs without permission.
2.4.5 Not use a name or marketing strategy that misleads the public or makes guarantees of outcome to consumers.
2.4.6 Disclose fully all ownership and financial relationships between associated programs, services, and professionals where there is a potential for a conflict of interest.

3.0 EMPLOYEE PRACTICES

The program/school will only provide services (including assessment services), that lie within the scope of the service, training and qualifications of its staff. The program/school will accurately and factually represent the competence, education, training, certification and experience of its employees. NATSAP members will not discriminate on the basis of race, religion, gender, or sexual orientation.
3.1 Hiring Practices

3.1.1 Applicants are required to complete an Application for Employment. The application form must include the following.

3.1.1.1 Previous place(s) of employment.

3.1.1.2 Signature, verifying that all information is correct and factual.

3.1.2 Upon extending an offer for employment, the program/school will obtain:

3.1.2.1 A criminal background check including driving history.

3.1.2.2 A minimum of two professional references (written or verbal).

3.1.2.3 Proof of professional credentials.

3.1.2.4 A medical examination or statement signed by the employee assuring fitness to execute the physical and mental requirements delineated in the job description.

3.1.2.5 If the employee is required to drive a company vehicle, or is asked to transport program participants in his/her own car, the Department of Motor Vehicle will be contacted to determine that the respective employee has a valid driver license.

3.2 On-Going Employee Practices

3.2.1 Each employee will have a written job description. The job description will include the following:

3.2.1.1 Job title.

3.2.1.2 Duties and responsibilities.

3.2.1.3 Minimum level of education, training and work experience required for the position.

3.2.1.4 Physical demands of the position.

3.2.1.5 Lines of authority. (Delineation of supervisory responsibility)

3.2.2 The program/school shall have written Employee Policies and Procedures that will include policies on:

3.2.2.1 New Employee orientation procedures including:

3.2.2.1.1 Orientation in philosophy, objectives and services.

3.2.2.1.2 Emergency procedures. (Fire, Disaster, etc.).

3.2.2.1.3 Current program/school policy and procedures including behavior management.

3.2.2.1.4 First aid and CPR training.

3.2.2.1.5 Statutory responsibilities, including those covered by state and federal laws.

3.2.2.2 Continuing staff training and development.

3.2.2.3 Performance appraisals.

3.2.2.4 Methods for filing and addressing employee grievances.

3.2.2.5 Disciplinary actions, termination, and discharge practices.

3.2.2.6 Sexual and other forms of harassment or misconduct.

3.2.2.7 Abuse reporting laws

3.2.2.8 Vacations, holidays, illness, extended leave, military leave, and jury duty.

3.2.2.9 Volunteers, interns, and contract personnel if applicable.

3.2.2.10 Confidentiality and information disclosure within the limits recognized by appropriate professional standards, including state and federal regulation.

3.2.2.11 Transporting program participants and their parents/guardians.

3.2.2.12 Prevention and investigation of allegations levied by program participants regarding employee misconduct.

3.3 Personnel File

3.3.1 The program/school will maintain a personnel file on each employee that includes:

3.3.1.1 Application and/or resume

3.3.1.2 Background clearance.

3.3.1.3 Proof of credentials including education, licensure, certifications, etc. as applicable.

3.3.1.4 Proof of medical examination or statement of ability to perform duties.

3.3.1.5 Signed job description.

3.3.1.6 Documentation of new employee orientation and ongoing staff development training.

3.3.1.7 Performance evaluation(s).

3.3.1.8 Emergency contact information.

3.3.1.9 Documentation of disciplinary actions, termination or discharge.

3.3.1.10 Signed confidentiality agreement regarding the exchange of information concerning program participants, their families, and fellow workers.

3.3.1.11 Copy of driver's license (if employee is required to drive a company vehicle as part of the job).
3.3.1.12 Documentation of employment status e.g., hourly, salary, part-time, full time, exempt, non-exempt, etc.

