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Transforming a Youth Residential Program with Positive Behavior Supports, Families, and Communities

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For some time, a variety of entities throughout the United States have expressed concerns about the outcomes and high cost of residential treatment (New Freedom Commission on Mental Health, 2003; U.S. Dept of Health and Human Services, 1999). Poor outcomes of many such programs can lead to the misperception of a reduced need for these services and poor value for the investment. The value of residential treatment programs has been further questioned in relation to the much publicized deficiencies of state foster care systems (Children's Law Center of Los Angeles, 2006).

In response to these concerns, EMQ Children and Family Services, a mental health and social services agency, began a process to transform its residential program from a 20th-century model utilizing intensive day treatment for children. In this model, all children in the program are provided a similar set of services (typically individual, family, and group therapy) for a specific number of hours per day. The transformed program would adopt a more flexible 24/7 model in which services are determined by individual needs and a family-centered approach rather than a predetermined program structure. Moreover, the new program would capitalize on the existing strength-based services, expand them in the context of the family and community, incorporate current best practices and/or evidence-based practices, and therefore achieve more positive outcomes. There would be emphasis on each child's right to a permanent placement with family and a movement toward minimizing the length of stay and control-based interventions, as well as eliminating the use of physical restraints. Ultimately, such a program would reduce the youths' dependence on institutions and build individual and family resilience.

Residential Youth Demographic Profile

The program serves approximately 82 youth annually. Two cottages serve youth 6 to 12 years of age; one cottage serves youth ages 12-15; and a shorter-term program serves youth ages 12 to 18. The youth tend to be predominately male (66%) and Hispanic American (50%), with Caucasian the next most prevalent (26%). The Department of Social Services is the largest referral source (71%) to the program. About 20% are receiving Special Education services. Some youth may present with cognitive challenges. Others may have histories involving substances (e.g., in-utero exposure, use themselves, or are from families with substance use problems). The average length of stay varies between cottages with a range of 11- 24 months, and the short-term program averaging 3 months.

Program Admission Criteria

The primary criteria for admission to the program is that a youth is seriously emotionally disturbed as defined in Section 5600.3 of the California Welfare and Institutions Code and in need of Residential Care Level (RCL) 14 treatment and supervision. RCL 14 is the most restrictive residential level of care available prior to placement in a locked facility. In addition, in order to be considered for the agency's residential services, the youth has to meet one or more of the following criteria: (a) demonstrate impairment in at least two of the following: self care, school functioning, family relationships, community functioning; and having been placed out of home or is at risk to be placed out of home; (b) display one of the following: psychotic features significant risk of self or other-harm; (c) meet special education eligibility requirements (per Section 7570 of Chapter 26.5, Division 7, Title 1, Government Code); or (d) have met criteria for an Axis I diagnosis

within the past year.

Process of Change Method

Residential Program Strengths and Areas for Improvement

Based on the input derived from the focus groups and questionnaires, the program identified the areas in which the original program has been successful: (a) a strength-based approach, which builds on the child's and family's assets and utilizes these assets as part of treatment; (b) individualized care for each child within the limits of a residential treatment payment; (c) culturally competent and structured treatment; and (d) well-trained, caring, and compassionate staff, with a relatively long term of service (8 years average length of employment) and low turnover (8.62% pre-implementation). The team then identified areas in which the current program could be improved: (a) encourage more family involvement; (b) build a closer connection with community; (c) provide a transitional aspect to bridge formal services and return to the family; (d) increase use of evidence-based practices; implement specifically Positive Behavioral Interventions and Supports (PBIS) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); and (e) teaching of skills applicable to natural settings (e.g., community and family) and thus reduce dependence on the residential program.

