INTERSECT SERVICES

Professional Therapeutic Community Network (PTCN) has been providing high quality therapeutic foster care, mental health and behavioral rehabilitative services to the children and families of Oregon since its inception in 1997.

PTCN is a licensed child welfare organization which is currently providing out patient and therapeutic foster care for males and females ages 5 and older with cognitive, behavioral and emotional problems. PTCN also has 24 hr. Residential Programs for IDD youth and adults.

INTERSECT Services at PTCN are designed to support youth and families impacted by sexual abuse. Children and youth who have engaged in sexually reactive and/or abusive behaviors require specialized and direct interventions. The adult caregivers for these children and youth need specialized supports and services to address the complex issues of risk management, behavior intervention, and working through the many challenging emotional and social impacts of sexual abuse. The majority of children and youth with sexual behavior problems are at high risk of placement instability and disruption due to the complexity and impact of sexually abusive behaviors.

INTERSECT is accessible at any point in the continuum of care with DHS-Child Welfare youth. They can be accessed at a CPS level of intervention, foster care, in a residential placement, incarceration, ILP, etc… anywhere along the continuum. These services are also designed to provide training and consultation to ancillary staff working with youth and families with sexual abuse risk management needs. INTERSECT is designed to address where a youth and their Caregivers/Family are in their treatment needs, risk needs, and where they are at in the care continuum.

ACCESSING INTERSECT SERVICES: Begins with Referral

- **Screening of records and individual**
  - Prior Authorization - Referral to: Glenda Marshall for authorization.
  - Referral to PTCN: Glenda sends the authorization and referral data to PTCN who reviews the referral and Accepts or Rejects.
  - PTCN Assigns a Clinician who contacts the DHS-CW caseworker to begin identifying and coordinating service elements.

- **Intake Process**
- Upon acceptance to the program the attending Therapist coordinates an intake meeting, attended by Caregivers, Referring agency (DHS or DD), Guardian, Youth, Therapist, Skills

trainer as well as family members and previous placement resources. The purpose of this meeting is to complete legal documentation, develop an Initial Service Plan and agree upon roles and responsibilities of the treatment team members which ensure the service delivery fits the need of the youth and their family.

- PTCN has created a ***Roles and Responsibilities Framework*** that guides the discussion and assists in each team member's function in the attainment of the goals set forth in the Initial Service Plan.
- The Caregivers outline their home rules, their family life & culture and generally explain what it is like to live in their home. The youth reads aloud the treatment contract and signs it with hand-written personalization of specific individualized treatment items. At this time, all necessary legal paperwork is signed. The *parents are provided a Grievance Procedure* and walked through how PTCN communicates and desires to ***pro-actively solve problems***.

Initial Service Plan – An initial service planning meeting is attended by all parties involved with the youth being admitted including but not limited to:

- The Youth
- Community Partners
- Clinical Staff
- School Personnel
- DHS Child Welfare Caseworker
- Prior placement resources
- Parole or Probation officer
- Proctor Parents

The initial service plan meeting looks at the following areas:

- A plan to address specific behaviors including the intervention to be used
- A plan for any overnight home visits
- Anticipated discharge date
- Any identified needs of Risk Management
- Existing orders for medication and any prescribed treatments for medical conditions
- Caregiver Needs and Supports for Stability of Placement
- The Behavior Management System, Developmental Tracking System and household rules which are employed in the home
- The assembled team discusses any necessary restrictions placed on contact between the resident and family members and/or significant others including off-site visits, on-site visits, telephone contact and/or contact via regular mail or e-mail.

The written Initial Service Plan is signed within 48 hours of completion of Intake to the program.

Orientation/Assessment

This stage is focused on a Caregiver & Youth Assessment, orientation to INTERSECT Services, Integrating the Caregivers and youth into the therapeutic community.

- **Assessment and Evaluation (Youth Service)-** Within 60 days of a child's admission into PTCN's program, the attending therapist completes a written Assessment and Evaluation which identifies (but is not limited to) the following areas:

- Medical
- Family
- Cultural
- Mental Health
- Alcohol and Drugs
- Educational
- Vocational
- Social Living Skills
- Placement Plans
- Family Contact
- Legal status/custody status
- Problems, Reason for Placement
- Pertinent Historical Information;
- Child Behaviors
- Response to Current Services
- Strengths and Assets
- Significant Incidents and/or Interventions;
- Supervision Level
- Risk/Needs Assessment.

- **Assessment and Evaluation (Caregiver Service)-** Within 60 days of a child's admission into INTERSECT, the attending therapist completes a written Assessment and Evaluation addressing Caregiver Capacity to Manage Sexually at Risk Youth which identifies (but is not limited to) the following areas:
    1) The ability to meet the youth's basic physical and emotional needs
    2) Caregiver Needs & Supports
    3) The quality of the relationship and communication between the parent and youth as well as the victim
    4) The parent's attitudes about sexual behaviors and the offense as well as his/her own history of victimization
    5) The capacity to provide intensive supervision
    6) Current level of denial
    7) Willingness and ability to follow safety and treatment recommendations

Developmental Assessment

The clinical staff collaborates with the Caregivers during this phase to assess the youth's current level of developmental functioning. A **Psychosocial Developmental Assessment** (completed by their attending Developmental Counselor who seeks input from the rest of the Clinical team, Caregivers, Parent, Family and DHS or DD worker) is completed within 60 days of admission to PTCN. The Psychosocial Developmental Assessment procedures are based on:

- Series of Clinical Interviews with the youth and available family members,
- Collateral Data Review,
- Behavior and Developmental Stage Tracking by Proctor Parents,
- Caretaker & Parent Interviews

The clinical team works together with the Caregiver & Parents to discover family systems history and evaluates emotional, sexual, and physical trauma. With help from the youth, family and referring agency evaluations are made on social systems, self-regulation, protective factors, educational history, sexual abuse trauma, and coping competencies. Treatment planning looks at strengths/needs to identify resilience, coping mechanisms, and protective factors.

Recommendations are made on treatment needs, interventions needing to be put in place and how to strengthen existing Caregiver and Family connections.

The Youth

Upon entering the program each client is assigned to a Therapist and begins their introduction to PTCN's community. During Orientation, the youth is being assessed, informed about their Risk Reduction Strategies, and learning about developmental stages.

The Caregivers & Family

Upon entering the program Caregivers and Parents are provided an opportunity to attend Caregiver Consultation. This allows the Caregivers and Parents to begin a supportive dialogue about how difficult and traumatic the situation can be when learning and coping with a child who has serious behavioral and emotional problems. This process usually begins in Individual time with the therapist and leads to a group consultation with current parents who can support them in the program.

- **Individualized Master Service Planning and Quarterly Treatment Review -** Within 90 days of admission into PTCN's program and every quarter thereafter, the team re-assembles to discuss the youth's current functioning and movement toward goals. The attending therapist facilitates this meeting which discusses (but is not limited to) initial service plan and the following areas:
    - Offense specific issues
    - Medical information
    - Family
    - Cultural
    - Mental health
    - Alcohol and drugs
    - Social living skills
    - Placement Support
    - Family contact
    - Caregiver Needs & Supports
    - Transition/Titration Needs
- **Aftercare/Transition Plan –** The attending Clinical Staff for each youth facilitates transition planning in whether a youth needs a higher or lower level of interventions. After care (beginning with the End in mind) and transition planning begin during the intake process and are updated at each quarterly treatment plan meeting. Thirty days prior to Discharge, Clinical Staff updates the Master Service / Treatment Plan with the team identified during the initial service plan and master service plan review meetings. This plan includes (but in not limited to) the following:
    - Identification of Caregiver & Youth services and supports.
    - Identification of the Caregiver's & child's individual needs and unmet goals;
    - Identification of person or agency responsible for providing the aftercare services.
- **Discharge Summary -** Within 15 days of the youth's discharge from INTERSECT, a written Discharge Summary is forwarded to the DHS Caseworker and Caregiver. This summary discusses the progress toward Master Service Plan goals.

