St. Catherine University

SOPHIA

Master of Social Work Clinical Research Papers | School of Social Work

5-2013

Is there a correlation Between Building and/or Strengthening Developmental Assets and the Reduction in Mental Health Symptoms in Youth?

Angela C. Marti Jedinak
St. Catherine University

Follow this and additional works at: https://sophia.stkate.edu/msw_papers

 Part of the Social Work Commons

Recommended Citation

Jedinak, Angela C. Marti. (2013). Is there a correlation Between Building and/or Strengthening Developmental Assets and the Reduction in Mental Health Symptoms in Youth?. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/227

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact amshaw@stkate.edu.

Is there a correlation between building and/or strengthening developmental assets and the reduction in mental health symptoms in youth?

Submitted by Angela C. Marti Jedinak, LGSW
May 2013

MSW Clinical Research Paper
The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social work research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work
St. Catherine University and University of St. Thomas
St. Paul, Minnesota

Committee Members:
Katharine Hill, Ph.D. (Chair)
Dean Grace, Ed.D.
Crystal Brown, LGSW

Abstract

The purpose of this study was to determine if developing or strengthening developmental assets in youth, can reduce mental health symptoms. Despite the multitude of risk factors youth may have in their life, if countered with a high amount of protective factors or assets; research shows that youth can still have positive youth development. In turn, this provides children with skills to become engaged, empathetic, compassionate adults. This study examines if there is a correlation between building and/or strengthening assets and the reduction of mental health symptoms in children residing at a residential facility in Northern Minnesota.

Acknowledgments

First and foremost, I would like to thank my undergrad professors Dr. Peter Stacey and Jennifer Gervais, LICSW. Dr. Stacy gently counseled me towards the profession of social work, and Ms. Gervais taught me foundational skills and the essence of meeting the client where they are at.

Additionally, this process would have not been possible without the love and support from my husband, family and friends. All your encouragement is greatly appreciated.

Finally, an immense thank you goes to my committee members. It is their passion and expertise about this population and area of social work that made this study interesting, fun and valuable. Thank you for your dedication and willingness to bring more awareness to the importance of advancing mental health treatment for children. My clinical research chair, Katharine Hill, was a true support through this process as well. I value and appreciate Katharine's expertise and calm demeanor and ability to bring humor to our classroom with grace and passion for what she does.

Table of Contents

Introduction

Historically, programs and mental health professionals attempting to reduce mental illness symptoms and negative behaviors in youth, utilize a problems or deficit-based approach. Consequentially, little attention has been given to building or strengthening the youth's developmental assets. Recently, we have begun to see a paradigm shift from deficit-based or problem-orientated emphasis on mental health treatment, to recognition of valuing strength-based approaches (Cox, 2008 & Kegler et al., 2003).

Positive youth development is researched by the Search Institute (2012), in which they assess youth's developmental assets. Overall their research has shown that the assets are powerful influences on the youth's behavior. The more assets a child has, the more likely they are to thrive in adolescence and become responsible, caring adults. This recent trend towards recognizing youth's strengths is the enhancement needed to move in the right direction of curing rather than stigmatizing and instilling hope rather than despair (Cox, 2008).

Traditionally, a thorough assessment of the youth's problems and behaviors is conducted to aid in goal setting for treatment of their mental illness. This study aims to illuminate the importance of mental health professionals considering a strength-based approach in their treatment modalities. Asset strengthening or building, not only helps reduce or even prevent problem behaviors and brain-related pathology, but also provides healthy development (Mannes et al., 2007).

In addition, two assessment tools are introduced in this study to illustrate the effectiveness of a strength-based approach in mental health treatment for youth. Minnesota Department of Human Services mandates that all mental health professionals assess the youth every six months with the Child and Adolescent Intensity Instrument (CASII). The Youth Assessment Scale (YAS) instrument, designed by Dr. Oman (2002), can be utilized so that only

the scales used to measure the strength of the targeted asset are used. Dr. Oman designed the YAS scales to be used separately in this manner. Finally, recommendations are made to enhance the validity of this approach and offer evidence-based research for mental health professionals working with youth who are disadvantaged.

Youth and Mental Health

Serious gaps exist for children and adolescents in need of mental health treatment and the programs/health structures that effectively can meet these needs (Cosgrave, et al., 2008; Horwitz et al., 2012; Weist, et al., 2001). The child welfare system encounters youth with high rates of social and emotional developmental problems, as well as health and academic difficulties. Many youth in the child welfare system go untreated (Horwitz, et al., 2012). In fact, recent studies confirm that less than a third of youth that have documented mental health needs, receive care (Weist, et al., 2001). Extraordinarily, of the 9,282 respondents that participated in a Harvard Medical School survey that assessed the mental health of people in the U.S., more than half of them met the criteria for a DSM-IV disorder sometime in their lives. Most importantly, the first onset of symptoms occurred in childhood or adolescence. The leader of this study, Dr. Kessler stated "this is why prevention and treatment interventions have to focus on youth" (Mahoney, 2005, p. 24).

Another growing concern in the mental health field is the cost of treatment. As an example, youth in foster care use Medicaid-reimbursed services at a rate of eight to 15 times greater than other youth using Medicaid (Burns, et al., 2004). Although more research needs to be conducted to asses if the benefits of residential treatment facilities are cost productive; in very recent years, there has been national concern about the cost and effectiveness of treatment in residential treatment centers for youth. For example, in the state of Maine, 170 residential treatment beds have closed. Most outpatient services are less expensive and insurance companies are more inclined to pay for these services (Butler & McPherson, 2006; Holstead et al., 2010).

With the ever rising health-care costs and the demands for mental health services, mental health professionals have to use best practices and improve standards of care (Minnesota Department of Human Services, 2012). To support mental health professionals diagnostic and

treatment decisions, measurement instruments are being used to prove the necessity of mental health treatment for youth. The mental health system is continuously attempting to improve the delivery of services to youth by strengthening the validity and reliability of these tools (Fallon et al., 2006). The instruments to complete the assessments can be cost-efficient and offer a commonality for providers in hopes of positive outcomes not only on an individual level, but on a societal level as well (Children's Mental Health, 2008).

According to meta-analytic reviews on treatment models focusing on prevention, early intervention, and a continuous support system: prevention programs for youth yield significant benefits showing reduced rates of social, behavioral and academic problems in the future (Weisz, 2005). Schools are the most commonly accepted setting for a deliverance of these services for children, therefore offering significant opportunity to improve mental health services in this system. As an example, interdisciplinary approaches have been implemented in schools, as well as conducting needs assessments within the community to improve mental health programs (Weist, et al., 2001). Furthermore, the Search Institute (2012) in Minneapolis, Minnesota has done significant research with over 2.2 million youth finding consistent results across all cultural and socioeconomic groups. They found that youth equipped with developmental assets, aides in the prevention of mental illness manifesting.

Developmental Assets

The Search Institute in Minneapolis, Minnesota (2012) has identified 40 developmental assets in youth that help influence their choices in becoming thoughtful, accountable, and successful adults. The Search Institute defines the 40 Developmental Assets as common sense, positive experiences and qualities that help influence choices young people make. The 40 developmental assets were created in 1990 with groundwork in youth development, resiliency and prevention. The researchers conclude the more developmental assets young people

experience; the less likely they are to engage in high-risk behavior (Collins, 2005; Garbarino, 2001; Search Institute, 2012). The Search Institute identifies the top five assets as the following: family support, positive family communication, other adult relationships, a caring neighborhood, and a caring day care or educational setting (2012). Research by Bullis and colleagues (2001), found that some of the adolescents in their study, learning or strengthening the exact same assets the Search Institute identified, discontinued illegal activity. One additional asset that was found in their study included having associations with peers who were not engaged in illegal activity. The adolescents that did not succeed after the program were those that lacked post-program support such as adult support.

Overall, The Search Institute found these results to be evident with all socioeconomic groups and cultures. Furthermore, the level of assets provided for people working with children, offers an accurate and better predictor of high-risk involvement than poverty or being from a single parent home does. There are many ways to help children strengthen or build developmental assets, whether it is in a formal therapy setting or out in the community; it is highly effective in assisting children to become healthy, productive community members.

Literature Review

Mental Health Treatment with a Deficit-Based Approach

Historically, mental health professional's focus consisted of a reductionist, problem orientated approach (Richardson, et al., 2002; Reininger, et al., 2003). The standard method to

treating adolescent mental health typically begins by a mental health professional conducting a comprehensive assessment of the current problems. This includes assessing the stressors in the adolescent's home life, as well as in other environments, such as school and social settings. The typical action is to then formulate a treatment plan to reduce the problems and behaviors (Cox, 2008). Treatment has been driven by focusing on pathology and deficits for the past 50 years (Mannes et al., 2007). Miranda and Williams conclude that for a long time, mental health professionals have evaluated youth's deficits in order to treat them for their problems (2011).

The *Diagnostic Statistical Manual on Mental Health Disorders, Edition Four,* (DSM-IV) has become the fundamental tool for mental health professionals. It provides a classification of mental disorders and criteria for guiding the professional to a diagnosis. Another key component of the DSM is the provided numerical medical codes which mental health professionals use to be reimbursed for their services from medical insurance companies. To date, the DSM has focused merely on clinical validity which is the claim that the diagnosis parallels to the clinician's subjective views of a disorder (Kraemer, 2007). This level of clinician subjectivity has been controversial in published articles. Clemmons et al., states that by labeling a client with a diagnosis or a problem, one is focusing on their problems (2007). Clients receiving mental health services are then stigmatized, producing doubt rather than confidence and encouraging avoidance rather than eagerness (Cox, 2008).

Negative Factors on Human Development

Many of the problems that youth endure are a result of negative factors that effected their development. The most rapid brain growth takes place in utero and from birth to four years of age. During this growth, the child's brain is extremely plastic and vulnerable. This time period

provides great opportunity for safe and nurturing environments to be provided. However, it is also the time when neglect and trauma can be the most devastating on the developing brain (Perry & Szalavitz, 2006). The ways in which youth are socialized in their families and environment strongly influences developmental outcomes (Herrenkohl, et al., 2000). When clinicians conduct assessments and gather evidence to make a diagnosis, investigating the early development years may be crucial to combatting the problems youth are facing.

Risk Factors. There are several risk factors that can hinder positive health outcomes in adolescents. Rew and Horner (2003) found that gender, childhood distress, trauma, parental divorce, or death of a sibling or parent all interfere with healthy development. Gresham and colleagues conclude that risk factors can have a large influence on youth's response to interventions. They also determine that risk factors are associated with poor developmental results, as well as positive outcomes being much more difficult to obtain (2007).

High-Risk Behaviors and Negative Outcomes. The Search Institute (2012) identifies four categories of high-risk behavior in youth including; problem alcohol use, violence, illicit drug use, and sexual activity. High risk behaviors also include, eating disorders, gambling and school truancy (Collins, 2005; Rew and Horner, 2003). Interestingly, the term *risk* originates from epidemiology to reflect ones chances of opposing outcomes of morbidity and mortality in response to internal and external pressures. This in turn, intensifies the child's susceptibility to negative developmental and health outcomes (Rew & Horner, 2003). In addition, these high-risk behaviors are exhibited by youth with internalizing and externalizing behaviors. Youth that internalize behaviors may exhibit social withdrawal, shyness, anxiety and depression. Externalizing behaviors are shown more outwardly with aggression, defiance, and noncompliance. Youth experiencing severe social, emotional, and behavioral extremes and

insufficiencies are at a much higher risk for both long and short-term negative outcomes (Crews, et al., 2007). Some of the negative outcomes include teen pregnancy, drug use, poor academic achievement, delinquency, referral to mental health agencies, and illegal activity (Oman, et al., 2002; Crews, et al. 2007).