4.0 ADMISSION/DISCHARGE POLICY

The program/school will have a written Admission Policy, which defines the enrollment criteria and delineates inclusion and exclusion criteria. Such criteria will be consistent with the mission of the program/school. Admission forms will provide pertinent history including family, medical, psychiatric, developmental, and educational background information.
4.1 The Admissions screening process will examine the physical, emotional, behavioral, and academic history, in order to determine whether the program is appropriate in light of the prospective participant's needs and limitations
4.2 The program/school will provide program participants, parents, legal guardians, or other pertinent parties with a clear and informed statement of the nature of the services that will be provided including, risks associated with these services.
4.3 Upon admission, a file will be created for each program participant, containing the following:
4.3.1 Demographic information including emergency contact information.
4.3.2 Basic medical, family, behavioral, legal, educational, information including past and current assessments.
4.3.3 A signed statement indicating receipt of a copy of the student handbook or statement of Participants Rights and Responsibilities, or a witness attesting to the participant's refusal to sign.
4.3.4 Contract, release and consent forms.
4.3.5 Documentation of communication with parents, legal guardians, payer sources and other parties.
4.3.6 Photograph.

4.3.7 Copy of any grievance filings and action taken.

4.3.8 Documentation of services rendered.

4.3.9 Discharge summary and academic transcripts

4.4 The program/school will conduct on going assessment to determine appropriateness of continued placement.

4.5 Upon termination or discharge of a program participant, the program/school will make appropriate recommendations for continuing care and/or education.

5.0 BEHAVIOR MANAGEMENT PLAN

5.1 The program/school shall have a written Behavior Management Plan which describes:

5.1.1 How human dignity and rights will be respected in the application of behavior management practices.

5.1.2 Special treatment / intervention processes including such techniques as: seclusion, restraint, therapeutic holding, passive holding.

5.1.3 Procedures for handling emergency situations such as suicidality, abuse, assault, and runaway.

5.1.4 Acceptable and non-acceptable consequences.

5.1.5 On going training procedures for employees.

6.0 PARTICIPANT RIGHTS AND RESPONSIBILITIES

6.1 The program/school will have a written Student Handbook or statement of Program Participant Rights and Responsibilities as appropriate to the setting, purposes, and pertinent state and federal law. Such manual or statement will include statements regarding the following rights:

6.1.1 To receive care or services within the program’s capability, mission, and applicable law and regulations.

6.1.2 Freedom from discrimination.

6.1.3 The expectation of a safe environment with respect of human dignity.

6.1.4 Respect for privacy of information and records of each individual and family served.

6.1.5 A description of any restrictions in communication or visitation.

6.1.6 A description of privileges and limitations for participants.

6.1.7 A description of access to religious services and practices.

6.1.8 A statement indicating that the program/school retains the right to maintain a contraband free environment and a description of any search or testing procedures used in this effort.

6.1.9 Procedures for student/participant grievance and complaint will be clearly outlined along with a statement guaranteeing freedom from retaliation for making complaints.

6.1.10 A diet that is nutritionally sufficient for age and activity level.

7.0 HEALTH CARE ACCESS

7.1 The program/school will have a policy on health care that addresses the following issues:

7.1.1 Access to appropriate medical care.

7.1.2 Delineation of whom is authorized to dispense medications.

7.1.3 A policy on storing, accounting, and security of medication.

8.0 SAFETY

8.1 The program/school shall have Plant, Technology and Safety Policies and Procedures containing the following:

8.1.1 A fire and disaster plan which includes the following:

8.1.2 Delineating responsibility of all employees in the event of fire or other disasters

8.1.3 A description of available emergency services, escape routes, relocation plans, and other contingency plans.

8.1.4 Documentation of all fire and emergency drills.

8.1.5 Policies concerning staff training for emergencies and access to emergency medical care.

8.1.6 A safety committee who will be responsible for risk management as well as training and implementation of emergent procedures.

8.2 A policy or procedure for equipment maintenance and repair

8.3 An Infectious Disease Control policy

9.0 INCIDENT REPORTING

9.1 The program/school will have an Incident Reporting policy and procedures, including a reporting mechanism to the governing body.

10.0 PHYSICAL PLANT

The program/school will have facilities of a sufficient size, space, configuration, and condition to support the balanced integration of its programs and services, and manages its physical plant to keep risk within acceptable parameters for the participants as appropriate to the program/school's mission and goals.