ARRAY OF INTERSECT SERVICES PROVIDED at PTCN

Service Type:	*PTCN Provides:*	*Service Delivery Provider:*	*Amount:*
Individual Counseling (Youth)	*Individual Psychotherapy*	*QMHP*	*Per case*
	Sex Offense Specific	*QMHP--CSOT*	*Per case*
1:1 Skill Building (Youth)	*Developmental Coaching*	*QMHA-Developmental Couns.*	*Per case*
	Individual Skill Building	*QMHA-Developmental Couns.*	*Per case*
Caregiver Skill Building	*Individual Parent Coaching*	*QMHP & QMHA*	*Per case*
Group Counseling (Caregiver & Youth)	*Didactic Multi-Family Group*	*QMHP*	*Per case*
	Community Group		
	Accountability Group		
	Experiential Group		
	Peer Group	*QMHA- Develop. Counselor*	*Per case*
	Small Group Skills Training		*Per case*
	In-home Support	*QMHA-Develop. Counselor*	*Per case*
Caregiver Training	*Parent Consultation*	*QMHP*	*Per case*
	Formal Training-KAS	*QMHP*	*Per case*
	Parent Training	*QMHP & QMHA*	
Caregiver Counseling	*Family Orientation Group*	*QMHP*	*Per case*
	Family Therapy-Clarification	*QMHP*	*Per case*
	Supported Family Visits	*QMHA-Develop. Counselor*	*Per case*
Ancillary Training & Consultation (DHS, other support partners of Caregiver)	*Consultation & Training*	*QMHP*	*Per case*

INTERSECT SERVICES FRAMEWORK:

INTERSECT services are provided in a Therapeutic Community model that replicates a positive peer culture that is usually done in a residential facility. PTCN has worked diligently over the years in creating a community of individuals committed to working with High Risk youth in a community based setting to de-institutionalize and integrate high-risk, mal-adaptive youth into a real social milieu and community based Caregivers. PTCN is committed to working with youth and Caregivers in the long term, understanding that serious neuro-developmental and attachment disorders require consistency and continuity in all interventions and support strategies.

PTCN's staff—from the CEO to its Therapists and Developmental Counselors along with its Operations Director and office staff—work with a deep commitment in providing treatment in a therapeutic community setting.

INTERSECT services are designed to help support Caregivers who work with their youth on developmental skill acquisition, risk management strategies, and re-parenting exercises. Caregivers are trained and supported to provide data supported assessment of on-going treatment impacts by tracking developmental task achievement and reporting changes and challenges to their INTERSECT Clinical Team.

Individual and Group Skills Training is provided by our Developmental Counselors. This type of training and support is carried out at PTCN's offices and in the community (home based) where Caregivers & Youth can practice real-life application of new skills and competencies.

Therapists provide Individual and Group Counseling to both the youth and their families at PTCN's offices. Caregivers participate in Clinical Consultation with the Therapist in Individual and Group formats. In Group Consultation, Caregivers meet with other Caregivers of youth with similar needs. These modalities also provide a great way to enhance formal training and support needs of the Caregivers. Knowledgeable Adult Supervision Training is one of the components provided to Caregivers during Consultation.

PTCN utilizes a variety of therapeutic interventions in working with youth who have attachment issues and mal-adaptive behaviors. It merges the theoretical framework of Erik Erickson, Stanley Greenspan with Cognitive Behavioral Therapy with Social Skills Training.

95% of all PTCN members provide direct services to youth and families it serves.

PTCN engages in ***Multi-disciplinary Treatment Planning*** and has developed a new Roles and Responsibilities structure to its Treatment Planning to ensure ***family and guardian involvement*** in the Treatment and Decision making process. Families are encouraged to participate in the group work with their youth and we make sure that family passes and contacts are regularly

scheduled and agreed upon in the Master Service Treatment Plan. PTCN works with families through skill building during structured family skills training, focusing on rebuilding relationships, and providing family therapy. PTCN provides cultural enhancement, access & maintenance of cultural traditions to contribute to the healthy development of the youth and sustaining family bonds.

PTCN understands that special considerations are necessary when planning for transitioning youth with IDD and co-occurring mental health diagnoses into young adulthood. The ***transition planning*** process considers specific recommendations regarding the youth's readiness and community safety when preparing for independent living. At PTCN we look at the following:

- Collaborates with Independent Living Programs
- Encourages Caregivers to support community-based activities are carefully chosen to match the youth's interests, risk reduction profile and developmental stage
- Assists Caregivers in designing activities which develop the youth's awareness of pro-social behavior in a wide variety of settings
- Pays close attention to gender specific needs including program participation and available opportunities
- Supports healthy gender role modeling
- Assists Caregivers in developing skills and interventions to best support their youth
- Explores and assists Caregivers & Youth reconciling and potentially reunifying with his/her family in a manner that supports the needs of their past victims and potential for success.

CULTURE AND GENDER SENSITIVITY

While the PTCN program addresses cultural and gender, it is imperative to realize they are only two of a whole range of potential challenges encountered when trying to deliver an exceptional level of care. PTCN clinical staff and proctor parents are familiar with conditions facing DHS families and youth that may act as barriers, such as:

- drug and alcohol abuse
- gender differences
- gender variations
- cultural differences
- linguistic differences
- emotional disturbance
- physical and sexual abuse
- learning and developmental disabilities
- physical disabilities
- a clients' possible hesitation to participate in services

Although these may be barriers to treatment, they do not exclude clients from being accepted into PTCN's services and every attempt is made to engage the client to participate. PTCN

program staff is trained to create a respectful, accepting and caring relationship with clients that establish safety and trust. Caretakers and youth's willingness to participate in services is enhanced if they are treated with respect and integrity. Meeting a Caretakers and youth "where they are", whatever their conditions or barriers might be, is a basic tenet of PTCN's therapeutic community. PTCN clinical staff understand the importance of considering educational limitations, developmental delays and other disabilities. The pace of the intervention and presentation is modified in order to help Caretakers, youth and families to succeed.

FAMILY CULTURE

At the intake meeting a concerted effort is made to identify and connect with the youth's family culture. PTCN takes a close look at what the youth's family-of-origin culture is and how it plays out in the understanding and treatment of the youth in the program. Some of the cultural areas investigated might be ethnicity, language, spirituality, leisure, and poverty among others. Because of the various combinations of cultural backgrounds seen in the program, PTCN's therapists, developmental counselors and other staff all undergo basic gender/cultural training and are expected to attend one culture-orientated class or workshop per year. Additionally, PTCN actively engages the family-of-origin as part of their therapeutic community. Family members are encouraged to be part of weekly group therapy sessions and community meetings. The group therapy sessions awaken recognition of the youth's own culture while the community meetings provide support and education for family members.

One aspect of the family culture, **domestic violence**, deserves special attention. Often, domestic violence in the family-of-origin can be overlooked when compared to the level of mal-adaptive behavior the youth is exhibiting. PTCN offers treatment that includes assertiveness skills, independent living skills, social support building and safety planning for youth. PTCN staff is familiar with local shelters for victims of domestic violence and assists families in seeking safety when necessary. Domestic violence impacts youth adversely even when they are not the direct targets. Clinical staff offer developmentally appropriate interventions for youth who have witnessed and been traumatized by domestic violence to ameliorate the post-traumatic stress reactions.

LANGUAGE & ETHNICITY

PTCN contracts with service providers to work with non-English speaking families—offering interventions in their native languages. PTCN has experience with and provided services for families of African-American, Asian, Hispanic, Arabic, Slavic and Native American cultures. In the past PTCN has also worked with deaf youth who have sexually abused co-occurring with serious mal-adaptive behaviors. PTCN has utilized signers to provide assessment and treatment services in these cases.

Clinical Staff understand that cultural attitudes concerning maladaptive behavior can play a large role in how well the challenges of treatment and transition are met. Staff consider the cultural background in their teaching and therapy methods—working with a Caretakers and youth's individual way of receiving information.

DRUG AND ALCOHOL ABUSE

Drug and alcohol abuse issues are sometimes encountered when dealing with youth and their Caregivers. These issues affect both the youth and their families of origin. In the case where the client has these issues, PTCN's developmental-stage treatment provides a strong framework for helping them handle these issues. If a youth's own drug or alcohol issues exceed the therapeutic expertise of PTCN's clinicians, a referral is generated to a local addiction specialist. PTCN and the addiction specialist coordinate efforts to provide services in accordance with the youth's treatment plan. Addiction issues which originate with other family-of-origin members may well pose significant challenges effective participation in their own child's treatment. PTCN uses their therapeutic community to encourage these family members to seek out assistance for recovery and sobriety services and helps to identify appropriate local community drug and alcohol addiction resources.