To focus solely on client's deficits, and not allow them to be a part of their treatment, is most certainly a disservice for the client. Oman et al., (2002) states that focusing on youth assets or client's strengths may help in reducing the risky behavior. In approximately the last decade the literature supports an emerging paradigm shift from the problem oriented treatment approach to focusing on development and/or strengthening youth assets to assist them in becoming healthy, empathetic adults who can lead productive lives (Oman, et al., 2002), essentially empowering them to make healthier choices for themselves.

Mental Health Treatment with a Strengths-Based Approach

When analyzing if assets do indeed reduce mental health symptoms, it is important to note that research states, rarely, (if ever) is a single risk factor responsible for mental illness in children. In contrast, the same applies to assets; if a child only has a single or few assets, it is probably not enough to protect them from negative behaviors or mental illnesses emerging (Garbarino, 2001 & Crews, 2007). To provide a perspective of youth's assets, the Search Institute found that of the communities surveyed in the United States, 15% of youth reported having zero to ten of the 40 assets. Another 41% stated they have 11 to 20 assets, and about 35% have 21 to 30 assets. "Asset rich" youth, those having 31-40 assets, only accounted for 8% that were surveyed. In addition, it was found that through all racial and sociocultural groups and socioeconomic levels, youth with high levels of assets were much more likely to participate in thriving behaviors than those youth with insufficient assets (Mannes, et al., 2007). The Search

Institute also found in their research that several of the assets have been found to be relevant to all ethnic groups (Bruyere, 2010). Furthermore, asset strengthening or building, not only helps reduce or even prevent problem behaviors and brain-related pathology, but also provides healthy development (Mannes et al., 2007). There is also evidence that if these assets can be built in youth's childhood, long-term healthy behaviors and healthy lifestyles will result (Rew & Horner, 2003; Smith, 2006).

Mental health treatments that solely focus on reducing the risk factors have empirically proven to not be all-encompassing (Grace, 2008). As an example, Caldwell and colleagues (2004) discovered that an adult building or strengthening a relationship with a child, rather than focusing on the child's diagnosis or behaviors, resulted in better child outcomes. In this study, they implemented The Fathers and Sons Intervention Program. They discovered the quality, not the quantity of the time the youth spent with their father was essential for the child's well-being. This study clearly showed how strengthening an asset already in place, resulted in a healthy father-son relationship (Caldwell, et al., 2004). The Search Institute states the top two developmental assets for children from all ages is *Family Support* which is defined as family life providing high levels of love and support and *Positive Family Communication* which is defined as a young person and her or his parent(s) communicating positively, and a young person's willingness to seek advice and counsel from parents (2012). Paralleling the Search Institutes findings, in a 30-year longitudinal study it was found that a predictor of healthy developing children was the accepting, sensitive, and responsive adult caregiver. They found that over time the children showed better mental health and educational and socioeconomic outcomes (Bruyere, 2010).

To help illustrate, a study was conducted of 225 boys and 223 girls, ages 11-14 in an ethnically diverse metropolitan community. The participants completed the assessment, Inventory of Parent and Peer Attachment (IPPA) and a Youth Self Report (YSR) assessment, both having well-established reliability and validity in research. They found the assets *of self-worth* and *increases in the quality of relationships with parents* were associated with decreases in externalizing behaviors (Kuperminc et al., 2004) such as aggression, defiance, and noncompliance (Crew, et al., 2007). This study also found an association of increased positive peer relationships and decreased externalizing behaviors. In addition, in regards to educational outcomes, the researchers discovered that over the duration of the one year, increases in self-worth and efficacy resulted in higher GPA (Kuperminc et al., 2004). This finding is significant according to Rew and Horner (2003), as youth who are not successful in the school setting are at higher risk of drop-out and other risky behaviors.

Yet another significant 30 year study followed pregnant mothers and the family system, and then the children until they were 18 years old. They found that youth from high-risk communities and families, families in poverty, with parental alcoholism or mental illness that had high a number of assets, still could overcome the effect of their severely underprivileged backgrounds (Rew & Horner et, al., 2003). Much of the literature provides significant results of how building and strengthening assets of the child and the family system can lead to extensive positive results (Rew and Horner, 2003; Cox, 2008; Caldwell et al., 2004). It seems imperative that mental health professionals incorporate this model into their treatment modalities. The literature clearly supports that building or strengthening client's assets from a strength-based approach, is far more effective than reducing symptoms by focusing on their problems. After all,

in clinical social work practice, the cornerstone of treatment is to identify the client's strengths (Paquin, 2006).

The intention of this study is to determine if there is an association between building developmental assets and decreasing mental health symptoms for youth. The review of the literature led to this research question: Is there a correlation between building and/or strengthening developmental assets (independent variable) and the reduction in mental health symptoms (dependent variable) in youth? The researcher hypothesizes that as the Youth Assessment Scale (YAS) scores increase, the Child and Adolescent Intensity Instrument (CASII) scores will decrease indicating an association.

Conceptual Framework

Several theories that have guided mental health professionals during their work have also guided this study. This study will add to the practical application of resilience theory and strength-based approach, by illustrating an example of how effective asset building and/or strengthening can help reduce mental health symptoms in youth.

Resiliency Review

Resiliency theory is attentive to strengths rather than deficits and to the conceptualization of healthy development despite the risk exposure (Fergus & Zimmerman, 2005). Resiliency is defined by "the process of, capacity for or outcome of successful adaptation despite challenging or threatening circumstances" (Heller et al., p. 322). Furthermore, researchers conclude that a key component of resiliency is the presence of both risk and protective factors in an individual's life (Fergus & Zimmerman, 2005; Rew & Horner, 2003). These protective factors consist of both external factors such as family and internal characteristics such as self-efficacy (Fergus & Zimmerman, 2005; Grace, 2008). Children whose families are in poverty, have discord,

alcoholism and mental illness in the home they grow up in, are known to have risk factors that can contribute to the outcome of their childhood and adulthood (Rew and Horner, 2003).

With over 30 years of clinical research on children that have experienced trauma, Dr. Bruce Perry and colleagues has provided a greater perspective and understanding of resiliency for those working with youth. Perry found that with patterns of both stress and nurturing that children experience early in their lives fosters resiliency. Resilient children are made through the constant layers of repetitions and environmental exposures (Perry &Szalavitz, 2006). Even with chronic trauma, there is hope that it can be combatted with a phenomenon called neuroplasticity; the ability for the human brain to generate new nerve cells and other neural structures. Essentially, this is also known as "rewiring" (Weiss, 2007). As an example, exposure therapy has been found to be successful in the treatment of Post-Traumatic Stress Disorder (PTSD), implying that structural and functional neuronal activity can be reversible (Kolassa, & Elbert, 2007). This is encouraging in that when children who have mental health concerns, building assets seem to be able to counteract some of the damage that may have occurred in their lives and therefore their brains.

Research has also shown that genetics (biological factors) can equally serve as a protective function aiding in resiliency for some individuals (Curtis and Cicchetti, 2003). For example, it has been determined that children who have higher intelligence have the ability to see alternatives or solutions for difficult situations. Higher intelligence can also attract other caring adults such as a teacher or neighbor, allowing for a healthy adult-child relationship to form and foster healthy development (Szalavitz & Perry, 2010; Harvey & Delfabbro, 2004).

It is essential to understand the implications that resiliency has on the delivery of mental health services. With mental health professionals developing a clear picture of resiliency, they can better deliver services that help reverse the effects of trauma. By implementing skills,

services, and supports to foster the growth of resiliency, it becomes impactful to the individual on many levels (Bullis, et al., 2001). Another example where support was executed comes from the LA's Better Educated Students for Tomorrow (BEST) program. They found that ninety-eight percent of the children felt the adults that ran the program cared for them and had high-hopes for their success (Huang et al., 2000). The Search institute has identified "adult relationships" to be one of the most important assets for a child's healthy development (2012). In this study, the students' outcomes were significant. When the program was followed, it offered an environment for the children's brains to be "rewired." The researchers highlight, the more the students' attendance rates increased, the higher their standardized test scores increased.

Strength-Based Approach

This study also draws on the notion that humans have a tendency towards self-righting. Even children from confrontational, hostile environments can develop into healthy adults when their strengths are accentuated. The present study will be conducted within the conceptual framework that the strengths-based approach highlights the youth's strengths rather than focusing on their problems (Smith, 2006). According to Clark (1998), if the problem is focused on too many times while ignoring strengths, it can cause a client to assume a role of passive victim. By using strengths-based approach, youth can begin to understand how applying their strengths will result in positive change and growth (Bullis, et al., 2001; Oesterreich & Flores, 2009).

Methods

Research Design

Respondents from an urban mid-western, multi-service mental health agency for youth completed the YAS upon entering the agency and subsequently every three months. The CASII was completed by mental health professionals working with the respondents upon entry into the agency and then every six months.

The YAS determines relative strength of the youth's developmental assets. The research design was quantitative, secondary data analysis (Monette, et al., 2011). The CASII measured the severity of the mental health symptoms. Refer to appendix A to view an example of the YAS assessment tool. Refer to appendix B to view examples of the CASII score sheet and CASII.

Child and Adolescent Service Intensity Inventory (CASII)

The CASII is an instrument used to determine the intensity of services needed for youth within the mental health system of care. After a comprehensive clinical evaluation, the scores from eight dimensions are combined to generate the recommendation of level of care. The instrument has much flexibility in that it can be conducted in any setting regardless of any previous diagnosis, also providing assessment of three different disorders: psychiatric disorders, substance use disorders, or developmental disorders. (American Academy of Child & Adolescent Psychiatry, 2010). The raters are to have a broad range of clinical experience and have also had training on how to conduct the CASII. However, like the DSM, the CASII has great room for rater subjectivity. Still, after evaluating the CASII, it is said to have moderate or reasonable reliability when compared to the Child Global Assessment Scale and the Adolescent Functional Assessment Scale (Fallon et al., 2006). In 2009, the Minnesota Department of Human Services recommended that all youth receiving public and private mental health services be assessed with the CASII (Minnesota Department of Human Services, 2012).

Youth Assessment Survey (YAS)

The YAS was particularly developed to provide pre and post measurements of interventions employing the strengthening and/or building of the developmental assets (Oman, 2002). This assessment is unique from others assessments, in that it is completed by the youth. There are 37 questions that utilize a Likert scale. Of the 40 developmental assets recognized by the Search Institute, the YAS identifies seventeen assets including family communication, peer role models, future aspirations, responsible choices, community involvement, non-parental role models, constructive use of time, and cultural respect. Factor analysis has determined the YAS to be a reliable measure of youth assets and is recognized as an important step toward establishing a standardized measurement tool. Further, the YAS was designed to allow researchers to use individual asset scales to measure the strength of targeted assets (Oman et al., 2002).