Process and Treatment Vision and Goals

The major vision and goals for the service process were as follows: (a) family will become more involved with care, and satisfaction with services will increase; (b) at least 50% of the services will be provided in the youth or family's home or community; (c) youth will participate in community activities, outside the residence, at least once per day; (d) physical restraints will be eliminated and control-based interventions will be deemphasized in favor of internal controls and a needs-driven approach; and (e) all program staff will be thoroughly trained or retrained as needed to provide excellent services and meet these goals. The major visions and goals for the treatment of youth were as follows: (a) improvement in youth and family functioning will be demonstrated using objective measures such as Child and Adolescent Functioning Assessment Scale (CAFAS)(Hodges, 2000) scores and Child Behavior Checklist (CBCL)(Achenbach & Rescorla, 2001); and (b) when new services are in place, 75% of the youth in the program will return to live with family permanently.

Transformation Criteria

By consensus, the team concluded that a change to a mental health model which allows for individualized services versus a predetermined treatment structure based on payor requirements would be the most effective means to lay the foundation for the proposed improvements. The traditional day treatment structure for residential programs mandates four consecutive hours of services per day, which makes it difficult to individualize services for each child, and restricts the time available for connection in the community. With fewer restrictions on time and place of services, the mental health model would allow the staff to create individualized care plans and enable more treatment flexibility for the youth.

The team articulated the values of the current program that would prevail in the program proposal. That is, the program would continue to be family-centered, strength-based, needs-driven, culturally competent, outcomes-based, and individualized. These values were consistent with the agency's philosophy of care and in line with the vision of the changes needed. In particular, the criteria determining the length of stay and timing of discharge for a child would be clinically driven and based on data. Functional Behavioral Assessments (FBA) would be used to develop effective, data-driven behavioral plans.

The CAFAS and the CBCL outcome measures would continue to be used to evaluate the outcomes of the program. Residential services should be used when 24/7 clinical intervention,

supervision, and support are needed for a child's stabilization, but not used as a placement only. The program would reflect practices consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Residential Best Practice Principles (Blau, 2004), which emphasize the following: (a) strengths embedded in all aspects of care; (b) focus on resiliency and developmental needs ; (c) families as full partners; (d) focus on permanency planning; (e) truly individualized and culturally competent services; (f) focus on the need to be successful in the community; (g) full integration of residential services into the community and continuum of services; (h) comprehensive, developmentally appropriate assessments (psychosocial, trauma, physiological, cognitive, language, safety, and others); (i) use of specific evidence-based interventions; and (j) respectful, strength-based relationships and interactions are a cornerstone.

Work Teams and Tasks

The core team divided the tasks involved by forming several work teams. These teams were charged with information gathering necessary to make decisions critical to the program redesign. Composed of approximately six people each to make division of work practical and efficient, the teams operated on a consensus basis, with all teams sharing the same policies and procedures for making decisions and handling disagreements. By having these work teams operate concurrently, the core team ensured that the change process moved ahead more quickly and efficiently.

Focus group and customer survey work teams. To assess satisfaction with various aspects of the current residential program, the focus group work team sought formal input from youth currently in the program, youth and families of youth who had graduated from the program, internal and external customers who make referrals to residential services, and current EMQ residential staff to ascertain their opinions of the strengths and weakness of the current program.

Best practices/conferences work team. The best practices/conference work team reviewed other residential programs, in California and other areas in the United States, as well as attending various conferences to learn about the latest trends and up-to-date practices.

Population analysis work team. The population analysis work team conducted research to ensure that the needs of the youth in the residential program were understood clearly. This team analyzed more than seven years of internal data (e.g., demographics, needs, severity of problems) to verify that the changes that the core team envisioned were consistent with the population served.

Literature search/evidence-based practices work team. The literature search/evidence-based practices work team reviewed numerous studies related to the children's mental health to identify and evaluate evidence-based practices. These practices included, but were not limited to: Cognitive Behavioral Therapy (CBT), Functional Family Therapy (FFT)(Alexander et al., 1998), Multi-Systemic Therapy (Henggler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), and Trauma informed models such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)(Cohen, Mannerino, & Deblinger, 2006) and Positive Behavioral Interventions and Supports (PBIS)(Horner & Sugai, 2000). The team developed a short list of relevant practices and made recommendations accordingly.