CULTURE OF POVERTY

The families of youth & Caregivers brought up in a culture of poverty defined by Lewis (1996, 1998) share a strong feelings of marginality, of helplessness, of dependency, of not belonging, convinced that existing institutions do not serve their interests and needs—there is often a generalized mistrust of professional clinicians. These cultural stereotypes and attitudes can have a large effect on the family's attitudes and understanding with regard to the youth's mal-adaptive behaviors. This can be problematic in the youth's behavior remediation processes. To meet these challenges INTERSECT Clinical Staff seek to understand the Caregiver & Family's cultural background and how it impacts supporting the Caregiver participating in support services. We look for common ground to help establish a trusting professional relationship. For instance, sometimes the youth's family may be reluctant or fearful to engage in services. Focusing on the family's existing strengths helps to instill a sense of hope to allay their fears.

For youth entering into therapeutic intervention from a background of poverty, instruction in money management and practical shopping skills may be addressed in their Service Plan. They learn how to stretch resources through careful planning and how to use available community resources. PTCN works with the youth and his family to identify social & thinking patterns as a result of growing up in generational poverty.

GENDER

INTERSECT Services integrates gender specific perspectives and practice in applicable parts of the service continuum and work culture. PTCN assures that their staff is knowledgeable about the importance of gender specific service delivery systems. PTCN's program comprehensively addresses the needs of the individual and is responsive in ways that intentionally allows gender identity to develop. The program utilizes gender specific resources to provide information for programming based on best practices, promising models and current research such as "Guidelines for Effective Gender Responsive Programming for Girls" (www.ocjc.state.or.us) and "Building on Strengths…Helping Boys Succeed" (Hinton Associates.) PTCN has run side by side programs for both male and female youth with low IQ and serious sexually mal-adaptive behaviors, both programs are integrated in the wider PTCN Therapeutic community.

THERAPY GROUPS & COMMUNITY GROUPS

INTERSECT provides separate therapy groups for male and female youth. One outcome is that the separation allows a degree of perceived safety in dealing directly with their behavioral and emotional issues among a youth's own gender. The separate group is also especially important as females are often offended by a male offenders could experience a mixed group as re-traumatizing (Frey, 2006) Females deal with their peers in different ways and the group allows them to deal with uniquely female issues regarding identity and healthy sexuality and also the co-morbid issues such as victimization, depression, social interactions in the context of interacting with each other in healthier ways. This takes different forms in both male and female groups.

There are also community group meetings which include male and female youth with serious behavioral and emotional problems, their Caregivers and family (adult) members. This is not a therapy group, but a community group that discusses educational topics or community issues. The meeting provides a safe setting for Caregivers & Youth to learn how to interact appropriately in a community setting and solve problems.

PTCN also takes other gender issues into account in group and individual therapy:

In the literature it has been noted that females seemed more likely to have experienced a more extensive amount and severity of sexual and physical abuse than reported by males. Points of concern were that girls may be more affected by psychosexual and emotional developmental deficits and that the therapeutic relationship was where lots of distancing behaviors and projection took place as a result. (Matthews, Hunter Jr., & Vuz, 1997)

An anecdotal study by Turner & Turner (1994) is helpful in exploring the importance of the adolescent female abusers' relationships with their mother and seems to be an extremely important relationship to the treatment of all the girl's therapy, whether the mother was present and available or not. Basic emotional/psychosocial developmental tasks are much more difficult to master and there are often large deficits to contend with. In addition, these lacks are at the forefront of the presenting problems for these girls. Most have been in treatment for a different presenting problem before they were referred to us. Therapists spend a lot more time on the client's ability to manage feelings, have accurate body awareness and being able to focus enough to work on sexual issues. Relationships with others are primarily where missing developmental tasks are resolved, so the relationship with their Caregiver can be both closer and more problematic. This dynamic also appears in their attempts to triangulate with the Therapist, the Caregiver and other youth. Therapists find they need to spend more time managing those relationships and also helping the Caregivers deal with them as well.

The girls tend to romanticize their relationships to their victims and also to anyone who has offended them. In therapy emphasis is placed on seeing the reality of those situations and helping the girls identify what they truly want in terms of emotional attachment. Some of this is done in multi-family group with the male group members as context, but most is done in peer group, individual sessions and skills training.

The boys and girls have often been parentified in their relationships with family members, especially with their mothers. This was usually done due their mother's lack of a reliable partner and need for caretaking. This presents an unusual challenge to help boys and girls accept their role as a child both in the Caregivers Family and in the program. The parentification has also shown itself in an unusual interest in and desire to parent younger siblings. This also presents a challenge in that the family members and the community do not understand the risk present, as it is more accepted for adolescent girls to have an interest in young children than boys. This makes family and community partnership and education more important.

The males seem to be able to work on their offender treatment compartmentalized somewhat from family issues; the girls have shown that a holistic approach is necessary. Unlike the adolescent male clients, the females tend to have some family involvement, usually their mother. Even if the mother is not involved, this is a relationship that needs to have some attention in therapy because it seems to have a great impact on the girls' treatment progress. In many cases the plan is not for the girl to return home prior to adulthood, but structured contact is necessary. Even if the girl and her family are not ready for traditional family therapy or Multi-family Group involvement, the therapist can do carefully structured meetings together to work on such issues.

Relationships in peer group work are more important. The males often appear to be a group of guys working on separate issues in group. The girls tend to function in a different whole group dynamic, so peer group is a time to work on boundaries, structured relationships and how to be a trustworthy person, as well as separate socio-sexual development issues. At times when the group climate is hostile, the therapist needs to separate them and do individual work to emphasize how unacceptable this is to avoid perpetuating it.

Denial in the female population of youth with sexual behavior problems often takes much longer and the technique needs to be more subtle. One reason for this seems to be the added societal shame and inability to admit that a female could have serious behavioral issues. Females seem to need time to deal with that shame and feel safe enough to disclose issues. When they can admit this, things like healthy coping plans seem to progress much faster. It seems to be important for caregivers and treatment workers to acknowledge calmly and with extra praise and assurance that none of what they are disclosing is unexpected or outside of the program's experience.

References

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COMMUNITY COLLABORATION

Experience in Working with Multiple Community Partners

PTCN's community partners are engaged from the first steps of the process. The program's therapeutic community model encourages interaction with community partners from the moment a case is referred. At the intake meeting Caretakers, the youth and caseworker, family-of-origin, Therapist, Developmental Counselor and previous placement resources create an initial service plan. Not only are goals and tasks outlined but also a great deal of effort is expended on roles and responsibilities—clarifying who will deliver and be responsible for which services. Discharge plans are discussed and created at the intake meeting as well.

The youth's Individual Service Plan is put into place at Intake and is informed by communication with members of each youth's treatment team including Primary Caregivers, DHS workers, Juvenile Court Counselors, Probation Officers, school staff, CASA workers, ILP workers, family members, employers, mentors, DD case managers, youth pastors and respite providers. The treatment team is also employed as the process moves along by participating in problem solving youth and family issues. INTERSECT cooperates with these organizations and individuals and attends meetings to provide youth (and their families) the most well-rounded care possible addressing individualized treatment issues. As treatment progresses INTERSECT holds 90-day reviews to which all members of the treatment team are invited and discuss each youth's progress and struggles over the reporting period. The service plan and discharge plan are reviewed, updated and, if necessary recreated on a quarterly basis.

Here is a partial list of the organizations and agencies who are current partners in PTCN's treatment program.

- Native American Youth Association)
- Wisdom of the Elders Council (Native American Community)
- School Support Staff
- County Independent Living Programs
- County Mental Health
- Local Psychiatric Medication Providers
- DHS & OHA Licensed Residential facilities and programs.

This table outlines other community partners who contribute to the treatment program in a substantial way by supplying services and supporting Caregivers & Youths' treatment & transitioning plans.