Sampling and Recruitment

This study utilized non-random, availability sampling (Monette, et al., 2011). This study included 21 different respondents' from the three programs of the agency; residential treatment, after care, and day treatment. The respondents' demographics are both male and female, aged 10-19 years old. The respondents are Caucasian, African-American, Native American and mixed race that are from both rural and urban areas of the mid-west region. The respondents are youth who are severely emotionally disturbed (SED) and have at least one mental health diagnosis (Grace, 2008).

Data Collection

The respondent's CASII and YAS scores were recorded on an Excel spreadsheet by staff at the mental health agency. Scores were collected from all respondents from the time period of

January 2012 through April of 2013 in order to reflect a time period which coordinates with the times the CASII and YAS scores were completed. The scores were kept on the researcher's password protected laptop computer in a locked briefcase. The scores were not linked to any identifying information of the respondents.

Data Analysis

The researcher ran a correlation coefficient association determining the degree of the relationship from the scores of the YAS and CASII assessments that were recorded on an Excel spreadsheet (Monette, et al., 2011). The researcher collected descriptive statistics to determine mean age, gender, race and main mental health diagnosis of the respondents. Many of the respondents had up to five mental health diagnoses. For the purpose of this study, this researcher recorded the main mental health diagnosis that determined their treatment goals. This was determined by the mental health professional working with the respondent.

Protection of Human Subjects

The Excel documents only had the YAS and CASII scores recorded on them. There was no identifying data within these documents. Before the respondents started receiving services from the mental health agency, their parents or caretakers completed a standard intake packet giving the agency permission to conduct outcome studies with information that is collected throughout treatment. See Appendix C for a copy of the blank consent form. The Institutional Review Board (IRB) of the University St. Thomas reviewed and approved the study.

Strengths and Limitations

According to Smith (2008), the social sciences underutilize secondary data analysis. This study is able to do just that while capturing a high number of scores with a relatively diverse

population. In addition, utilizing secondary datasets allows for a relatively inexpensive way to conduct research, especially for the social sciences that often lack funding. This particular agency's director collected and organized this data for statistical purposes in order to evaluate the outcome and improve service effectiveness and delivery. Another strength of this secondary dataset is that it allowed for the privacy of respondents, while still producing valuable data. In turn, this data provided results that can move the work mental health providers do with youth, in a progressive and productive way. Governments rely heavily on statistics when determining policies, therefore the quantitative nature of this study can lend valuable input to the decisions made for the future of our youth (Smith, 2008). This type of data may lend to a more accurate representation of what is occurring at the agency, rather than solely relying on self-reporting survey's that allow for responders' bias.

The Minnesota Department of Human Services (DHS) conducted an "Outcome Measure Pilot of the Strengths and Difficulty Questionnaire (SDQ) and the CASII in 2008. It was found that the CASII has moderate test-retest reliability. It is important to note that the CASII is completed by a mental health provider that had training in how to complete the assessment. Within the context of this agency, the CASII is generally completed be the same mental health professional, which improves rater reliability. However, there are still rater variances in the scoring due to biases and different providers scoring children at different times of their treatment. According to the study, it was found that raters scored Black and Native American children and adolescents with higher CASII ratings than White or children in the "Other" category (Minnesota Department of Human Services, 2008). For future reliability with the YAS assessments, the mental health professional should assist the children and adolescents in

completing the instrument as an interview survey, not a paper and pencil survey in which the youth do alone.

This sample is not fully representative to the population of youth at this agency. For example the age range was three to 20 during the time period these statistics were assessed and recorded by staff at the agency. This study only captured respondents from age six to sixteen. The overall population gender representation for males during this time of treatment was 72.5%, whereas this sample was 71% female. In addition, four out of the five main mental health diagnosis of the population at the agency, were the same as in this sample. The population representative of race in this sample was similar to the overall population of the youth at the agency. The one exception was there were less Native American respondents reflected in this sample than in the overall population at the agency.

YAS scores in this study do not reflect the large change in asset strength compared to what was reported in Grace's (2008) quasi-experimental study. At least two factors affect this discrepancy. First, when comparing their self-report of progress to clinical assessments, girls with bi-polar disorder or borderline personality disorder were the least reliable reporters in the original study (Grace, 2008). The largest portion of this sample is female. Second, in general the scales work most reliably when administered as a brief interview and are least reliable as a paper and pencil survey. According to administrators at the agency, most of the scores to date are based on responses reported on paper rather than in an interview.

The most significant limitation was the small sample size; therefore it was not representative of the population of youth placed in this agency's programs. Two thirds of the youth served in the three treatment programs are boys. In this study 71% of the respondents are female. However 75% of the residential youth are male. Native American youth are also

underrepresented in the sample. This researcher utilized the scores that were available at the time of collection. The agency is continuing to collect scores. For future studies, with more scores available, it is likely the sample size will be more representative of the population.

Results

Data Analysis

The agency's treatment model focuses on eight critical assets when formulating the children's and adolescent's goals. The assets included: family support, achievement motivation, decision-making skills, adult mentors, positive peer relations, friendship skills, program activities and community service. The youth's diagnosis determines what assets are targeted in their treatment plan. This is based on evidence that the assets chosen will help the youth cope with the specific symptoms of their mental illness.

This researcher selected all respondents with completed YAS and CASII scores reported on the Excel spreadsheet. Sample subjects required two consecutive YAS scores to correlate with CASII scores corresponding to the same treatment intervention timeframe. This resulted in a total of 21 respondents and a total of 53 sets of scores. The agency uses eight of the 17 scales within the YAS instrument. Dr. Oman (2003), created the YAS so that scales could purposively be used separately to match up to each goal when writing treatment plans for the child. A child may have more than one goal, resulting in more than one YAS score per child. To help illustrate this, an example of Treatment Planning Guide can be viewed on Appendix D. This treatment plan derived from evidence-based research to provide intervention. Each goal area includes a brief but valid pre/post measure (Oman, 2009) of the asset the interventions are designed to develop or strengthen. This is why there are 21 respondents and 53 sets of scores. A set was determined by two consecutive three month YAS score matched with the six month CASII score

for the same time period. See examples of the YAS in Appendix A and the CASII in Appendix B. The respondents completed a YAS every three months during their treatment and the mental health professionals (clinicians) working with the respondent completed a CASII assessment every six months. The sample respondents had between one and four goals they were working on during the treatment period studied. Most had more than one mental health diagnosis, resulting in more than one goal set per respondent. This resulted in each of the respondents having more than one set of scores.

Descriptive Data

The respondents mean age was 10.7. 15 (71%) of the respondents were female and six (29%) were male. The youth racial/ethnic characteristics were 12 white respondents, 5 black respondents, 3 Native American respondents and 1 Hispanic respondent. Although many of the respondents had up to five mental health diagnoses, this researcher recorded the main diagnosis that influenced the treatment goals and developmental assets that were worked on. One respondent had Disruptive Behavior Disorder; one had a Mood Disorder, NOS; two had a diagnosis of Reactive Attachment Disorder; three had Major Depressive Disorder or Depression; three had Anxiety Disorder; four had Post-Traumatic Stress Disorder; and five had a diagnosis of Attention Deficit Hyperactivity Disorder. These percentages exclude two respondents, as this researcher was unable to obtain the mental health diagnosis. The two respondents were still included in the overall sample. Overall, this was a small sample size that does not fully represent the population characteristics of the agency population.

Findings

This researcher ran a correlation of the YAS scores combined and the CASII scores combined that resulted in an r-value of -.39, which is a moderate negative correlation (see Table 1). Correlations from +/- .2 to +/- .39 are considered moderate. +/- .4 and above represents a strong correlation. As the developmental assets increased and strengthened, the mental health symptoms decreased. YAS scores range from four to 16 and the CASII scores range from six to 35, with six being the least severe of mental health symptoms and 35 being the most severe. The average increase for the YAS scores was 0.79. The average decrease for the CASII scores was -1.66. Even a small increase in the YAS scores and a small decrease in the CASII scores, can lead to significant change (Grace, 2013, personal communication). The significance score of $p = .004$ (see Table 2), therefore indicating a statistically significant relationship at the .01 level. This indicates there is less than 1% probability that the results are due to chance (Monette et al., 2011). The results provide a moderate correlation with a very high level of confidence that the outcome accurately describes the relationship between variables for this sample.This researcher rejects the null hypothesis.

Table 1: YAS and CASII r-value

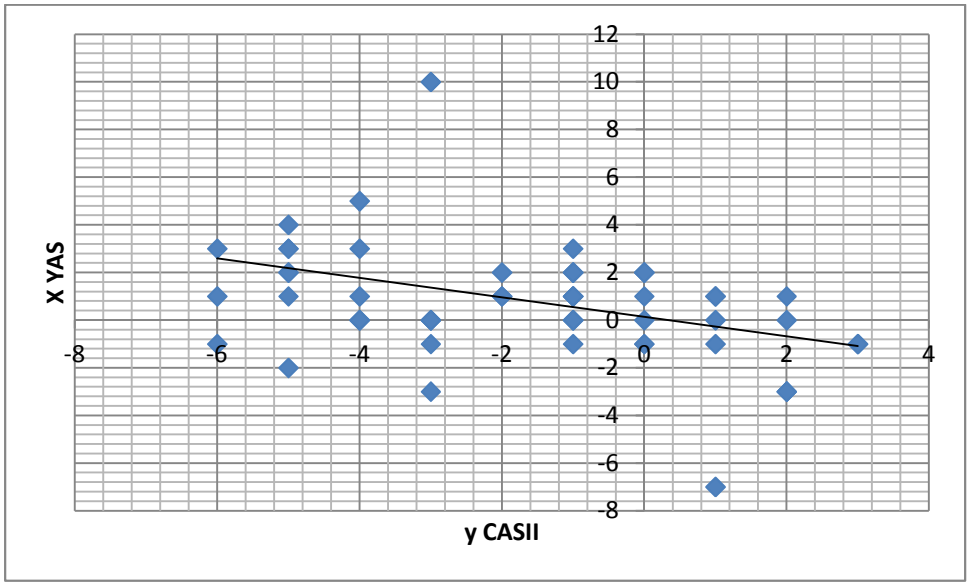

Table 2: YAS and CASII p-value

Correlations

		VAR00001	VAR00002
VAR00001	Pearson Correlation	1.000	-.390**
	Sig. (2-tailed)	.	.004
	N	52	52
VAR00002	Pearson Correlation	-.390**	1.000
	Sig. (2-tailed)	.004	.
	N	52	52

**. Correlation is significant at the 0.01 level (2-tailed).

Discussion

Discussion of Findings

This study examined the effectiveness of strengthening developmental assets to reduce mental health symptoms in youth that were being treated in a residential, day treatment or in foster care. The YAS was used to measure the relative strength of developmental assets and the CASII was utilized in this study to measure the changes in severity of the respondent's mental health symptoms. YAS scores range from four to 16. Scores from four to eight are considered weak, scores from nine to 12 are moderate and scores from 13-16 are strong. The lower the YAS score, the fewer assets a respondent has. The CASII scores range from six to 35, with six being the least severe of mental health symptoms and 35 being the most severe. The CASII scores are determined by a mental health professional that works with the respondent. These scores are divided into six levels of treatment, with the lowest level needing the least mental health services. The lower the score and level of treatment, the less severe the respondent's mental health symptoms are. As the YAS scores go up, more or stronger developmental assets have been recognized by the respondent and they are reporting this. As the CASII score goes down, the mental health professional is reporting less intense mental health symptoms.