Family inclusion work team. The family inclusion work team focused on practices and policies that would be used to increase family involvement and satisfaction with the services.

Practice Implementation Phase

Positive Behavioral Interventions and Supports (PBIS)

The Positive Behavioral Interventions and Supports (PBIS) system (Horner & Sugai, 2000) was selected for implementation as the residential program's core philosophy and umbrella practice because of its close alignment with EMQ's values and its record of achieving positive outcomes in schools. This approach is consistent with Child and Adolescent System Service Principles

(CASSP) (Stroul & Friedman, 1986; Stroul & Friedman, 1988; Stroul & Friedman, 1996). In particular, both the agency's residential program and PBIS focus on strengths and on data-driven decisions. PBIS would reinforce the program's current strengths and proposed new practices, and would help move the program towards its transformation goals for the following reasons: (a) use of evidence-based practices that target environmental (universal), at-risk groups, and individuals; (b) emphasis on data gathering and data driven decision making; and (c) orientation toward achieving broad goals and improving child and family quality of life.

In general, PBIS is a three-tiered approach which emphasizes prevention to problem behavior and identifying the smallest change to yield the largest gain. FBAs, a component of PBIS, provides information to understand the factors that prompt both problem and appropriate behavior, which in turn complements the psychosocial assessment process and results in a more effective treatment plan.

Residential application of PBIS. The residential program's 24/7 nature entailed an implementation of PBIS based on setting activities that are somewhat different from a school. Although at the time PBIS was selected there was minimal, if any, research on its effectiveness in residential facilities, there was some literature on its application in other settings (e.g., juvenile hall). The staff chose to emphasize the core values of respect, safety, responsibility, and cooperation, and focused on settings such as meal times, community time, family visits, hygiene, and chores. The values and settings matrix will be the foundation of a new points and level system. FBA and BSP will be used for youth not responding to the universal interventions in the setting.

Training. The PBIS philosophy has been widely deployed in educational settings (Eber, Sugai, Smith, & Scott, 2002) and is now implemented in all of EMQ's residential cottages. Due to the importance and scope of PBIS, a training consultant was hired to participate in a work team prior to implementation. The consultant provided an overview of PBIS for all staff and observed each residential cottage to understand its current operations, the staff's skills and knowledge, and the youth population.

All 60 staff involved in residential services then received three 8-hour training sessions on how to perform Functional Behavioral Assessments (FBA), develop Behavior Support Plans (BSP), and create environmental changes (e.g., modify the current point system). These environmental changes would be based on core values and positively stated behavioral expectations. In between each training session, the staff practiced the skills by developing proposed plans and evaluating the plans in the subsequent training sessions. Periodic booster training is provided on an ongoing basis as staffing needs are identified.

Family-Centered Practices

Family Finding. Other than family therapy, services in the original residential program had been focused primarily on the child. Many changes were implemented to shift the focus to involve the entire family. For children who had lost contact with their biological, nuclear, or extended families, "Family Finding," a method for locating family members, was implemented. This process attempts to locate family members to establish new connections or possibly serve as a permanent placement. This methodology uses the internet and records from the Department of Family and Children's Services to search for family members. Children in foster care often lose contact with family members, and through the Family Finding process, may be reconnected with family members.

Family fun activities. In the redesigned program, more "family fun" activities have been added. The activities include social events (e.g., movie nights, swim parties), holiday celebrations (e.g., Easter egg hunt), arts and performances (e.g., music, singing recitals). The aim of the family fun activities is to encourage positive interaction so that children and families can learn to play together, build on family strengths, distract them from other life challenges for a few hours, and develop supportive connections with other families. Program elements were designed to be culturally sensitive, meet

the developmental needs of each child and family, and are structured to support and enhance their strengths and assets.