Partners and Affiliations	
Entity/Agency	**Role**
Low Income Energy Assistance Program	*Emergency assistance with energy costs for youth as they transition into independent or semi-independent living*
Court Appointed Special Advocates	*Advocates for the best interest of abused/neglected children*

Bridgeway	*Substance abuse assessment and treatment*
Local Community Colleges	*Education, GED classes, vocational training*
Local Community Action Agencies	*Food and energy assistance, for youth as they transition into independent or semi-independent living*
DHS/Child Welfare	*Child abuse and neglect services and intervention*
Education Service Districts	*Assessment of child development and early intervention services*
Oregon Health Plan	*Insurance for youth as they transition into independent or semi-independent living*
Employment Services	*Sheltered workshop and JOBS program for youth as they transition into independent or semi-independent living*
County Victims' Assistance	*Information on abuse, protection and legal resources*
County Health Department	*Medication Management*
Local Housing Authority and Salem Housing Authority	*Low-income housing services for youth as they transition into independent or semi-independent living*
Marion/Polk Food Share	*Provide food boxes for youth as they transition into independent or semi-independent living*
Oregon Telephone Assistance Program	*Assistance with basic phone services for low-income participants for youth as they transition into independent or semi-independent living*
Public Schools	*Collaboration with IEPs, attendance, behavior plans, etc.*
Salvation Army	*Homeless shelter for youth as they transition into independent or semi-independent living as a resource if this becomes necessary*
Union Gospel Mission	*Shelter, meals, clothing and assistance with basic household items for youth as they transition into independent or semi-independent living as a resource if this becomes necessary*
Vocational Rehabilitation	*Disability assistance and job training services for youth as they transition into independent or semi-independent living as a resource if this becomes necessary*
Job and Career Center	*Assistance with job search, Internet and computer access for youth as they transition into independent or semi-independent living as a resource if this becomes necessary*
Community Action Agency	*Day Shelter, food and energy assistance, drug prevention network*
Career Networking Center	*Aid in finding employment for youth as they transition into independent or semi-independent living as a resource if this becomes necessary*
DHS Self Sufficiency	*Temporary assistance to low income, assistance to find the resources to care for their families independently for youth as they transition into independent or semi-independent living as a resource if this becomes necessary*
County Food Bank	*Distributes food to those in need if this becomes necessary*
Local Career Centers	*Assistance with job search, including telephones, computer access, and workshops*
Local Housing Authorities	*Provides Polk County with affordable, low income housing and community developments.*
Legal Aid	*Offers legal advice to low-income individuals and families*

Two of PTCN's community partners deserve a longer discussion:
DHS and the school systems.

DHS

The cooperation and collaboration between Professional Therapeutic Community Network PTCN and DHS has existed for over 20 years. PTCN sustains this positive relationship by:

- Respecting and accepting the different roles that PTCN and DHS have with families

- Remaining responsive and flexible to DHS's changing needs for services
- Responding promptly to DHS requests for services, information, and collaboration
- Working in partnership with DHS to assess and identify treatment needs and concerns
- Meeting with DHS units to provide innovative approaches to emerging family needs and practice guidelines
- Informing DHS caseworkers of treatment progress throughout the service period
- Focusing on permanency, safety and the well-being of children in DHS care
- Including DHS staff and community members in training offered by PTCN
- Serving on a variety of task forces and commissions in the community;
- Including school personnel, mental health providers and other key community members in work with families
- Attending court hearings, responding promptly to subpoenas, and attending Citizen Review Board hearings
- Consulting and collaborating with other DHS providers, such as Independent Living Program

SCHOOLS

PTCN's has a special focus on collaborating with their youth's local schools as well as their school districts. For instance, PTCN gives the school/district advance notice before accepting a youth into the program. Just having a child with borderline IQ and serious behavioral and emotional issues show up can put a good deal of stress on the school administrators, teachers and others. This notification also gives school officials a chance to consult with PTCN's Therapists, Skills Trainers and Proctor Parents before the child arrives. Encouraging Caregivers to collaborate with schools and being available to consult with the school and Caregiver together enhances the continuity of supports.

PTCN has done in-service trainings to help teachers and administrators deal with not only PTCN youth but the other youth that have been placed in their schools who have sexual behavior problems and other serious behavioral and emotional problems. We also work with schools to develop safety and supervision management plans for INTERSECT youth—another extra step greatly appreciated by school districts. Another way PTCN collaborates with the schools and other agencies is by participating in IEP meetings. While Caregivers are the IEP first contact and usually the parent-guardian, the Therapist is able to support the Caregiver by phone or in person to convey necessary risk and trauma-informed behavioral interventions management information. Developmental Counselors often develop working relationships with teachers and/or special education providers. They also educate school staff, work to help integrate treatment & school programs and facilitate information sharing with the youth's treatment team.

In the event there is a problem at school with a youth, INTERSECT staff encourages the Caregiver to bring it into their therapeutic community for support.

PROMOTING POSITIVE CAREGIVER & FAMILY CONNECTIONS

Any list of PTCN's community partners includes family members. They are considered part of the Therapeutic Community. Oftentimes, family members require substantial support. PTCN accomplishes this by including the family in the community dynamic, providing education, providing therapy sessions and referring family members to partner agencies if their needs can't be met within the therapeutic community.

A supportive family is essential if the youth is to be retained in the program and experience a successful transition. At PTCN every effort is made to encourage family participation and help guide them through their child's treatment process.

Family members are invited to be present at intake. Special effort is made to help them understand the treatment program their child is about to undertake and the role they can play in the therapeutic community. The intake team engages the youth and his family in a discussion about the youth's past and his family history as a way of discovering key issues to be addressed in treatment. The introduction to INTERSECT can at first glance, feel overwhelming to a youth's Caregiver. To support and promote participation, an Orientation & Consultation program has been instituted for Caregivers who want to take an active part in their youth's remediation.

Sometimes, because of repeated transgressions made toward family members, it is hard if not impossible, for family participation in a youth's treatment. Sometimes cultural attitudes towards maladaptive behavior preclude family acceptance of the youth. In cases like these it is not unusual for the clinical staff and Skills Trainers to become the surrogate family unit.

A youth's Caregivers & Family may be in need of services beyond what PTCN offers. Drug/alcohol abuse, physical or sexual abuse and psychiatric issues are some of the problems that interfere with family members' ability to function in the community and therapy groups. PTCN will work with the individual in encouraging them to receive supports and/or care in other support avenues.

Another place PTCN may contribute to the family and the community at large is in the clarification process. Some of the youthful offenders will be able to reunite with their families and live back at home. The return home is a long process and can take six months to a year after clarification has begun. Therapists working with those wronged by the youth's mal-adaptive behavior sometimes contact PTCN for information about the progress of youth in their program. If the youth is ready and the victim and their therapist wish it, PTCN participates and helps facilitate the clarification process.

Other ways PTCN empowers youth and their family:

- Providing opportunities for youth to visit with family members in a structured and supportive setting

- Encouraging & planning community-based activities focused on promoting healthy family interaction
- Creating and maintaining professional personal relationships with family members involved in their youth's treatment. This is done by staying in close contact regarding details of youth's treatment and the scheduling of visits/sessions
- Informing families about youth's risks and teach specific ways to manage risk
- Coaching youth and families to problem-solve their relationship/family issues
- Model healthy and appropriate behavioral interventions, then encourage family members to use similar interventions
- Setting activities/sessions schedule while being considerate of each individual family's differences (financial, cultural, safety, etc.)
- Creating opportunities for youth and family members to build healthy relationships
- Teaching and promoting healthy family interactions through activities such as board games and recreation (bowling, basketball, mini-golf, bike riding and walks in the park)

EVIDENCED BASED PRACTICE AND DEVELOPMENTAL FOUNDATIONS

PROGRAM OVERVIEW

Professional Therapeutic Community Network (PTCN) is a community-based organization committed to meeting the needs of individuals who have coexisting serious mal-adaptive behaviors. PTCN employs an Intensive Therapeutic Proctor Home model supported by both a comprehensive Master Service & Treatment Plan and a team of highly-trained Developmental Counselors and Therapists. PTCN's treatment program uses a tracking system to monitor the youth's movement through trauma informed ***Neuro-Developmental Stages***. Daily tracking enables the targeting of specific developmental tasks which need to be addressed to ensure client progress and resolve ineffective coping strategies. PTCN believes that people with the most severe mal-adaptive behaviors can be integrated into positive community settings, and that the levels of support should balance individual needs with community safety. PTCN's staff accomplish this by actively integrating the individual and his supporting family, culture, level of development, and learning style. The members of PTCN's therapeutic community work to support each other and to insure the best outcomes for the youth and families they serve.

EVIDENCE BASED PRACTICES

Evidenced based practices enhance the services PTCN provides to its youth, their families, community partners, schools, and to increase communication about the interventions it provides.

For the past 4 years, the professional mental health field has begun exploring Evidenced Based Practice that has emerged from Best Practice Standards. PTCN adopts the following definition of what Evidenced Based Practice involves as defined by the American Psychological Association: **"Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences."**

> "Evidence-based practice requires that psychologists recognize the strengths and limitation of evidence obtained from different types of research. Research has shown that the treatment method (Nathan & Gorman, 2002), the individual psychologist (Wampold, 2001), the treatment relationship (Norcross, 2002), and the patient (Bohart & Tallman, 1999) are all vital contributors to the success of psychological practice. Comprehensive evidence-based practice will consider all of these determinants and their optimal combinations. Psychological practice is a complex relational and technical enterprise that requires clinical and research attention to multiple, interacting sources of treatment effectiveness. There remain many disorders, problem constellations and clinical judgment and knowledge of the best available research evidence to develop coherent treatment strategies."
> Evidenced Based National Task Force Report, American Psychological Association, July 2005.