The six month CASII score is greater than the initial score despite the fact that most youth stabilize fairly rapidly in the treatment setting. This occurs in four of the 21 (19%) respondent's CASII scores. One factor that may be contributing to this is the therapist who is completing the ratings knows more about the youth's condition after six months than at placement. Therapists at the agency confirmed a lack of familiarity with cases at the time of the initial CASII is completed. In some cases, the CASII was completed by a referring social worker. As a result, the agency practice has been modified to delay completion of the initial CASII for three weeks.

This study attempted to confirm what was found in the deficit-based verses strength-based literature. The literature states within all sociocultural groups, youth with high levels of assets are much more likely to participate in thriving behaviors than those youth with insufficient assets (Mannes et. a, 2007 & The Search Institute, 2012). This sample included youth that were white, black, Native American and Hispanic. Additionally, it was found that strengthening or building assets, helps reduce or even prevent problem behaviors and brain-related pathology and provide long-term healthy development (Mannes et al., 2007; Rew & Horner, 2003& Smith, 2006). The findings in this study supported that strengthening assets was associated with reducing the severity of mental illness in youth.

Although this quantitative research indicated favorable clinical results, more rigorous research in needed to support asset strengthening and building with youth as an empirically validated treatment choice for youth experiencing severe emotional disturbances. The findings presented here should be viewed as preliminary and not conclusive. This is only a small sample size and additional research will be able to identify the developmental assets long-term effects and how they can foster healthy youth development and create better connections with their families. Additional research is necessary to support the idea of how strengthening developmental assets in youth, decrease mental health symptoms. For future studies, the researcher should incorporate more sets of scores that are correlated, offering a more inclusive study. A larger sample that is more representative of the population of respondents within the three programs should be included. In addition, it may be beneficial to examine the gender difference and the impact it may have on the outcome. This study did not correlate particular mental health diagnoses with the outcome, which could provide valuable insight into the efficacy of treatment interventions.

Implications

Social Work Practice. The social work profession as a whole should strive for a treatment approach that is not punitive in nature but rather empowering. Although this was a pilot project for the agency that the data was collected from, it is another swing in the paradigm shift towards a strength-based model that focuses on investing in youth by building on strengths. This study provided evidence and suggestions that a strength-based approach is valuable in clinical social work practice in treating children and adolescents with mental illnesses.

When a clinical social worker is writing a treatment plan, it should incorporate the asset-building model to reduce the severity of mental health symptoms. Additionally, the effectiveness can be measured with the YAS scales and the CASII, therefore providing us with additional statistics and informing the effectiveness of our practice. Several other examples of strength-based approach and their effectiveness have begun to emerge. A program in Florida illustrates how 108 at-risk adolescents has significant reductions in internalizing and externalizing mental health symptoms by teaching the adolescents self-regulation skills (Rapp-Paglicci, Stewart, & Rowe, 2011). Yet another study that implemented The Fathers and Sons Intervention Program, discovered the quality, not the quantity of the time the youth spent with their father was essential for the child's well-being. This study clearly showed how strengthening an asset already in place, resulted in a healthy father-son relationship (Caldwell, et al., 2004). Kuperminc (2004) and colleagues found the assets *of self-worth* and *increases in the quality of relationships with parents* were associated with decreases in externalizing behaviors. As evident, much of the published literature on building assets and mental illness reduction is within the last decade or so. This is cutting-edge in that we are making a strong case for informed research practice by empowering youth from a strengths-based approach and cultivating an environment that prepares youth for adulthood.

Policy. Clinical social work is a specialty within the practice of social work. Currently, clinical social workers are being reimbursed for therapy services under health insurance plans. Typically, health insurance companies reimburse for psychotherapy (Lechnyr, 1984), which focuses on problems that youth have and symptom reduction (Cox, 2008). Insurance companies may be interested in the strength-based approach for many reasons. First, by providing children with effective skills that replace ineffective behaviors, it will save on medical costs as it may reduce hospitalizations, self-harming behaviors, residential placements, and intensive treatments. The skills that are either built or strengthened can be utilized in any environment, assuring that not only was the symptom reduced, but it is residual, meaning it will stay with the child. If their mental health symptoms arise again, they have a better chance of coping and recovering quicker, which of course is appealing to insurance companies, as it would also cost less.

Subsequently, on a macro perspective, social workers should strive to promote the general welfare of society. The findings from this qualitative study is evidence that social workers can share with law-makers to help inform their decisions when passing laws that will impact the clients we work with. According to Henggler (1999), treatment resources should focus on building the youth's natural network and promoting healthy social development, therefore preventing youth being admitted into costly inpatient treatment. Much of the literature provides significant results of how building and strengthening assets of the child and the family system can lead to extensive positive results (Rew and Horner, 2003; Cox, 2008; Caldwell et al., 2004). This provides substantial information for social workers to begin having conversations with politicians about supporting funding for strength-based interventions, changing insurance company policies and furthering research. Insurance companies dictating our practice as clinical social workers, is reason enough to strive toward having conversations with politicians and the

insurance companies about why a strength-based model is an acceptable approach to therapy and reimbursement. Additionally, it provides an all-encompassing approach to equipping children to become successful, healthy adults, contributing to society.

Research. Within the context of this study, Howse (2010) and associates state more research is needed about how effective asset-based approach is. As clinical social workers working with children, it is vital to be knowledgeable of best practices and what is the least invasive treatment approach. Asset development focuses on strengthening assets that may be in the child's life already, supported by resiliency theory in which focuses on strengths rather than deficits. Even with children that may not have any development in a particular asset, according to Mannes (2006), it can be developed through providing skills treatment and therapy. The tools to further this study are readily available. The CASII is already mandated by Minnesota Department of Human Services; so all agencies that offer mental health services for youth have to keep record of these scores. This study has shown how valuable assessments can be in directing one's clinical social work practice, therefore offering an opportunity to collect data and offer a systematic way of informing our practice. Additionally, the YAS does not have a cost. Dr. Oman only asks the instrument is properly cited in any publication of results. Further research with these two assessments will lead to recognition of a supported strength-based therapeutic approach to treatment.

For future studies, some areas of the research should be adjusted. The sample size should be larger to prove statistical significance. The sample should be more representative of the population. Additionally, the study could be expanded to more agencies to provide a broader overview of youth in Minnesota.

Conclusion

This study is an important stage in developing recognition to a strength-based therapeutic approach for mental health treatment. Focusing on ways to prove that strength-based therapeutic approaches are more effective than the deficit-based approach is important. Research shows that asset strengthening or building, not only helps reduce or even prevent problem behaviors and brain-related pathology, but it provides healthy development (Mannes et al., 2007 & Search Institute, 2012). Utilizing strength-based approaches not only during times of mental health crisis, but as prevention methods has great implications and promise for the future of children's and adolescent's mental health.

Appendix A

Appendix: Pre/Post Measures of Asset Development

a. Family Support

These questions are about how often you talk to your parents or other adults in your home. Please circle the number that best describes how often you talk to your parent(s) or guardian(s).

1. How often do you talk to your mother, father (or an adult in the household) about your problems?

1	2	3	4
Almost never	Some of the time	Usually	Almost always

2. How often does your mother, father (or an adult in the household) tell you that he or she wants good things for you?

1	2	3	4
Almost never	Some of the time	Usually	Almost always

3. How often do you talk to your parents about what is right and wrong?

1	2	3	4
Almost never	Some of the time	Usually	Almost always

4. How often do you feel comfortable talking to your parent(s) about personal matters?

1	2	3	4
Almost never	Some of the time	Usually	Almost always

A. Achievement Motivation

These questions are about your future. Please circle the number that best describes your feelings.

1. How important is it to your family that you continue your education after high school?

1	2	3	4
Not important at all	Somewhat important	Very important	Extremely important

2. As you look to your future, how important is it to you to stay in school?

1	2	3	4
Not important at all	Somewhat important	Very important	Extremely important

3. What are the chances that when you are an adult you will be successful in whatever you choose to do?

1	2	3	4
Very low	Low	High	Very High

4. What are the chances that when you are an adult you will be doing the kind of work that you like?

1	2	3	4
Very low	Low	High	Very High

5. What are the chances that when you are an adult you will be respected by other people?

1	2	3	4
Very low	Low	High	Very High

B. Decision-making skills: Responsible Choices

These statements describe a person who may or may not be like you. Please circle the number that tells how well the statement describes you.

1. You can say no to activities that you think are wrong.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

2. You can identify the positive and negative consequences of a behavior, and choose appropriately.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

3. You try to make sure that everyone in a group is treated fairly.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

4. You take responsibility for what you do.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

C. Decision-making skills: Healthy Choices

These statements describe a person who may or may not be like you. Please circle the number that tells how well the statement describes you.

1. You take good care of your body by eating well.

1	2	3	4

Not at all like you A little like you Mostly like you Very much like you

2. You take good care of your body by exercising.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

3. It is important to you to maintain a healthy body weight.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

4. It is important to you to be physically active every day.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

D. Decision-making skills: Problem-solving

These questions are about how you feel when you are doing things. Please circle the number that best describes you.

1. I can solve most problems if I invest the necessary effort.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

2. If I am in trouble, I can usually think of a solution.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

3. I can usually handle whatever comes my way.

1	2	3	4
Not at all true	Hardly true	Moderately true	Exactly true

4. When you are confronted with a problem, you can usually find several solutions.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

E. Adult Mentors

These questions are about adults other than your parents. Please circle the number that best describes how much you agree or disagree with each one.

1. Most of the adults you know are good role models for you.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

2. You know adults who encourage you often.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

3. There is an adult at your school who is concerned about your well-being.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

F. Positive Peer Relationships

These questions are about your closest friends. Please circle the number that best describes how often each occurs.

1. Do most of your friends follow the rules their parents make for them?

1	2	3	4
Almost never	Some of the time	Usually	Almost always

2. Do most of your friends stay out of trouble?

1	2	3	4
Almost never	Some of the time	Usually	Almost always

3. Do most of your friends choose healthy behaviors or activities?

1	2	3	4
Almost never	Some of the time	Usually	Almost always

4. Are most of your friends responsible?

1	2	3	4
Almost never	Some of the time	Usually	Almost always

G. Friendship Skills

These questions are about people from other racial/ethnic backgrounds. Please circle the number that best describes your feelings.

1. You respect the beliefs of people even if they are of a different race.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

2. You have friends from other racial/ethnic groups.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

3. You trust people from other racial/ethnic cultures.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

4. You treat others fairly no matter what their race.

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

H. Participation in Program Activities

These questions are about things you may do after school. Please circle the number that best describes how much you do each of them.

1. You participate in organized Northwood activities outside of class.

1	2	3	4
Almost never	Some of the time	Usually	Almost always

2. About how many times each week did you participate in organized activities after school hours? (These can be related to Northwood, community youth groups, sports, lessons, or other activities.)