Caregiver support. Parents and/or caregivers can share experiences in this group setting and improve their parenting skills. In addition, caregivers are involved in meetings about the child and in treatment decisions. Formal caregiver support/education groups were established to improve the likelihood that the child will function well once he/she leaves the program. Consistent with the family-driven philosophy, the family's voice is the most important input, and services are tailored to the unique needs of each child and family.

Family visitation. The original residential visitation policy restricted visits and passes when a child engaged in disruptive behaviors. This policy was revised to incorporate new attitudes toward visitation and remove any perceived obstacles to presence of family, caregivers, and community members. The team uses a coaching model to work closely with the family from the time a child enters the program. Parents and caregivers are taught to intervene and support their child, even if disruptive behaviors occur. To further support the child, the family is encouraged to participate in daily activities and welcomed at the residential cottage more often than with the previous policy. Parents and caregivers can learn from the staff as needed, including shadowing staff to understand constructive ways to meet the child's needs. The redesigned program emphasizes caregiver visitation as a child's right, not a privilege.

Community-Based Services

Transitional care service. Transitional service was adopted as a component of the transformed EMQ program. The goal of the transitional service is to support the improved functioning achieved during the child's stay in the residential program when the child returns to the home and community. Another objective of transitional service is enabling shorter lengths of stay. Group, family, and individual therapy are offered, along with case management. If necessary, services may be provided at the families' homes to ensure that support plans are tailored to the unique needs of each family, and to help the child and family reunify. Also, as a specific enhancement to traditional group activities all children have at least one activity per day outside the residential setting.

Strength-Based Services

Although EMQ adopted a strengths-based philosophy over a decade ago and has incorporated strengths into all aspects of care, as part of the transformation the residential team wanted to ensure that these practices were consistently implemented throughout the residential program. The foundation of a strengths-based approach is the recognition that all children and families have multiple assets and interests, and resiliency. Children with special needs and their families can address these needs most effectively by harnessing their inherent strengths. The implementation of PBIS helped bolster the strengths-based approach. Staff is trained to emphasize strengths by focusing on positive behavior, stating behavioral expectations in a positive framework, and ignoring negative behaviors whose function is to gain attention and that do not jeopardize safety. Children are taught how to meet expectations, with these expectations defined in observable and measurable terminology. Creative incentives are provided consistently, and each child is engaged in activities based on his or her interests and skills.

Other Strategies for Reducing Use of Restraints

The PBIS approach can lead to development of alternatives to physical restraints, thus reducing their use. Via the FBA process, the residential staff has been taught how to analyze the triggers for undesirable behaviors and the needs that the behaviors fill, so that they have tools to help reduce the likelihood that restraints would be needed. This complements and enhances the Cornell University Therapeutic Crisis Intervention (TCI) technique to minimize use of restraints (Residential Child Care Project, 2006). TCI was developed in the early 1980s as a prevention model for

residential child care facilities that aims to avert crises from occurring, de-escalate crises, effectively manage acute crises, reduce or prevent potential injury to children and staff, and educate staff about using constructive ways to handle stressful situations.

Results

Process Outcomes

Family Involvement. The Family Centered Behavior Scale (FCBS)(Allen, Cay-Brown, & Petr, 1995) is used to assess family involvement. Prior to implementation the mean score was 4.7 out of a possible 5 (n = 16). Although the total score was high, individual review of the items suggested improvements could be made in the following areas: (a) “Helps us get the help we want from our family, friends, and community” ; (b) “Helps us to do the same kinds of things that other children and families do”; (c) “Makes decisions about my child’s care without asking me what I want”; (d) “Suggests things that we can do for our child that fit into our family’s daily life”; and (e) “Understands that I know my child better than anyone else does”. New components of the program address these issues. Although not a statistically significant drop from the pre-implementation, after the program transformation, the mean score was 4.3 (n = 13).