TREATMENT PHILOSOPHY

PTCN's ***Neuro-Developmental Model*** is informed by the latest research on Post-Traumatic Stress and how it impacts brain development. Over the last 10 years, 100% of the youth served in PTCN's BRS placements have co-occurring PTSD and cognitive impairments related to environmental insults (abuse, neglect, fetal drug effects, head trauma, attachment disruptions, etc….). Research in the last 5 years has provided additional knowledge about how trauma impacts brain development and the resulting behavioral disorders in social-emotional functioning.

Abuse and Neglect remain the most common cause of chronic traumatic stress in children. Yet, repeated losses, separations, and exposure to family violence has a similar impact. In Bessel van der Kolk's (Trauma, Memory, and Self-regulation, 1997) work he found that boys who witness violence by their fathers have a 1000 percent greater likelihood of growing up to abuse their partner than men who were not exposed to marital violence when they were young.

A growing body of research is emerging to indicate that for abused children the earlier trauma occurs, the longer it lasts, and the more intense it is determines the severity and malignancy of its effects. Additionally, the prognosis is worse when the abuse is at the hands of a parent rather than a stranger. Therefore, because of the deep neurobiological wounds associated with prolonged abuse, recovery for these children is a far more difficult and arduous process.

Brain Impairments due to Trauma
Each youth with a traumatic history and lower intellectual functioning comes with their own particular set of symptoms in response to trauma. Many youth have the same types of trauma but do not necessarily manifest the same disorder. They do share similar developmental disturbances and a range of symptoms associated with stress-induced neuro-deficits. There appears to be four domains of neurological impairment:

A. ***Dysregulation of the Stress Response System and Limbic Irritability.*** What occurs in this area is serious impact on the child's amygdala. Repeated traumatic stress creates a highly reactive response to stress there by the child requiring very little to set him/her off in an emotionally dys-regulated state. Overwhelming stress appears to alter neurotransmitters and hormones involved in the stress response system. It alters brain structure that provides an inhibitory stress function. Chronic maltreatment can lead to opposite functions that PTCN sees in many of the youth it serves. When a normal youth is under stress his/her nervous system is activated and goes into a hyperaroused state. Chronically abuse youth get the reverse effect and exhibit a state of apparent calm. This activation essentially decreases epinephrine, norepinephrine, etc.. which normally are increased. This state of reverse calm under stress induces a soothing numbness to their body. It has been described as "it is like riding the gas and the brake at the same time" while simulateously resulting in a "freeze response". (Allan Schore, *Effects of early relational trauma on right brain development, affect regulation, and infant mental health*. Infant Mental Healthy Journal, 22, 2001). Over time this becomes a primitive defense mechanism to dissociate from bodily sensations and current reality may become a child's primary adaptation to stress (B.D. Perry. *Violence and Childhood*, 2000).

B. ***Decrease in the Hippocampal Volume & Abnormal Activity in the Cerebellar Vermis.*** The hippocampus is the hub of conscious memory and learning. The hippocampus brings together memory traces and replays them over and over where it is integrating the experience and etching it further into longer term memory. Eventually memories are linked together independently of the hippocampus. Until memory is etched into long term memory the hippocampus has to retrieve and process. Abuse and neglect damage the hippocampus in reducing its size and circuitry. This impairs verbal memory. Trauma triggers significant amount of cortisol to protect the body. Too much cortisol eats at the neural network of the brain. This damages the hippocampus and in abused children impairs their ability to process current experiences. A breakdown in emotional regulation and integration of memory adds to the fragmentation and learning problems.

C. ***Underdevelopment of the Left Hemisphere & Communication Problems between Brain Hemispheres.*** Maltreatment appears to impede normal development of the left side of children's brains (Teicher, et al., 1997 & 1998. The left side of the brain was less developed than the right side in abused children. They were also abnormalities in the corpus callosum (fiber tract that connect the left and right sides) and abused children struggled with laterality problems (ability to tell left from right and impaired motor skills). Brain size in abuse children was also assess and found to be smaller than non-abused children. The longer a child was abuse the smaller their brain and the more symptoms of intrusive thoughts, avoidance, hyperarousal and/or dissociation.

Decrease in IQ was correlated with smaller brain size. Underdeveloped left side of the brain tends to impede development of language and reasoning skills. Meta-cognition (thinking about your own thinking and monitoring ones self) and self regulation of negative emotions were impacted. If the left and ride side of the brain are not in sync, higher order thought and emotional processing are impaired (Hoptman & Davidson, 1994). This can add to memory fragmentation and emotionally states can be so over-whelming because access to language to process is inhibited.

D. ***Neuroendocrine & Immune System Dysfunction.*** Abuse & neglect appear to also influence growth-related hormones. Wang, Bartolome,and Schanber, 1996 at Duke University discovered that a biological chain of events that link touch to the suppression of growth. Van der Kolk is finding that there may be a direct link between adverse childhood experiences and a greater likelihood of adult diseases such as cancer, lung disease, diabetes, and heart disease.

A Psycho-biological Model is emerging that described the results of repeated trauma on brain development and function. The research is indicating that nearly all the psychological symptoms

brought by trauma have an associated neurological impairment. There appear to be 7 core symptoms:

1. **Problems in regulating emotional & arousal:** Abused children and limited intellectual functioning youth tend to oscillate between extreme arousal or numbed responsiveness. They have no feelings or too many to process. Chronically traumatized children tend to engage in self destructive behaviors to regulate emotional states. Borderline IQ & Pervasive Developmental Disability youth often times have a ***Non-Verbal Learning Disability***. They are considerably less proficient in identifying facial expressions of emotion (McAlpine, C. and Kendall, KA. *Recognition of facial expression of emotion by persons with mental retardation*, American Journal of Mental Retardation. 1991). Failure to recognize emotion accurately in others leads to serious misinterpretations of others intent and a projection of trauma related fears onto others.
2. **Alterations in consciousness and memory:** Dissociation is oftentimes seen in youth with traumatic experiences. It can become a way of life. It provides the abused child with a means of avoiding painful memories and the terror of on-going abuse. When abuse is chronic, children are more likely to experience amnesia, especially if they continue to live with the perpetrating parent (Chu, et al. *Memories of Childhood Abuse*, 1999). Dissociation blocks the full perception and storage of the memory is incomplete. Unfortunately not only does the youth begin to forget their own trauma but a distorted sense of reality with the family and others emerges. Abused youth have so much to feel but struggle processing it.
3. **Damage to self concept and identity:** A youth's identity or self concept is rooted in how others treat them. Typically abused youth see themselves as weak, ineffectual, helpless, and utterly alone. They mistakenly assume they deserved the abuse. Sometimes in an attempt to preserve their attachment to the parent they will fragment the abuse and/or rationalize it.
4. **Disruptions in cognitive capacities:** A growing number of studies are finding that abused children had significantly lower IQ scores. Verbal IQ was the lowest (Carrey, NJ. *Physiological and cognitive correlates of child abuse.* Journal of the American Academy of Child and Adolescent Psychiatry, 34. 1995) Trauma tends to create a rigid thinking style and is compounded by limit IQ status. This impacts a youth ability to cognitively adapt to change and associating appropriate rules to the emerging situation. A youth's play is also constricted and affects how they learn about their world, themselves, and problem solving.
5. **Hyperactivity and attention problems:** Abused children tend to have attention problems due to being emotionally dys-regulated. They are constantly scanning the environment looking for clues to suggest something bad may happen.
6. **Relationship problems:** There are intimacy deficits in the lives of abused children given that their lives have been full of attachment losses and multiple disruptions in placements. Some may long for emotional connections and fear it while other are repulsed by it and avoid mutuality with caretakers at all costs. Mutuality is a difficult and suspect process for abused children.
7. **Alteration in the systems of belief:** Repeated trauma shatters a youth's system of beliefs. Belief systems are the way they view they view themselves, the world, and their place in it. Cognitive distortions are means of processing painful experiences and avoiding shame or responsibility for their own actions when they begin to harm others.

PTCN has found that the earlier remediation interventions are used in working with trauma affected borderline IQ youth the greater the treatment effect is in resolving PTSD symptoms and developmental impasses.

Daniel Seigel, a leading authority in attachment and neurology reports:

A major theme of attachment research and effective treatment studies is that intervention via the medium of the attachment relationship is the most productive approach to creating lasting and meaningful results. Attachment research suggests a direction for how relationships can foster healthy brain function and growth: through contingent, collaborative communication that involves sensitivity to signals, reflection on the importance of mental states, and the nonverbal attunement of states of mind.