1	2	3	4
None	One time	Two times	Three or more times

3. You participate in a school sports team or group such as softball, basketball, chess or photography clubs.

1	2	3	4
Almost never	Some of the time	Usually	Almost always

4. You participate in out-of other community sports teams or groups (church groups, clubs, etc).

1	2	3	4
Almost never	Some of the time	Usually	Almost always

I. Community Service

1. You volunteer on a regular basis to help others in your community.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

2. You work to make your community a better place.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

3. You know where to volunteer in your community.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

4. You participate in volunteer or community service groups.

1	2	3	4
Not at all like you	A little like you	Mostly like you	Very much like you

Appendix B

CASII SCORE SHEET

Client:_____Clinician:_____Date:_____

Case #:_____ Age_____Gender_____Race_____

CASII

CASII Administration		**Services Involved with case (# of hours per month)**	
☐ Entry into Service	☐ 6 months	____Case Management	
☐ Annual	☐ 18 months	____Individual Therapy-IP	____Family Therapy-FP
☐ Exit from Service		____Crisis Service	____Group skills-GS
☐ Other _____		____Individual Skills-IS	____Family Skills-FS
		____Day Tx-DT	____Residential Tx-RT
		Medication ____PCP	_____Psychiatrist
County of Residence: ☐ County A ☐ County B ☐ Other: please specify _____			

1. Calculation of CASII Composite Score						
Dimension	**Dimension Ratings (circle each score)**					Rating
I. Risk of Harm	1	2	3	4	5	
II. Functional Status	1	2	3	4	5	
III. Coexisting Conditions (Comorbidity)	1	2	3	4	5	
IV. Recovery Environment						
A. Environmental Stressors	1	2	3	4	5	
B. Environmental Supports	1	2	3	4	5	
V. Resiliency	1	2	3	4	5	
VI. Treatment Acceptance & Engagement						
Child/Adolescent **(use higher of**	1	2	3	4	5	
Parent/Caregiver **two subscales)**	1	2	3	4	5	
Composite CASII Score (*Add numbers in right column*):						
2. CASII - Derived Level of Care (I-VI) Recommendation (Shaded areas may increase level recommendation): Level 0 – 6-9 Level 1 - 10-13 Level 2- 14-16 Level 3 – 17-19 Level 4 – 20-22 Level 5 – 23-27 Level 6 – 28+						

Derived Level of Care Recommendation:_____

Actual Level of Care:_____

Reason for Deviation from Recommended Level:_____

CASII Key:

Level 0: Basic Services:

Package of prevention and health maintenance services assumed to be available to the community

Level 1: Recovery Maintenance and Health Management.

Maintenance services after more intensive services (e.g. medication services, brief crisis counseling).

Level 2: Outpatient Services.

Closest to traditional once/week visits.

Level 3: Intensive Outpatient Services.

From 2 visits/week up to few hours for 3 days per week; includes multiple services (e.g. big

brother, church services, mental health services) necessitating coordination (case mgmt.)

Level 4: Intensive Integrated Service Without 24-Hour Medical Monitoring.

Wraparound plan required, increased formal supports (respite, homemaking services or paid mentors); can include day treatment or partial hospitalization; active case management essential.

Level 5: Non-Secure, 24-Hour, Medically Monitored Services.

Group home, foster care or a residential facility, can also be provided by tightly knit wraparound

services.

Level 6: Secure, 24-Hours, Medically Managed Services.

Inpatient psychiatric settings or highly programmed residential facilities; could also be provided

in a community setting with wraparound. Case management essential. Time at this level of care held to minimum for optimal care and smooth transition to lower levels of care.

Child and Adolescent Service Intensity Instrument (CASII)

Child Name:_____ Date Assessed: _____/_____/_____ Services Start Date: ____/_____/_____
Child ID: _____ D.O.B.:____/____/____ Gender: ___M ___F
Rater Name: _____
CASII Administration: ☐ Entry into Service ☐ 6month ☐ Annual ☐ 18 months ☐ Exit ☐ Other _____

Dimension I. Risk of Harm ***(Circle the number below that best represents the child's or adolescent's current potential to be harmed by others or cause significant harm to self or others)***

Low Risk of Harm (1)	**Some Risk of Harm (2)**	**Significant Risk of Harm (3)**	**Serious Risk of Harm (4)***	**Extreme Risk of Harm (5)****
b. No indication of current suicidal or homicidal thoughts or impulses, with no significant distress, and no history of suicidal or homicidal ideation. c. No indication or report of physically or sexually aggressive impulses.	a. Past history of fleeting suicidal or homicidal thoughts with no current ideation, plan, or intention and no significant distress. b. Mild suicidal ideation with no intent or conscious plan and with no past history. c. Indication or report of	a. Significant current suicidal or homicidal ideation with some intent and plan, with the ability of the child or adolescent and his/her family to contract for safety and carry out a safety plan. Child or adolescent expresses some aversion to carrying out such behavior.	a. Current suicidal or homicidal ideation with either clear expressed intentions and/or past history of carrying out such behavior. Child or adolescent has expressed ambivalence about carrying out the safety plan and/or his/her family's ability to carry	a. Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior; without expressed ambivalence or significant barriers to doing so, or with a history of serious past attempts that are not of a chronic, impulsive, or consistent

d. Developmentally appropriate ability to maintain physical safety and/or use environment for safety. e. Low risk for victimization, abuse, or neglect f. Other:	occasional impulsivity, and/or some physically or sexually aggressive impulses with minimal consequences for self or others. d. Substance use without significant endangerment of self or others. e. Infrequent, brief lapses in the ability to care for self and/or use environment for safety. f. Some risk for victimization, abuse, or neglect. g. Other:	b. No active suicidal/ homicidal ideation, but extreme distress and/or a history of suicidal/ homicidal behavior. c. Indication or report of episodic impulsivity, or physically or sexually aggressive impulses that are moderately endangering to self or others (e.g. status offenses, impulsive acts while intoxicated; self – mutilation; running away from home or facility with voluntary return; fire setting; violence toward animals; affiliation with dangerous peer group). d. Binge or excessive use of alcohol or other drugs resulting in potentially harmful behaviors. **e.** Episodic inability to care for self and/or maintain physical safety in developmentally appropriate ways. f. Serious or extreme risk for victimization, abuse, or neglect. g. Other:	out the safety plan is compromised. b. Indication or report of significant impulsivity and/or physical or sexual aggression, with poor judgment and insight, that is/are significantly endangering to self or others (property destruction; repetitive fire setting or violence toward animals). c. Indication of consistent deficits in ability to care for self and/or use environment for safety. d. Recent pattern of excessive substance use resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use. e. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety. f. Other:	nature, or in presence of command hallucinations or delusions that threaten to override usual impulse control. b. Indication or report of repeated behavior, including physical or sexual aggression, that is clearly injurious to self or others (e.g., fire setting with intent of serious property destruction or harm to others or self, planned violence and/or group violence with other perpetrators) with history, plan or intent, and no insight and judgment (forcible and violent, repetitive sexual acts against others), c. Relentless engaging in acutely self endangering behaviors. d. A pattern of nearly constant and uncontrolled use of alcohol or other drugs, resulting in behavior that is clearly endangering. e. Other:
Rationale/Comments:				

* Requires level 5 independent of other dimensions
**Requires level 6, independent of other dimensions

Child and Adolescent Service Intensity Instrument (CASII)

Child Name: _____ Child ID:

Dimension II. Functional Status ***(Circle the number below that best represents the child's or adolescent's current level of functioning)***

Minimal Impairment (1)	**Mild Impairment (2)**	**Moderate Impairment (3)**	**Serious Impairment (4)**	**Severe Impairment (5)**
a. Consistent functioning appropriate to age and developmental level in school behavior and/or academic achievement, relationships with peers, adults, and family, and self care/hygiene/ control of bodily functions. b. No more than transient impairment in functioning following exposure to an identifiable stressor with consistent and normative vegetative status. c. Other:	**a.** Evidence of minor deterioration, or episodic failure to achieve expected levels of functioning, in relationships with peers, adults, and/or family (e.g., defiance, provocative behavior, lying/cheating/not sharing, or avoidance/lack of follow through); school behavior and /or academic achievement (difficulty turning in homework, occasional attendance problems), or biologic functions (feeding or elimination problems) but with adequate functioning in at least some areas and/or ability to respond to redirection/intervention. b. Sporadic episodes during which some aspects of self-care/hygiene/control of bodily functions are compromised. c. Demonstrates significant improvement in function following a period of deterioration. d. Other:	**a.** Conflicted, withdrawn, or otherwise troubled in relationships with peers, adults, and/or family, but without episodes of physical aggression. **b.** Self-care/hygiene deteriorates below usual or expected standards on a frequent basis. c. Significant disturbances in vegetative activities, (such as sleeping, eating habits, activity level, or sexual interest), that do not pose a serious threat to health. d. School behavior has deteriorated to the point that in–school suspension has occurred and the child is at risk for placement in an alternative school or expulsion due to their disruptive behavior. Absenteeism may be frequent. The child is at risk for repeating their grade. e. Chronic and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities. f. Recent gains and/or stabilization in functioning have been achieved while participating in treatment in a structured, protected, and/or enriched setting. g. Other:	a.Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors. b. Significant withdrawal and avoidance of almost all social interaction. c. Consistent failure to achieve self-care/ hygiene at levels appropriate to age and/ or developmental level. d. Serious disturbances in vegetative status such as weight change, disrupted sleep or fatigue, and feeding or elimination, which threaten physical functioning. e. Inability to perform adequately even in a specialized school setting due to disruptive or aggressive behavior. School attendance may be sporadic. The child or adolescent has multiple academic failures. **f.** Other:	a. Extreme deterioration in interactions with peers, adults, and/or family that may include chaotic communication or assaultive behaviors with little or no provocation, minimal control over impulses that may result in abusive behaviors. b. Complete withdrawal from all social interactions c. Complete neglect of, and inability to attend to self-care/hygiene/ control of biological functions with associated impairment in physical status. d. Extreme disruption in vegetative function causing serious compromise of health and well being. e. Nearly complete inability to maintain any appropriate school behavior and/or academic achievement given age and developmental level. f. Other:

Rationale/Comments:

* Requires level 5 independent of other dimensions
**Requires level 6, independent of other dimensions

Child and Adolescent Service Intensity Instrument (CASII)

Child Name:_____ Child ID:

Dimension III. Co-occurring Conditions Medical, Substance Use, Developmental, and Psychiatric Comorbidity