Satisfaction of Services. Based on the Youth Satisfaction Survey (YSS)(Riley & Stromberg, 2001) and the Youth Satisfaction Survey-Family Version (YSS-F)(Riley & Stromberg, 2001), overall, youth and their families have been and continue to be satisfied with the program.

Figure 1 Youth Satisfaction Survey Results

Figure 2 Caregiver Satisfaction Survey Results

Community Activities At Least Once Per Day. Since implementation of the new redesign, all youth in residential treatment have been involved in at least one community based activity on a daily basis. The activity is based on the individual’s strength and interest. Examples have included sports, dance, homework, tutoring club, martial arts, and art classes. Whenever possible, these activities were located in the youth’s neighborhood, caregivers/parents were engaged to assist with transportation, and funding for the activities to sustain involvement beyond treatment was explored. This ensures connection to community resources beyond formal services.

Restraints. Our data show that restraints tend to be used with identified youth, rather than as a general practice. That is, it is often the case that one youth will have multiple incidents which increases the overall frequency of restraint use in the program, as opposed to restraints being used on a number of different youth at any given time. FBAs have been conducted with these youth to decrease the frequency of restraints for these identified youth.

Treatment Outcomes

Functioning and Behavior. The following data represents the outcomes of youth who left the program after implementation of PBIS.

CAFAS. The CAFAS is a measure of functioning based on the therapists’ perspective in eight different domains: Performance in school, home, and community; behavior towards others and self; mood; thinking; and substance use. There was a statistically significant (t =18, p < 0.01) change in overall functioning are measured by the total CAFAS scores between program entry and exit. In addition, approximately 74% had clinically meaningful improvement.

CBCL. The CBCL is used to assess behavior from the caregiver perspective. There were statistically significant changes in scores for internalizing, externalizing, and total behaviors (t =10, p < 0.01 for each) between program entry and exit. In no instances did severity of behaviors

increase. Also, scores reflected clinical improvement in behaviors for the majority of youth for each measure: 54.5% for internalizing behaviors, 72.7% for externalizing behaviors, and 54.5% for total behaviors.

Individual Behavior Support Plans. Approximately 20-25% of the youth required an FBA and have BSPs. Table 1 shows an example of types of behaviors and outcomes for a few of the children who had behavioral support plans.

Table 1

Behaviors and Outcomes for Children with Behavioral Support Plans

Child's Name	Target Behavior	Baseline Frequency	Post-Behavioral Support Plan Frequency
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"Roger"	Hitting, kicking, throwing playground equipment	6 to 10 times per day	1 to 2 times per day
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"Charles"	Telling others what to do	15 to 20 times per day	2 to 3 times per day
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"Jason"	Manipulating, arguing with staff, not following directions	2 to 3 times every 15 minutes	2 to 3 times per day
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Living in the Community

Before Family Finding was introduced, only 37% of youth not living with family at the beginning of the program were reunited with family by the end of treatment. Since implementation of Family Finding, of all the youth not living with family in the beginning of treatment, 22% have been placed with members of their biological families, and 50.0% were connected with family members. Searches are in progress for the other youth.

Once funding is secured to hire a staff person specifically dedicated to Family Finding, it is expected that 90% of youth will have established family connections by the end of their stay in the program, and that 70% to 75% of all youth will be reunited with family members upon leaving the program.

Discussion

As the changes were implemented, anticipated and unanticipated challenges arose. As part of the overall process, staff is working to understand and address the challenges.

Facilitative Factors

Staff Support for Sustainability. The EMQ staff, especially those directly involved with providing services to children, was supported throughout every stage of the change process. Because the agency approach was aligned with PBIS, acceptance of change, and its prompt implementation were facilitated. At each stage, the core leadership team and senior management acknowledged positives of the process and openly discussed concerns or issues that needed improvement without judgment or labeling behavior.