The quality of attachment youth have with their caregivers is related to their ability to self regulate. ***PTCN's Neuro-Developmental Stages*** provide detailed assessment information about what needs to be worked on in order for the youth to resolve trauma influenced developmental impasses.

Borderline Intellectual Functioning

In the past twenty years, professionals in mental retardation and developmental disabilities have become increasingly aware of the importance of mental health issues and psychiatric disorders in working with people with intellectual disabilities. There has been growth and development of the National Association for the Dually Diagnosed (NADD), recognition of the mental health issues of persons with mental retardation in major diagnostic manuals (DSM-IV, AAMR diagnosis and classification), and the establishment of professional outlets devoted to dual diagnosis (NADD Bulletin, Mental Health Aspects of Developmental Disabilities). Additionally, there has been a significant increase in research and scholarly contributions on dual diagnosis in both journals focusing on mental retardation/developmental disabilities/intellectual disabilities and in more general journals in psychiatry/psychology and related areas.

The research, however, has focused primarily on adults. For example, in two primary professional outlets that focus on dual diagnosis, The NADD Bulletin and Mental Health Aspects of Developmental Disabilities, the vast majority of articles focus on adult or general dual diagnosis issues. An informal review indicates that less than 10% of the articles have specific or major themes on child and adolescent issues. The Journal of Clinical Child and Adolescent Psychology had no articles with a major focus on issues of children and adolescents with mental retardation. The Journal of the American Academy of Child and Adolescent Psychiatry fared somewhat better, relatively, consistently publishing a number of articles about children or adolescents with mental retardation. However, the focus of these articles is relatively narrow, largely presenting studies on medication effectiveness or atypical case studies. Overall, it is apparent that mental health issues of children and adolescents with intellectual disabilities has garnered little attention in the professional and research literature.

Treatment and prevention interventions in childhood and adolescence may partially ameliorate more severe issues in adulthood. The mental health needs of children and adolescents with mental retardation appear to parallel patterns seen with adult populations. Further, there are options for both assessment and therapeutic interventions with children and adolescents that appear to be underutilized. Additionally, comprehensive services in the community appear to represent a "missed opportunity" for both assessment and intervention.

PTCN believes that effective therapeutic interventions can also be carried out in a variety of settings. A small meta-analysis was also consistent with the moderate levels of overall effectiveness. A closer analysis of the child/adolescent findings shows outcome and effectiveness rating were generally comparable to those studies conducted primarily with adults. Twenty-four (26% or the 92) studies were conducted with children or adolescents. Of those twenty-four studies, 42% were conducted with children or adolescents identified as being in the mild range of mental retardation, with 58% identified as being in the moderate or lower range of mental retardation. Individual and group interventions were equally represented, and there was a range of the theoretical bases for the interventions. In general, the child/adolescent research base did not look substantially different from the adult base. Prout and Nowk-Drabik noted that the overall finding of moderate levels of effectiveness and benefit suggested that psychotherapeutic interventions should be more frequently considered in treatment plans with person with mental retardation.

Another promising study evaluated Multi-dimensional Therapeutic Foster Care (MTFC) compared with group care (GC) for chronic child/adolescent behavior problems (Chamberlain & Reid, 1998). MTFC integrates multiple intervention modes, including individual and family therapy, and social skills training, in multiple domains such as family, school, and peer group. The parents were trained in the use of behavior management techniques (see Chamberlain & Reid, 1998). The MTFC intervention produced more favorable results, with boys showing improvement in academics and a decrease in legal interventions. They had fewer behavior problems, fewer delinquent acts, including serious or violent crime. The authors state firmly that the lynchpins in the program (which has been conducted over 15 years) are the foster (proctor) parents, who are carefully selected, trained and supported.

PTCN has been assessing and treating youth for over 20 years who exhibit interpersonal aggression, cruelty to animals, property destruction, fire setting, sexual acting out to and with others, impulsive, tantrums, argumentative, defiant, and running away. The majority of youth also have cognitive and emotional difficulties that include one or more of the following: depressed or withdrawn, drug affected, organic impairments, inability to understand cause and effect, cognitive processing problems, inability to recognize danger, impaired reasoning skills, low frustration tolerance, deficits in interpersonal skills, and have a history of multiple failed placements and abuse and neglect.

PTCN is able to utilize the emerging Trauma informed Neurological research into practical

daily interventions in assisting their youth in over-coming developmental challenges. PTCN has integrated the central construct that research demonstrates:

"Building solid attachments with caregivers is the foundation for improved self regulation and resolving developmental trauma."

RESEARCH INFORMED INTERVENTIONS AT PTCN:

PTCN uses research informed assessment and treatment interventions. PTCN has been engaged in Best Practice Standards from its inception. Two of its principal clinicians have been developing Best Practice Standards for over 20 years—they have written policy for National Task Forces and consulted with DHS-CW, OYA, and SPD in the development of Best Practice Standards.

The Best Practice types of services employed at PTCN involve ***a Multi-modal*** approach to ensure a comprehensive integration of interventions. These include the following:

1. Individual Counseling
2. Group Counseling
3. Multi-family Group Counseling
4. Individual and Group Skills Training
5. Family Counseling
6. Developmental Stage and Level System Tracking
7. Community Supervision

PTCN provides individualize treatment planning and interventions for the youth it serves. The following intervention types are research informed in working with Borderline IQ, Autism Spectrum Disorders, Complex PTSD, Attachment Disordered, and Developmental Disorders.

1. **Cognitive-Behavioral Therapy**. There is robust research on cognitive restructuring and altering cognitive distortions in most behavioral disorders. This applies to juveniles who alter their mental framework to rationalize and justify serious misbehaviors. A small but reasonably rigorous body of literature addresses treatment effectiveness sufficient to shape treatment approaches.
    a. Williams & Jones, 1997 – found internalized control over behavior with MR/DD clients.
    b. Arrowclough et al., 2001; Kuipers et al., 1997; Oosterban, van Balkom, van Oppen & van Dyke, 2001 – benefits maintain and increase over time.
    c. Tafrate, 1995; Edmondson and Conger, 1996; Beck and Fernandez, 1998 – CBT treatment of anger and aggression is effective for adolescents and adults.
    d. Murphy & Clare, 1991; Black and Navaco, 1993; Howells, Rogers, & Wilcock, 2000 – reported case histories of people with aggressive behavior had reduction in aggression levels with group and individual CBT.

e. Moore, Adams, Elsworth & Lewis, 1997; King, Lancaster, Wynne, Nettleton & Davis, 1999 – clinically significant post treatment reduction in aggression for DD clients living in the community.

2. **Social Stories.** Originally created by Carol Gray, MS to work with Autism Spectrum Disorders. These stories work equally well with borderline IQ youth in developing new skills and working through traumatic memories. Low cognitive functioning youth have little sense of what is called the "Social Contract" (unspoken social mores and rules).
3. **Comic Strip Conversations.** Carol Gray, MS created these to address social interaction and sequencing. PTCN tailors these to teach and assist their low-functioning youth in the development of new skills and processing difficult trauma related issues.
4. **Role Playing**. Used in victim empathy enhancement and developing new skills acquisition in self-regulation, assertiveness, anger management, etc. (*Daniels, Maxin. "Use of Role Play to Develop Empathy and Relapse Prevention", 2005*)
5. **Skills Building**. Training employed to develop and practice new skills and make treatment work in the real world that is supported and coached. *(Steele, Elkin, Roberts. "Handbook of Evidence-Based Approaches to Social Skills Training with Children and Adolescents", 2007*). Social skills focus on (but not limited to):
   a. Self soothing & calming;
   b. Creating positive interactions;
   c. Getting to know others;
   d. Starting Conversations;
   e. Making Requests;
   f. Recognizing and expressing feelings directly;
   g. Setting personal limits and boundaries;
   h. Putting self in others shoes;
   i. Problem solving; etc…..
6. **Multi-systemic-modal treatment Interventions**. (*Bourduin & Schaffer, 2002*). PTCN pulls from this holistic model in which the youth's family, school, work, peer's and neighborhood are viewed as interconnected systems with dynamic and reciprocal influences on the behavior of family members. This framework supports PTCN's Therapeutic Community model. Researchers also note the promise of Multisystemic Therapy (MST) with low cognitive functioning youth who have serious mal-adaptive behaviors. They sight the sound research design and positive outcomes from treatment efficacy studies (*Borduin, Henggeler, Blaske, & Stein, 1990; Borduin & Schaeffer, 2002; Saldana, et al., 2006*). Those that received MST evidenced fewer behavior problems, improved family and peer relationships, better academic performance, and reduced rates of recidivism.
   a. Bourdin, 1999 – used with success with violent and chronic adolescent offenders.
   b. Chamberlain & Reid, 1998 – produced favorable results with adolescent males (15 year follow-up).
7. **Art Therapy.** PTCN utilizes art therapy based interventions in helping youth resolve abuse and neglect trauma; work on issues indirectly where direct focus would increase over-whelming negative emotions; explore roles and social norms; discover and discuss

family dynamics; and develop a Trusting Relationship with caregivers. (Riley, Shirley. Integrative Approaches to Family Art Therapy. 1994).

a. Tomasulo, 1998 – Interactive Behavior Therapy uses role playing with MR/DD clients to develop concept integration.