No Co-morbidity (1)	Minor Co-morbidity (2)	Significant Co-morbidity (3)	Major Co-morbidity (4)	Severe Co-morbidity (5)
a. No evidence of medical illness, substance abuse, developmental disability, or psychiatric disturbances apart from the presenting problem. b. Past medical, substance use, developmental, or psychiatric conditions are stable and pose no threat to the child or adolescent's current functioning or presenting problem. c. Other:	a. Minimal developmental delay or disorder is present that has no impact on the presenting problem and for which the child or adolescent has achieved satisfactory adaptation and/or compensation. b. Self-limited medical problems are present that are not immediately threatening or debilitating and have no impact on the presenting problem and are not affected by it. c. Occasional, self-limited episodes of substance use are present that show no pattern of escalation, with no indication of adverse effect on functioning or the presenting problem. d. Transient, occasional, stress-related psychiatric symptoms are present that have no discernible impact on the presenting problem. e. Other:	a. Developmental disability is present that may adversely affect the presenting problem, and/or may require significant augmentation or alteration of treatment for the presenting problem or co-morbid condition, or adversely affects the presenting problem. b. Medical conditions are present requiring significant medical monitoring (e.g., diabetes or asthma). c. Medical conditions are present that may adversely affect, or be adversely affected by, the presenting problem. d. Substance abuse is present, with significant adverse effect on functioning and the presenting problem. e. Recent substance use that has significant impact on the presenting problem and that has been arrested due to use of a highly structured or protected setting or through other external means. f. Psychiatric signs and symptoms are present and persist in the absence of stress, are moderately debilitating, and adversely affect the presenting problem. g. Other:	a. Medical conditions are present or have a high likelihood of developing that may require intensive, although not constant, medical monitoring (e.g., insulin-dependent diabetes, hemophilia). b. Medical conditions are present that will adversely affect, or be affected by, the presenting disorder. c. Uncontrolled substance use is present that poses a serious threat to health if unabated and impedes recovery from the presenting problem. d. Developmental delay or disorder is present that will adversely affect the course, treatment, or outcome of the presenting disorder. e. Psychiatric symptoms are present that clearly impair functioning, persist in the absence of stressors, and seriously impair recovery from the presenting problem. f. Other:	a. Significant medical condition is present that is poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease). b. Medical condition acutely or chronically worsens or is worsened by the presenting problem. c. Substance dependence is present, with inability to control use, intense withdrawal symptoms and extreme negative impact on the presenting disorder. d. Developmental disorder is present that seriously complicates, or is seriously compromised by, the presenting disorder. e. Acute or severe psychiatric symptoms are present that seriously impair functioning, and/or prevent voluntary participation in treatment for the presenting problem, or otherwise prevent recovery from the presenting problem. f. Other:

Rationale/Comments:

Child and Adolescent Service Intensity Instrument (CASII)

Child Name: _____ Child ID:

Dimension IV. Recovery Environment: Environmental Stress

Minimally Stressful Environment (1)	Mildly Stressful Environment (2)	Moderately Stressful Environment (3)	Highly Stressful Environment (4)*	Extremely Stressful Environment (5)**

a. Absence of significant or enduring difficulties in environment and life circumstances are stable. b. Absence of recent transitions or losses of consequence (e.g., no change in school, residence, or marital status of parents, or no birth/death of family member). c. Material needs are met without significant cause for concern that they may diminish in the near future, with no significant threats to safety or health. d. Living environment is conducive to normative growth, development, and recovery. e. Role expectations are normative and congruent with child's or adolescent's age, capacities, and/or developmental level. f. Other:	a. Significant normative transition requiring adjustment, such as change in household members, or new school or teacher. b. Minor interpersonal loss or conflict, such as peer relationship ending due to change in residence or school, or illness or death of distant extended family member that has moderate effect on child and family. c. Transient but significant illness or injury (e.g., pneumonia, broken bone) d. Somewhat inadequate material resources or threat of loss of resources due to parental underemployment, separation, or other factor. e. Expectations for performance at home or school that create discomfort. f. Potential for exposure to substance use exists. g. Other:	a. Disruption of family/social milieu (e.g., move to significantly different living situation, absence or addition of parent or other primary care taker, serious legal or school difficulties, serious drop in capacity of parent or usual primary care taker due to physical, psychiatric, substance abuse, or other problem with expectation of return to previous functioning). b. Interpersonal or material loss that has significant impact on child and family. c. Serious illness or injury for prolonged period, unremitting pain, or other disabling condition. d. Danger or threat in neighborhood or community, or sustained harassment by peers or others. e. Exposure to substance abuse and its effects. f. Role expectations that exceed child or adolescent's capacity given age, status, and developmental level. g. Other:	a. Serious disruption of family or social milieu due to illness, death, divorce, or separation of parent and child or adolescent; severe conflict; torment and/or physical/sexual abuse or maltreatment. b. Threat of severe disruption in life circumstances, including threat of imminent incarceration, lack of permanent residence, or immersion in alien and hostile culture. c. Inability to meet needs for physical and/or material well-being. d. Exposure to endangering, criminal activities in family and/or neighborhood. e. Difficulty avoiding substance use and its effects. f. Other:	a. Traumatic or enduring and highly disturbing circumstances, such as 1) violence, sexual abuse or illegal activity in the home or community, 2) the child or adolescent is witness to or a victim of a natural disaster, 3) the sudden or unexpected death of a loved one, 4) unexpected or unwanted pregnancy. b. Political or racial persecution, immigration, social isolation, language barriers, and/or illegal alien status. c. Incarceration, foster home placement or re-placement, inadequate residence, and/or extreme poverty or constant threat of such. d. Severe pain, injury, or disability, or imminent threat of death due to severe illness or injury. e. Other:
Rationale/Comments:				

* Requires level 5 independent of other dimensions
**Requires level 6, independent of other dimensions

Child and Adolescent Service Intensity Instrument (CASII)				
Child Name:_____ Child ID:				
Dimension IV. Recovery Environment: Environmental Support				
Highly Supportive Environment (1)	**Supportive Environment (2)**	**Limited support in Environment (3)**	**Minimally Supportive Environment (4)**	**No Support in Environment (5)**
a. Family and ordinary community resources are adequate to address child's developmental and material needs. b. Continuity of active, engaged primary care takers, with a warm, caring relationship with at least one primary care taker. c. Other:	a. Continuity of family or primary care takers is only occasionally disrupted, and/ or relationships with family or primary care takers are only occasionally inconsistent. b. Family/primary care takers are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes. c. Special needs are addressed through successful involvement in systems of care (e.g., low level special education, tutoring, speech therapy). d. Community resources are sufficient to address child's developmental and material needs. e. Other:	a. Family has limited ability to respond appropriately to child's developmental needs and/or problems, or is ambivalent toward meeting these needs or addressing these problems. b. Community resources only partially compensate for unmet material and emotional needs and/or child or adolescent has limited or inconsistent access to network. c. Family or primary care takers demonstrate only partial ability to make necessary changes during treatment. d. Other:	a. Family or primary care taker is seriously limited in ability to provide for the child's developmental, material, and emotional needs. b. Few community supports and/or serious limitations in access to sources of support so that material, health, and/or emotional needs are mostly unmet. c. Family and other primary care takers display limited ability to participate in treatment and/or service plan (e.g., unwilling, inaccessible, cultural dissonance). d. Other:	a. Family and/or other primary care takers are completely unable to meet the child's developmental, material, and/or emotional needs. b. Community has deteriorated so that it is unsafe and/or hostile to the needs of children and adolescents for education, recreation, constructive peer relations, and mentoring from unrelated adults. **c.** Lack of liaison and cooperation between child-servicing agencies**.** d. Inability of family or other primary care takers to make changes or participate in treatment. e. Lack of even minimal attachment to benevolent other, or multiple attachments to abusive, violent, and/or threatening others. f. Others:
Rationale/Comments:				

Child and Adolescent Service Intensity Instrument (CASII)				
Child Name: _____ Child ID:				
Dimension V. Resiliency				
Full Resiliency and/or Response to Treatment (1)	**Significant Resiliency and/or Response to Treatment (2)**	**Moderate or Equivocal Resiliency and/or Response to Treatment (3)**	**Poor Resiliency and/or Response to Treatment (4)**	**Negligible Resiliency and/or Response to Treatment (5)**
a. Child has demonstrated significant and consistent capacity to maintain development in the face of normal challenges, or to readily resume normal development following extraordinary challenges. b. Prior experience indicates that efforts in most types of treatment have been helpful in controlling the presenting problem in a relatively short period of time. c. There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment. d. Other:	a. Child has demonstrated average ability to deal with stressors and maintain developmental progress. b. Previous experience in treatment has been successful in controlling symptoms but more lengthy treatment is required. c. Significant ability to manage recovery has been demonstrated for extended periods, but has required structured settings or ongoing care and/or peer support. d. Recovery has been managed for short periods of time with limited support or structure. e. Able to transition successfully and accept changes in routine with minimal support. f. Other:	a. Child has demonstrated an inconsistent or equivocal capacity to deal with stressors and maintain normal development. b. Previous experience in treatment at low level of intensity has not been successful in relief of symptoms or optimal control of symptoms. c. Recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings. d. Has demonstrated limited ability to follow through with treatment recommendations. e. Developmental pressures and life changes have created temporary stress. f. Able to transition successfully and accept change in routine most of the time with a moderate intensity of support. g. Other:	a. Child has demonstrated frequent evidence of innate vulnerability under stress and difficulty resuming progress toward expected developmental level. b. Previous treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure to treatment. c. Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings. d. Developmental pressures and life changes have created episodes of turmoil or sustained distress. e. Transitions with changes in routine are difficult even with a high degree of support. f. Other:	a. Child has demonstrated significant and consistent evidence of innate vulnerability under stress, with lack of any resumption of progress toward expected developmental level. b. Past response to treatment has been quite minimal, even when treated at high levels of care for extended periods of time. c. Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure. d. Developmental pressures and life changes have created sustained turmoil and/or developmental regression. e. Unable to transition or accept changes in routine successfully despite intensive support. f. Other:
Rationale/Comments:				

Child and Adolescent Service Intensity Instrument (CASII)

Child Name: _____ Child ID:

Dimension VI. Treatment, Acceptance and Engagement: Child or Adolescent Acceptance and Engagement

Optimal (1)	**Constructive (2)**	**Obstructive (3)**	**Adversarial (4)**	**Inaccessible (5)**
a. Quickly forms a trusting and respectful positive therapeutic relationship with clinicians and other care providers. b. Able to define problem(s) and accepts others' definition of the problem(s), and consequences. c. Accepts age-appropriate responsibility for behavior that causes and/or exacerbates primary problem. d. Actively participates in treatment planning and cooperates with treatment. e. Other:	a. Able to develop a trusting, positive relationship with clinicians and other care providers. b. Unable to define the problem, but accepts others' definition of the problem and its consequences. c. Accepts limited age-appropriate responsibility for behavior. d. Passively cooperates in treatment planning and treatment. e. Other:	a. Ambivalent, avoidant, or distrustful relationship with clinicians and other care providers. b. Acknowledges existence of problem, but resists accepting even limited age-appropriate responsibility for development, perpetuation, or consequences of the problem. c. Minimizes or rationalizes problem behaviors and consequences. d. Unable to accept others' definition of the problem and its consequences. e. Frequently misses or is late for treatment appointments and/or is noncompliant with treatment, including medication and homework assignments. f. Other:	a. Actively hostile relationship with clinicians and other care providers. b. Accepts no age-appropriate responsibility role in development, perpetuation, or consequences of the problem. c. Actively, frequently disrupts assessment and treatment. d. Other:	a. Unable to form therapeutic working relationship with clinicians or other care providers due to severe withdrawal, psychosis, or other profound disturbance in relatedness. b. Unaware of problem or its consequences. c. Unable to communicate with clinician due to severe cognitive delay or speech/language impairment. d. Other:

Rationale/Comments:

Child and Adolescent Service Intensity Instrument (CASII)

Child Name:_____ Child ID:

Dimension VI. Treatment, Acceptance and Engagement: Parent and/or Surrogate Care Giver Acceptance and Engagement