11.0 EDUCATIONAL SERVICES

Educational services will be consistent with the mission of the program/school and may include: fully developed college preparatory academic programs leading to a diploma, individual courses offered for credit, services such as academic packets or online courses offered for credit through materials developed or administered by third party providers, and academic support and skills development offered for no credit. Some programs may choose to outsource academic services to private contractors or public school districts. The scope, extent, and instructional methodology of the educational services including, whether the services are provided in house or out sourced, will be fully disclosed by NATSAP members to any interested party, program participants, families, referring professionals, and school, college and university admission's offices. All programs/schools that offer academic credit to program participants as a part of their in house services shall:

11.1 Maintain an academic transcript for each program participant in his or her permanent file that is current and up-to-date.

11.1.1 Required information at a minimum includes:

11.1.1.1 Program/school name, address, phone number, and date prepared

11.1.1.2 Student name, address, and DOB

11.1.1.3 Admission date, emission date,

11.1.1.4 Grading scale

11.1.1.5 List of individual classes, with grades and credit earned, and GPA

11.1.2 Program/schools that grant diplomas and advertise as a school, or as providing academic or educational services comparable to a school will include the additional information on the transcript:

11.1.2.1 If applicable, diploma earned and graduation date.

11.1.2.2 Accrediting body and the program/school's accreditation status

11.1.3 Program/schools that provide academic or educational services may include the following additional information on the transcript:

11.1.3.1 Standardized test scores (PSAT, SAT, ACT, ITBS, etc.)

11.1.3.2 Immunization records

11.1.3.3 Class rank

11.2 Provide a written description of educational services that includes:

11.2.1 A profile of educational services with descriptions of ages and grades taught

11.2.1.1 Educational philosophy

11.2.1.2 Graduation requirements leading to a diploma

11.2.1.3 Policy delineating how credit is earned and assigned

11.2.1.4 School calendar

11.2.1.5 Policy describing curriculum oversight and quality assurance

11.2.1.6 Official school contact for questions about the educational program

11.2.2 A curriculum catalog with:

11.2.2.1 Course descriptions

11.2.2.2 Scope and sequence

11.2.2.3 Goals and objectives

11.2.2.4 Method of instruction

11.2.2.5 Evaluation and assessment

11.2.3 A student profile

11.2.4 Teacher qualifications including education, experience, and/or certification.

11.3 Any diploma granting program/school that represents itself as a school will abide by the NATSAP Supplemental Standards for Therapeutic Boarding Schools

Ethical Principles

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

In applying to become or continue as a member of The National Association of Therapeutic Schools and Programs, we agree to:

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

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

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

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

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

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

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

Value continuous professional development, research, and scholarship.

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

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

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

Provide an appropriate professional referral if we are unable to continue service.

As an executive of ____, a member program/program applying for membership with the National Association of Therapeutic Schools and Programs, I have signed below to indicate that our organization supports and follows the above Ethical Principles.

Signature Name (Please print or type)

Title Date

The NATSAP definition of the relevant programs:

Outdoor Behavioral Health (Wilderness Programs and Outdoor Therapeutic Programs) - subscribe to a diverse treatment model that incorporates 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.

Source: www.natsap.org

Appendix G

JCAHO: Standards and performance measurement

Joint Commission standards address the organization's level of performance in key functional areas, such as patient rights, patient treatment, and infection control. The standards focus not simply on an organization's ability to provide safe, high quality care, but on its actual performance as well. Standards set forth performance expectations for activities that affect the safety and quality of patient care. If an organization does the right things and does them well, there is a strong likelihood that its patients will experience good outcomes. The Joint Commission develops its standards in consultation with health care experts, providers, measurement experts, purchasers, and consumers.

Introduced in February 1997, The Joint Commission's ORYX initiative integrates outcomes and other performance measurement data into the accreditation process. ORYX measurement requirements are intended to support Joint Commission accredited organizations in their quality improvement efforts. Performance measures are essential to the credibility of any modern evaluation activity for health care organizations. They supplement and help guide the standards-based survey process by providing a more targeted basis for the regular accreditation survey, for continuously monitoring actual performance, and for guiding and stimulating continuous improvement in health care organizations. Some accredited organizations are required to submit performance measurement data on a specified minimum number of measure sets or non-core measures, as appropriate, to The Joint Commission through a Joint Commission listed performance measurement system.

Note: A complete list of the Joint Commission's standards for performance is available only through accreditation manuals which can be purchased through the Joint Commission.

Source: www.jointcommission.org

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