8. **Motivational Interviewing.** This is a person-centered, directive method of communication for enhancing intrinsic motivation to change by exploring and resolving ambivalence. *(Prescott, D. Evidenced Based Practices, OATSA. 2007*) PTCN staff use Motivational Interviewing techniques in working on youth's trauma, mal-adaptive behaviors, family conflicts, and working through emotional impasses. PTCN clinical staff and proctor parents are trained in the six stages of change: Precontemplation; Contemplation; Preparation; Action; Maintenance; and Relapse.
9. **New Me/Old Me.** This approach was developed by James Haaven, MS for working with MR/DD individuals to assist them in differentiating harmful behaviors that had become ingrained in their self image. This approach allows for a thoughtful differentiation of harmful behaviors and integrating of newly acquired healthy behaviors to build a positive self image.
    a. Blasingame, et al., 2006 – identifies "old me" cognitions leading to problem behaviors.
    b. Brown & Pond, 1999 – associate body sensations with feelings & feelings come and go in waves.
    c. Linehan, Dialectical Behavior Therapy, 1993 – help identify and label feelings.
10. **Trauma Remediation and Rebuilding Attachments**. This ***trauma informed*** work assists in understanding the physiological and neuro-developmental responses to stress, developing strategies for improved self regulation, attachment to caregivers, and improving executive brain functioning. *(Creeden, Kevin. "Trauma, Attachment, and Neurodevelopment,2005).*
11. **Sensory Motor Integration.** Frank Belgau, 2001, created the **Learning Breakthrough Program** a sensory motor integration program that all PTCN staff and proctor parents have been trained in. Research has shown that it is important to have interventions engage more areas of the brain which means that treatment must be multi-modal and engage the sensory-motor areas of the brain in which language is compromised.

THERAPEUTIC COMMUNITY MODEL

PTCN has created a therapeutic community setting for its program. This therapeutic community is built around a ***multi systemic approach*** to intervening in serious behavior problems. The therapeutic community is dependent upon the nurturing of a positive peer culture whereby youth and families support each other in growth promoting ways. The therapeutic community relies on multiple modes of intervention and service types.

Clinical Therapists, Skills Trainers, Proctor Parents, youth, family-of-origin, community partners and the other PTCN staff work together and support one another to help youth and families experience real-life change and ***develop healthy attachments***. This works because of a

tremendous integration of duties and responsibilities. The chart below illustrates one example among many of the cooperation and planning that characterizes PTCN's therapeutic community.

TREATMENT SERVICES	PARTICIPANTS	SCHEDULE	FOCUS
Multifamily Group	*Parents, Youth, Proctor Parents, Skills Trainer, Therapist*	*Weekly*	*Educating and integrating treatment modules, Self regulation, Healthy Coping Cycles, Problem Solving, Resolving Trauma, Thinking Errors, and Responsible Behaviors.*
Peer Group	*Program Youth and Therapist*	*Weekly*	*Work on treatment plans as well as deal with day-to-day problems*
Community Group	*P Parents, Youth, Proctor Parents, Skills Trainer, Therapist*	*Once a month in place of Multifamily Group*	*Discuss changes in the program and engage in problem solving*
Individual Sessions	*Youth and Therapist*	*2-4 times a month*	*Youth deal with sensitive issues & work on mutuality to work through issues of Mistrust due to abuse.*
Family Sessions	*Youth, Family, Therapist*	*Once a month or as needed*	*Family members get some of their treatment needs met without the whole community looking on.*
Proctor Parent Consultation	*Proctor Parents, Therapist*	*Prior to every Multifamily Meeting*	*Supervising family of the youth will need weekly support and consultation on a variety of day-to-day behavior management and tx issues.*

Developmental Stages Summary

The multi-stage developmental process at PTCN is presented in a linear fashion for clarity. There are many challenges and learning the integration of positive behaviors can be difficult. Often youth show regression in their development tasks and sometimes even in their development phases. PTCN provides a community environment where Youth can learn, fail and be given an opportunity to try again.

Moving on to the Next Level

Working in a true Multi-systemic therapeutic community requires the help of many people. When a youth demonstrates that they have finished their work in any one stage—by consistently scoring in the 75th percentile achievement on the developmental tasks associated with this stage (see Measuring and Tracking below) they can petition the therapeutic community to move to the next level of developmental functioning.

Developmental Stages: Meaning, Roles, and Success

Self-Regulation – *"Stop, Look, Listen, Relax."*

This is the first and most basic level of the PTCN Neuro-Developmental system. While some youth enter at a more advanced level, many are struggling with the challenges of self regulation due to childhood trauma or developmental disabilities. Youth who have been traumatized or raised in chaotic situations/systems are more prone to having attachment issues. Youth with co-occurring Borderline IQ, attachment-disorders have difficulty bonding and creating mutuality with others. When youth have been abused and traumatized a trauma-bond is often created with an abuser. This trauma bond can be modified through learning self-regulation skill that lead to a more positive way of dealing with emotions and building healthy relationships with caretakers.

PTCN utilizes a variety of therapeutic interventions in working with youth who have attachment issues and mal-adaptive behaviors. It uses techniques like modeling, role playing, positive & corrective feedback and employs social learning principles to teach social skills in individual and group formats. These attachment challenges are met by monitoring the developmental tasks associated with self-regulation. Caretakers and Parents play a critical role in emotional interventions like "co-regulation".

PTCN measures success at this stage by the achievement of developmental tasks such as:

- The youth's response to **co-regulation**,
- Following structure,
- How the youth attends to surroundings and activities without losing self control,
- How the youth attempts to interact positively with others,
- How easily the youth can be guided into engaging and using the social contract (as in the unspoken rules of how to interaction with others in social settings),
- Etc.

During Self-Regulation, if the Caretakers and/or family is amenable, therapy is begun. If the family has multiple abuse behaviors toward each other family visits are structured and most often

held in the office. Even when held in the community they are can be supervised by the Developmental Counselors as prescribed in the Master Service & Treatment Plan. The Treatment team assesses who in the family could serve as a safe and knowledgeable adult supervisor or who could become one with support and training. The clinical team creates a safety plan and community activity contract / pass contract which identify warning signs, risk situations and clarifies prevention strategies.

Remediation at the Self-Regulation level is based on the work of Stanley Greenspan, MD as further developed by Alan N. Schore,Ph.D. Schore proved that early traumatic or chaotic experiences negatively affect attachment at a neuro-endocrinological level. The remediation process is seen as a re-programming of an almond-sized and shaped brain structure section of the brain called the amygdala.

Youth with Borderline IQ limitations are generally having serious struggles in the functioning of their Prefrontal Cortex. The Prefrontal Cortex is where the Executive Function of the Brain is located. The Executive Function basically controls the ability "organize and plan" behavior. It additionally involves emotional regulation. The right hemisphere controls emotion-affect and the left hemisphere control language. Between the two hemispheres is the corpus callosum. It is a fiberous material that electrical and chemical signals must pass through to communicate with the left and right hemisphere.

In Borderline IQ youth, many have a co-occurring history of FAS/FAE. Emotional regulation is typically a hallmark of these two population groups and significant work is employed to begin getting the Prefrontal Cortex to work in a functional fashion.

When dealing with self-regulation, the Therapist is working with the youth on learning to identify thoughts and feelings and developing a framework within which they can understand and express their feelings. Therapists utilize materials from the Autism Spectrum and Developmental Disability literature to being assisting youth in developing and augmenting neuron-pathways. Getting the left and right hemisphere to communicate and calm is tedious and time consuming but rewarding work.

When dealing with self-regulation, the Therapist is working with the youth on learning to identify thoughts and feelings and developing a framework within which they can understand and express their feelings.