Optimal (1)	Constructive (2)	Obstructive (3)	Adversarial (4)	Inaccessible (5)
a. Quickly and actively engages in a trusting and positive relationship with clinician and other service providers. b. Sensitive and aware of the child's or adolescent's needs and strengths as they pertain to the presenting problem. c. Sensitive and aware of the child's or adolescent's problems and how they can contribute to their child's recovery. d. Active and enthusiastic in participating in assessment and treatment. e. Other:	a. Develops positive therapeutic relationships with clinicians and other primary care takers. b. Explores the problem and accepts others' definition of the problem. c. Works collaboratively with clinicians and other care takers in development of treatment plan. d. Cooperates with treatment plan, with behavior change and good follow-through on interventions, including medications and homework assignments. e. Other:	a. Inconsistent and/or avoidant relationship with clinicians and other care providers. b. Defines problem, but has difficulty creating a shared definition of development, perpetuation, or consequences of the problem. c. Unable to collaborate in development of treatment plan. d. Unable to participate consistently in treatment, with inconsistent follow-through. e. Other	a. Contentious and/or hostile relationship with clinician and other care providers. b. Unable to reach shared definition of the development, perpetuation, or consequences of problem. c. Able to accept child's or adolescent's need to change, but unable or unwilling to consider the need for any change in other family members. d. Engages in behaviors that are inconsistent with the treatment plan. e. Other:	a. No awareness of problem. b. Not physically available. c. Refuses to accept child's or adolescent's, or other family members' need to change. d. Unable to form relationship with clinician or other care provider due to significant cognitive difficulties, psychosis, intoxication, or major mental illness or impairment. e. Other

Rationale/Comments:

Appendix C

VI

CONSENT FOR STUDENT PARTICIPATION IN [redacted] OUTCOME STUDY

Dear Parent or Guardian, Approved Feb. 5, 2008

[redacted] is conducting an ongoing study of our treatment effectiveness. The study involves asking students to complete two surveys, one at the beginning of treatment and a second prior to discharge. With your consent, your child will be asked to participate. The purpose of the study is to learn how we can better provide the experiences, supports, and boundaries that help youth overcome adversity and develop healthy attitudes and behavior.

The study is being conducted by [redacted] Director of Training and Development for [redacted] Dean has served youth and families at [redacted] for 34 years. You will have the opportunity to meet him through the Parents as Partners program.

Procedures: If you agree that your child can participate in this study, we will ask him or her to complete a survey about developmental assets. We will ask your child to complete the survey again before discharge from our program.

Risks and benefits of being in the study: The survey asks youth to describe their attitudes and values about family, school, friends, and activities by indicating whether they agree or disagree with a number of statements. They will not be asked to disclose confidential or personal information. By completing the surveys they will help us learn how we can improve our services to the youth in our care.

Confidentiality: Consistent with [redacted] policy your child's confidentiality will be protected. Individual scores on the surveys will only be shared with the treatment team for the purpose of developmental assessment and planning.

Findings of the outcome study will not identify the students involved by name. Only age, grade, gender, race, and an agency code number are recorded from the completed surveys. The information provided by the surveys will be reported as cumulative data (all together) and will not allow readers to identify individual students. As a parent you are welcome to request a copy of the current survey results.

Voluntary nature of study: Your child can choose whether or not he or she wants to participate. Students are also free to opt out of the study at any time. Whether or not youth participate will make no difference in how they are treated in our program or by our staff.

Contacts and Questions: The researcher for this study is [redacted] If you have questions or concerns for him you can contact him at [redacted] You may also contact your student's Team Supervisor.

Statement of Informed Consent: I understand that if I have any questions regarding this research that have not been answered by the researcher or [redacted] case manager.

I have read the above information and approve my child's participation.

Student Name (please print): _____

Parent or Guardian Signature: _____ Date: _____

Appendix D

XXXXX CHILDREN'S XXXXXX

STRENGTH-BASED TREATMENT PLANNING GUIDE:

ASSET BUILDING TREATMENT INTERVENTIONS

1st Edition 2007; Current Edition Revised 05/2013

INDEX

Other Related Diagnosis: Conduct Disorder

Presenting Problems: Easily loses temper, refuses to accept limits or follow directions, argues with adults, deliberately annoys others, is easily annoyed, blames others for mistakes or misbehavior, is often resentful and angry, and often spiteful and vindictive. Oppositional students seek power in relationships and often claim equality with adults.

REACTIVE ATTACHMENT DISORDER, 313.89 pp: 13-14

Presenting problems: Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interaction, may be excessively inhibited or indiscriminately sociable, "love-hate" relationships with adults, possible experience with abuse or neglect, depressive symptoms negatively impacting adult relationships, often uses misconduct to push adults away.

MOOD DISORDERS, pp: 15-19

Relevant Diagnosis: Dysthymia, Major Depressive Disorder, Depressive Disorder NOS, Bi-polar disorders I & II, Cyclothymic Disorder, Mood Disorder NOS

Presenting Problems: In children: hyperactive behavior, significant conflict with primary parent, excessive worrying, tearfulness, unprovoked hostility, poor communication, running away

In adolescents: Irritable, isolated from family and friends, sudden deterioration in academic performance, loss of interest in previous activities, sad, hopeless, changes in sleep patterns, suicidal thoughts

ANXIETY DISORDERS, pp. 20-21

Relevant Diagnosis: Social Anxiety Disorder, Generalized Anxiety Disorder, Panic Disorder, Phobias, Obsessive Compulsive Disorder, PTSD

Presenting Problems: Level of anxiety or fear markedly exceed the level typical of developmental stage, high motor tension, autonomic hyperactivity (high heartrate, breathing, nausea, diarrhea), hypervigilant, phobias, excessive worry about abandonment, excessive guilt

BORDERLINE PERSONALITY DISORDER, pp. 22-24

Presenting Problems: Emotional dysregulation, intense negative emotions, identity confusion, impulsive behavior, interpersonal instability, non-suicidal self injury, suicidal attempts, aggression related to past abuse

PERVASIVE DEVELOPMENTAL DISABILITIES/AUTISM SPECTRUM DISORDERS, pp. 25-27

Relevant diagnosis: Asperger's Disorder, PDD-NOS, High functioning Autism

Presenting problems: Unable to take another's perspective, inability to "read" people, inflexible about shifting attention or changing activities, difficulty deciding which stimuli to attend to, difficulty organizing and prioritizing, gets stuck on tangents and off topic, has difficulty generalizing skills to new settings, highly sensitive to certain sensory stimulus (sight, smell, sound, feeling).

FETAL ALCOHOL SPECTRUM DISORDER, pp. 28-29

Presenting Problems: Irreversible brain trauma secondary to prenatal alcohol abuse. Treatment focuses on secondary diagnoses and disabilities which commonly include ADHD acquired, speech and language deficits (particularly pragmatic and social communication), visual/motor and sensory deficits, mental retardation, oppositional behavior, conduct problems, attachment disorder, posttraumatic stress, depression.

References, pp. 30-33

Appendix: Pre/post asset measures, pp. 34-39

Guidelines to intervention:

Following are evidence-based interventions for the primary mental health issues faced by the students and families we serve. An outcome study conducted in 2007-2008 clearly demonstrated the efficacy of the asset-building approach to serious emotional disturbance (Grace, 2008). The sources of evidence for these interventions are cited in the reference list at the end of this guide. These interventions share a developmentally-oriented, strength-based approach because interventions based on a symptom reduction approach are less effective and less durable (Roth, Brooks-Gunn, Murray, & Foster, 1998). The literature associated with positive psychology maintains that helping clients develop resilience can increase the effortful control of youth over externalizing behavior problems and reduce internalizing symptoms (Seligman, Schulman & DeRubeis, 1999; Eisenberg et al, 2004).

Although the guide is organized by diagnosis, the author recognizes that the seriously emotionally disturbed students we serve have an average of four and a half diagnoses. Consequently, for the treatment team in general, and the case manager in particular, it is useful to have some guidance as to where to begin. The following principles can provide a rough guide to planning:

1. Treat mood disorders first. Treatment will typically include medication therapy. Note that during the initial period of medication therapy there may be an increased risk for suicidal ideation. A sound risk management plan is essential. It is necessary to address a student's mood before he or she is likely to respond to efforts to teach coping skills. Depressed mood represents stress and practitioners need to understand no one learns well under high levels of stress.
2. Conduct problems need to be addressed before trying to build capacity for relationships. Youth with attachment issues often use misconduct to distance themselves from others and maintain a sense of control. The literature disputes the belief that attachment disorders "cause" conduct problems. In general, they should be treated as separate but related issues.

3. Neurological conditions may limit capacity and require helping adults to distinguish between misbehavior that is a lack of ability versus a lack of motivation. For example, some students will be diagnosed with both Asperger's disorder (a neurological condition that implies a limited capacity to accurately interpret social realities) and Oppositional Defiant Disorder (a diagnosis that assumes the ability to accurately interpret social reality). The evaluator concluded that while there was some degree of impairment, in many situations the student did understand that his behavior was aggravating to others. Because diagnostic categories all represent a range of functioning, there is no substitute for knowing the individual students we work with. To the degree that students lack capacity to cope, treatment should provide supports and structures that help compensate and enable the young person to experience success.
4. To change behavior, ask yourself what you want the student to do instead of the problem behavior. (Do not assume the absence of misbehavior will be good behavior.) Focus on teaching (modeling and reinforcing) those skills. If you have properly identified what makes behavior rewarding for the student, the new behavior will quickly replace the old (Premack, 1965).

Asset-building model:

The following interventions are designed to build one or more of eight critical assets. Multiple studies (Scales, 1999; Oman et al., 2002; Reininger et al., 2003; Murphey et al., 2004; Eisenberg, et al., 2004) found these assets to significantly reduce risk factors (behavior problems and symptoms of stress) associated with the identified diagnosis.

These eight assets are:	Number of significant associations with reduced risk behaviors
▸ Family support	7
▸ Achievement motivation	8
▸ Decision-making skills	8
▸ Adult mentors	5
▸ Positive peer relations	8
▸ Friendship skills	1
▸ Program activities	5
▸ Community service	3

In the following guide, these assets are described as goals to improve healthy functioning and reduce the negative impact of a diagnosed mental illness. Achieving each goal is broken into

steps described as treatment objectives. Each objective, with evidence-based interventions designed to achieve the objective, is intended to be accomplished during a treatment plan period (generally about three months). *Information in italics is intended for case managers, not to be duplicated in the plan itself.*

Evaluation and modification of treatment:

Each goal area includes a brief but valid pre/post measure (Oman, 2009) of the asset the following interventions are designed to develop or strengthen. These measures will enable the case manager to assess the effectiveness of the intervention in both building healthy coping skills, and in reducing symptoms (by correlating asset strength to the frequency or severity of behavior problems). Collectively, analysis of pre/post asset scores along with summary student data (sex, age, diagnosis) will continually inform and improve the effectiveness of approaches to specific disorders.

At the beginning and end of each treatment planning period an assessment of asset strength should be completed. If the treatment interventions resulted in developing or strengthening the targeted asset and reducing symptoms, the treatment focus should generally move on to the next objective necessary to achieve the goal. If the objective was not achieved the team needs to determine whether progress justifies continuing with the current interventions or if a different approach is needed. For example, continuing a plan may be reasonable if, although overall progress was not adequate, the student made significant gains in the last few weeks of the treatment period. However, do not continue a treatment approach without evidence that it is reasonable to expect adequate progress. In most cases, this guide provides options to pursue an alternate path to the same goal. The treatment team should consider another related objective and set of interventions to achieving the goal.