An increase in staff turnover would be expected under conditions of significant change. Because the turnover rate under the previous program was low (8.62% for period from January 1, 2005

through September 1, 2005), and professional support was available consistently, the turnover rate during the change implementation remained modest (10.0% for the period from September 1, 2005 through May 1, 2006). This low turnover rate contributed to efficient implementation of the changes and continuity of services for the youth in the program.

Guidance from Systems, Data, and Consultants. The changes implemented were consistent with the EMQ treatment philosophy, the stated values of the program, and the new goals in that changes built on existing strength-based and individualized treatments. This, along with formal methodologies for change management and quality improvement, helped the staff manage the change process. The agency's Outcome and Evaluations Department, data gathering and management practices, and electronic records further facilitated the incorporation of best evidence-based practices.

Frequent guidance from an experienced consultant who understood the original residential program and spent time carefully observing its operation greatly facilitated the implementation of PBIS. The agency supported the transformation by specifically earmarking dollars for training, resources and materials, contracting a consultant, travel, and conference fees. Without such sponsorship, the scope and depth of recommendations for change would not have been possible.

Challenges

Documentation and Data Integration. Several factors posed challenges to the planned changes. To obtain the proper reimbursement for the program's services, the paperwork and documentation tasks for the mental health payor are onerous. Many staff were concerned about meeting the documentation standards on time. This challenge has largely been overcome by providing comprehensive training and adding more computers, so that documentation standards could be met consistently.

Another challenge was how to ensure that RCL points were met to maintain Level 14 criteria. Staff need only sign off on this report. Given the rich mental health services provided, the point requirements were met consistently.

The documentation requirements were streamlined so as to reduce redundancy and have the data more user-friendly. With an increase in data collection, (e.g., FBA) the information needed to be integrated into the documentation in a usable and streamlined manner. Learning how to use data to inform all practices is expected to continue as a core practice of the program. Through use of an electronic record, the agency is developing more efficient methods to analyze information, so that data-driven treatment decisions can be made in a timely manner.

Balancing Community Services and Residential Services. An ongoing challenge is to maintain the effective supportive connections with the community so youth and families will decrease dependence on formal residential services, have shorter lengths of stay, and a smoother transition back to the community. Families sometimes want to continue intense formal supports because of fear of decompensation without any support. A focus on transferring formal supports to the caregivers via parenting skill-building and connection to community resources will ensure sustainability of the youth's improved functioning.

Regulatory mandates on EMQ promote an intense sense of responsibility and a tendency to desire tight control over interventions. In this environment, maintaining an intensive 24/7 system of care while implementing change is an ongoing challenge. Furthermore, by the time children require residential services their behaviors have become disruptive in various domains of life. As such, rebuilding community-based supports is critical.

Sustainability. The change process demands that "old" practices be critically examined. Given that services continued to be delivered it was a challenge to have a balance between maintaining quality of care and continuing the transformation process. Sustainability of change is a concern,

particularly as consistency and accountability among staff in different cottages working different shifts are expected. Furthermore, successful implementation of PBIS demands this consistency. To address these concerns, the residential team created a sustainability plan with checks and balances procedures. In any transformation process, staying focused on change over time can be challenging.

Transportation and Logistics. Transportation has become challenging with the policy of having each child involved in one activity per day outside the residence. The geographically dispersed population and the effort to maintain the children's activities in their original communities have combined to create a logistically complex system. These challenges are being addressed on an ongoing basis, and staff are creatively developing plans to ensure access to community-based activities while ensuring that children are adequately supervised.

The transformation of the residential program illustrated the inherent strengths of the established EMQ philosophy and practices. The new program reinforced agency's strengths, which further enabled the transformation. The program continues to track progress on a quarterly basis with particular attention to evaluating trends in average length of stay, CAFAS scores, use of physical restraints, and reduction of target behaviors that interfere with the youths' quality of life. While the post 6-months data do not immediately demonstrate the positive outcomes of the program it is expected that positive outcomes will be revealed over time, as is expected with any significant cultural change.

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