During this phase Developmental Counselors help youth to work on reflective identification of feeling and emotional regulation states, assisting with daily creative processing and self-reflection activities. They also assist youth to appropriately respond to caregivers request on such tasks as following directions, abiding by structure, and emotionally tuning with their proctor family.

Trusting Others – *"You're Okay, I Can Share."*

According to Erik Erikson, hope is a product of trust. PTCN's treatment plan utilizes the research of Kevin Creedan M.A. LMHC ("Neurological impact of trauma and implications"), Bessel A. van der Kolk ("Traumatic Stress" published by Guilford in 2007), self-determination theorists (Deci & Ryan, 1985, 2000) and The Search Institute (Benson, Leffert, Scales & Blyth, 1998). The psychological emphasis of their work focuses on the theories of Bowlby & Winnicott (1969), stating that secure attachment provides for the development of trust and autonomy.

Here PTCN measures success by the achievement of developmental tasks such as:

- A youth's ability to share time, feelings and objects with others
- How well the youth seeks out co-regulation
- The youth's ability to calm self
- Honesty regarding daily activities and choices
- Etc.

The Therapist assists the youth in learning about the general cycle of mal-adaptive behaviors and gains understanding on how to work through traumatic memories. Memory work helps youth ***"learn healthy ways to reduce emotional arousal without the use of dissociation"***(Judith T. Stien & Joshua Kendall, Psychological Trauma and the Developing Brain (Haworth Maltreatment Trauma Press, 2004)). Dissociation is defined as a defensive tactic used by youth to cope with anxiety build-up in an attempt to exit an overwhelming psychological situation. Memory work is most valuable when it is found that a youth's dissociative behavior has become a neurobiological habit that prevents them from dealing with the situation at hand. This avoidance can be slowly overcome by a steady cautious effort at desensitizing youth to the problematic situations and painful memories. As the therapy progresses this memory work can unlock fears and unmask emotional triggers that hold the youth in a cycle of serious misbehaviors.

During this stage the Developmental Counselors work with the youth on:

- Sensory-motor integration;
- Sharing with others; and
- Personal strengths and weaknesses that is an ego-strength building exercise as well as an identification process for thoughts, feelings and behaviors that cause youth to mistrust the people who are caring for them.

The Caretaker and clinical team develops plans and safety nets and puts those in place in practical ways. There are clear developments of safety plans as they youth becomes more aware of their offense cycle. Depending on safety concerns, the supervision requirements may decrease and there may an increase in social interactions in the community. There are more community based activities involving structure and recreation with family members. During this stage, visits may be supervised by a capable, knowledgeable adult who may or may not be a member of the clinical team. The Clinical Staff work with the Caretakers and family, modeling

appropriate interventions so that caretakers and families can begin to provide safety and structure for their own youth.

Autonomy – *"I Think I Can, I Have Something of Value to Offer."*

At the Autonomy stage of development the youth's ego-strength matures and they are ready to begin establishing social trust, the ability to follow rules, accept loss and engage in their own problem solving. PTCN measures success at this stage by the achievement of these developmental tasks such as:

- Copying/imitating Caretaker/Parents
- Expressing wants and needs assertively
- Accepting personal responsibility
- Initiating problem solving and takes action
- Etc.

In this stage the Therapist is helping the youth to process trauma, by developing a personal sense of empathy. They begin working on empathy impairment and internalization of personal accountability while separating the accountability of others.

Developmental Counselor assist youth with techniques like creating a victim collage & victim role play to increase victim empathy and by assisting and preparing youth to provide a detailed account of one personal offense (to diminish secrecy), restructure and clarify their misbehavior cycle. The youth is further integrated into community-based activities. As he/she personalizes their risk to the community and starts to understand how to cope with those risks, they are given more opportunities to practice pro-social behaviors. There are more "safe and appropriate" day-long home visits when the youth reaches this stage.

Initiative – *"I Can Do It, I Am Capable*."

The Initiative developmental stage is connected to purpose. The youth learns that they can do things on their own. He is gaining personal confidence. PTCN measures success at this stage by the achievement of developmental tasks like when the youth can:

- Identify how he tolerates frustration,
- Persevere at tasks,
- See complex cause and effect, Identifies their values as important and can express reasons why,
- Etc.

This stage finds the Therapist helping the youth with healthy coping strategies; integrating treatment into real life experiences, arousal management, creating a semi-independent living plan, re-structuring & identifying health vs. deviant arousal and developing a healthy system that reinforces intimacy & sharing with another person.

The Developmental Counselors, Caregivers and youth work together on independent living skills, employment opportunities and healthy coping strategies specific to the youth's personal struggles. The Developmental Counselor also helps the youth to recognize the specifics of their personal offense cycle and fine tunes their cognitive re-structuring.

At this stage, Youth are being held more accountable for functioning in the school and community.

Industry – *"I can succeed, I can learn, being productive is meaningful."*
In this stage, the youth begins to develop a sense of self worth in relation to others and can recognize major disparities in personal abilities relative to other youth. They also grasp an understanding of personal competence. The Youth are able to produce and give back to their community and feel they fill a valuable role in their family and community. They are a productive member of the treatment team. PTCN measures success at this stage by the achievement of developmental tasks such as:

- Tracking the youth's enjoyment of learning
- Taking pride in their accomplishments
- Demonstration of empathy, demonstrating of group loyalty
- Maintaining group values
- Etc.

The Therapist continues working with the youth to enhance and mature adaptive coping strategies and social development.

The Developmental Counselor assists Caregivers and the youth with re-assessing their strengths and weaknesses, as the youth is now more capable of giving a more accurate representation. They encourage peer-to-peer relationships both inside and outside of the treatment community, and they support the growth of ego-strength to work through family-of-origin issues.

Youth who have reached this developmental stage are ready to begin to deal with healthy separation from caregivers with appropriate adolescent independence and are more capable of establishing healthy cross gender relationships. Youth will see changes in unsupervised community access, unsupervised peer-to-peer interactions and increased choice in their proctor home environment. Family is encouraged to engage their Youth in life skill activities to assist with their preparation for a return to the general community in an independent living, semi-independent living or family situation.

Group Identity – "*I am not perfect, you're not perfect but I can accept that."*
Youth begin to question themselves, how they fit in the community and direction of their lives. Youth value loyalty and fidelity to the group and seek out positive influences and community contacts. PTCN measures success at this stage by the achievement of developmental tasks such as:

- Youth keeps commitments
- Thinking fades from black & white. Youth prefers shades of grey
- Is more open minded
- Bases values on societies laws
- Etc.

In this stage, Therapists work with the youth on their leadership within their peer group, clarifying their role as a mentor and sharing their stories in socially appropriate ways within the peer group.

The Developmental Counselors help the youth on relating their personal growth through treatment to others, confirmation of an after care plan for successful independent or semi-independent life and setting this plan into motion. For youth stepping down from a Residential Treatment setting clinical staff encourages family visits aimed at re-integration into the family and community following treatment as is safe and appropriate.

Individual Identity – *"I can regulate my behavior, select and guide my decisions and actions, without undue control from or dependence on parents"*

Erikson describes the Individual Identity stage as autonomy from caretakers where youth develops a defined sense of self and becomes secure in their ability to successfully integrate into their community. PTCN measures success at this stage by the achievement of developmental tasks such as:

- Positive risk taking
- Open-mindedness which matures while maintaining integrity
- Integrates values and laws into their personal beliefs
- Gains personal meaning in spiritual expression
- Etc.

The Therapist helps youth on planning aftercare resources, developing and instituting local support systems within the community where the youth will return. The Therapist helps Youth to develop personal means of monitoring their own functioning and self-reflective techniques to ensure healthy coping.

The Developmental Counselors work with the youth to implement the transition, coordinate with local natural supports to ensure continuance of after care plan and network with community resources to assist with successful independent or semi-independent living. The clinical team partners with the youth to develop a celebration and recognition ceremony.

Discharging from PTCN

When the operationally defined outcome goals of the treatment plan have been met, stepping down into a less restrictive placement or modifying the current placement in an after-care setting is appropriate. The step-down process is a coordinated effort between the Caregivers, youth, family, clinical staff and caseworker. Together they determine types of services that will help the youth maintain the developmental, behavioral and psychological changes that were brought about through the intervention. Therapists provide a written discharge summary report with within fifteen days of completion of services. The report includes information regarding who participated in the intervention, specific treatment approaches, skill-based interventions that the youth completed, outcome of treatment and a follow-up plan developed with the family and the caseworker.