DISRUPTIVE BEHAVIOR DISORDER, 312.9

Symptoms: Disruptive Behavior Disorder is characterized by conduct or oppositional defiant behaviors that do not meet the criteria for Conduct Disorder or Oppositional Defiant Disorder.

Other Related Diagnosis: Explosive Behavior Disorder

Presenting Behavior Problems: Physical aggression, property destruction, verbal aggression, verbal explosiveness

Discharge goal: _____ will reduce the severity of symptoms related to disruptive behavior disorder by learning **decision-making skills** leading to improved personal restraint.

NOTE: *When student's diagnosis also indicates a mood disorder or impairment to student's ability to focus attention, review case with psychiatrist to determine if medication therapy is indicated.*

Objectives:

1. _____ will regularly practice activities which build self-discipline and tolerance for delayed gratification.

Measurable Indicators:

A. Complete pre/post asset measure, survey I found in Appendix.

B. Percent of times per week student follows through with planned activities.

C. Reduction in frequency/severity of physical/verbal aggression.

Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Participate in a group fitness program at least three times a week emphasizing aerobic exercise: running, swimming, xc skiing, hiking, biking, etc. Complete a personal fitness exercise routine daily.
    i. Self-monitor behavior by maintaining a personal fitness log, recording daily workouts and weekly totals.

    Glasser (1976) and Allison, et al. (1995) found that regular aerobic exercise reduced aggressive behavior.

    Svingen (2006, personal communication) recommended teaching self-discipline in the context of physical exercise as a precursor to learning emotional self-discipline.

b. Participate in a chess club (after-school activity) or role-playing games which require careful planning, twice or more each week.

    Zayas and Lewis (1980) noted when adults facilitated role play games they could insure that students experience consequences for anti-social

behavior and rewards for pro-social choices. Their study of maladjusted adolescent boys found such experiences had the effect of changing student value-orientations.

2. _____ will purposefully engage in activities which provide a healthy outlet for emotion.

Jongsma and associates (2003) recommend teaching aggressive youth to express anger through respectful verbalizations, art mediums, and healthy physical outlets.

Measurable Indictors:

A. Complete pre/post asset measure, survey C found in Appendix
B. Percent of recorded weekly follow through on planned activities.
C. Reduction in frequency/intensity of physical or verbal acting out.

Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Participate in creative arts activities, including in-school and after-school programs, at least three hours a week.
    i. Regularly share creations with adults.
b. Engage in 30 minutes of aerobic activity daily (walking, running, biking, swimming).
c. Participate in games and sports which provide a controlled and safe context for aggressive behavior (e.g. kicking balls or throwing foam balls at opponents).
d. Talk to adults daily about emotions (adults coach student in skill-building during teaching conferences).
e. Journal daily about emotions and share with adults during daily conferences as well as in therapy sessions.
f. Discuss efforts to maintain self-control with group members at least weekly.

3. _____ will regularly reflect on decision-making skills, especially values and choices.

Measurable Indictor:

A. Complete pre/post asset measure, survey I found in Appendix

B. Amount of time spent in mentoring activity per week reported as percent of planned mentoring activities weekly.

C. Reduction in aggressive behavior/verbal acting out.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Spend time each week with an adult mentor.
Oman and associates (2002) found mentoring was uniquely effective in deterring violent behavior among young adolescent males from single parent homes.

i. Focus on activities of interest to student.
ii. Provide personalized adult support.
iii. Convey pro-social messages about self-control and respect for others.

4. _____ will regularly participate in structured and supervised **youth programs**.
Caldwell, et al. (2004) claims many youth are ill-equipped to self-initiate meaningful activities. She notes it is unreasonable to assume that if youth are prevented from engaging in risky behavior they will possess skills for the constructive and meaningful use of free time. The lack of ability to make good friends is associated with spending time instead with antisocial and delinquent peers, which is a risk factor for antisocial conduct (Poulin, Dishion & Haas, 1999).

Measurable Indictor:

A. Complete pre/post asset measure, survey I found in Appendix I
B. Number of times per week student participates in organized youth activities.
C. Resistance to negative peer pressure on homevisits.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Regularly interact with pro-social peers who model age-appropriate self-control and decision-making skills.
i. Staff encourage responsible peers to help facilitate and/or lead activities.

b. Unsupervised peer activities limited to peers who model pro-social values and self-control.
c. Provide opportunities to participate in structured youth programs during home visits, to build relationships and routines in preparation for discharge.

ATTENTION DEFICIT HYPERACTIVITY DISORDER, 314.01

Symptoms include inattention and hyperactivity-impulsivity which significantly impair the student's academic and/or social functioning and are not better accounted for by another mental health disorder such as mood disorder, anxiety disorder or pervasive developmental disorder.

Relevant Diagnosis: ADD, ADHD Combined Type; ADHD Predominately Inattentive Type

Related Diagnosis: Learning Disorders: Reading Disorder; Mathematics Disorder; disorder of Written Expression; Academic Problem

Presenting Behavior Problems: Inattentiveness, impulsive behavior, a history of performance below expected level given ability, fails to complete homework, poor study skills, postpones homework in preference other activity, history of family members experiencing academic problems and/or disinterest, history of unrealistic parental pressure negatively affecting performance, student acts out when frustrated in learning, anxious about tests, academic performance has declined in response to stressful event.

NOTE: For ADHD or related diagnosis, review possible medication therapy with consulting psychiatrist.

Discharge goal: _____ will reduce symptoms of inattentiveness and impulsiveness by strengthening the asset of **achievement motivation** as demonstrated by academic performance commensurate with his/her intellectual ability.

Achievement motivation is an internal asset resulting from external structures which challenge and support the student to discover their capacity for success.

Objectives:

1. _____ will demonstrate a commitment to learning by completing assigned work on a daily basis.

   The following interventions are advocated by Jongsma and his associates (2003).

   Measurable Indicators:

   A. Complete pre/post asset measure, survey B found in Appendix
   B. Daily completion of assigned school work.

C. Improvement in grade average.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. _____ will receive individualized instruction.
b. Time for homework is provided daily.
c. _____ is responsible to maintain a homework log and have all materials available. Adults will pre-teach students about their responsibilities.
d. Adults will check with teachers daily to insure accountability.
e. Adults will discuss school (learning, progress, and value of) daily with the student at or near the supper hour.
    i. Plans are made for completion of homework.
    ii. Homework is a priority over social and recreational activities.
    iii. Adults will arrange "breaks" as appropriate, based on progress toward completion of assigned work.
f. Adult assistance is available each school day evening.
g. Set challenging goals for academic achievement with commensurate rewards.
    i. Goals/contracts can be with individual student or student group.

2. _____ will be actively engaged in the school community.
A study by Huang and associates (2003) found a strong affiliation with the school community contributes significantly to motivation to learn and improved standardized test scores. No other educational intervention has been found to achieve similar improvements except teaching to the test.

Measurable Indicators:

A. Complete pre/post asset measure, survey I found in Appendix
B. Number of times per week student is engaged in any of the designated activities, reported as a percent of planned activities.
C. Improvement in grade average.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Participate in after-school program activities.
b. Participate in student council.
c. Participate in student community service projects. (E.g. tutoring younger students, contributing art work for food shelf fund raiser, musical performances for senior citizens, etc.)
d. Participate in Junior Achievement club.

OPPOSITIONAL DEFIANT DISORDER, 313.81

Symptoms: A pattern of negative, hostile and defiant behavior lasting 6 months or more involving 4 or more of the problem behaviors described below and which significantly impair

academic and/or social functioning. The behavior does not meet the criteria for Conduct Disorder and is not due to either a psychotic or mood disorder.

Other Related diagnosis: Conduct Disorder, Reactive Attachment Disorder

Presenting Problems: Easily loses temper, refuses to accept limits or follow directions, argues with adults, deliberately annoys others, is easily annoyed, blames others for mistakes or misbehavior, is often resentful and angry, and often spiteful and vindictive. Oppositional students seek power in relationships and often claim equality with adults.

Discharge goal: _____ will reduce the severity and frequency of oppositional behaviors by learning to make **responsible** and helpful **choices**.

*Responsible choices are an outcome of building the asset of **decision-making skills***

***NOTE:** The following asset-building interventions assume that appropriate boundaries and consequences are in place to hold youth accountable for anti-social conduct. These disciplines should include:*

- *Establish clear expectations and consequences, including rewards for meeting expectations and punishments for refusal. Think these expectations through carefully, don't sweat the small stuff, focus on key issues in the student's relationships (accepting authority, demonstrating respect, being responsible for homework and chores).*
- *State clearly what behaviors you want. Be sure you can and do check on compliance.*
- *Use positive reinforcement to teach pro-social conduct.*
- *Use contracts to target specific desired behaviors. Make the measurements visible and concrete. Increase students' chances for success by rewarding the accumulation of tokens.*
- *Remember you have total control over dispensing or withholding rewards as a consequence for behavior!*
- *When using punishment as a disciplinary method "link" consequences that require cooperation to those that adults have complete control.*
- *When possible, allow youth to choose the punishment for their misconduct from a list previously reviewed with him or her. (This tactic tends to shift the student's focus onto his/her choices.)*
- *When correcting behavior, ask what, not why. Do not discuss or accept excuses.*
- *Confront "victim" tactics. Focus on the student's choices.*
- *Hold child responsible to fix what he or she breaks (all the time, whether he "meant to" or not).*
- *Consistently follow through on consequences, EVERY TIME. Stick with your approach. Adult endurance is more important than the size of the consequence.*

Objectives:

1. _____ will regularly engage in **service to others**.
   Based on the Premack principle (1965) service to others meets the same motivational needs to exercise power while replacing problem behaviors.

   Measurable Indicator:

   A. Complete pre/post asset measure, survey J found in Appendix
   B. Percent of assigned tasks completed.
   C. Reduction in arguing/refusal/anti-social conduct.
   Expected level: ___ Objective accomplished: yes: ___ no ___

   Possible Interventions:

   a. He/she will complete daily assigned tasks/chores to help the group or family.
   b. He/she will participate in weekly community service with his/her group.
      According to Eccles and Gootman (2002) youth who believe they make a difference in the world experience an enormous and very healthy sense of personal power.
   c. He/she may be provided an opportunity to assist another student as a peer tutor, or possibly by mentoring a younger student with similar behaviors.
   d. He/she will seek out and consistently follow through with one or more special assignments that he/she takes responsibility for. These may include:
      i. Completing group jobs without direct supervision, such as shoveling walks, sweeping the kitchen or gym, vacuuming halls, weeding gardens, raking, etc.
   e. Based on the successful accomplishment of the above steps and responsible conduct, _____ may apply for a paid position on or off campus.

2. _____ will learn to make **responsible choices**.

   Measurable Indicator:

   A. Complete pre/post asset measure, survey I found in Appendix
   B. Based on [group check, daily conference or journal entry], percent of time student either makes responsible choices or accepts responsibility for poor choices, in contrast to projecting or denying responsibility.
   Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Adults will regularly affirm their confidence in _____'s abilities.
b. He/she will be involved in family/group decision making.
c. _____'s group will practice healthy lifestyle choices.
   Taking good care of one's self physically and emotionally is an excellent way to develop personal power (Eccles and Gootman, 2002).

d. He/she will be involved in courses and activities designed to help teach problem-solving skills, friendship skills, cultural competence, resistance to negative peer pressure, and conflict resolution skills.
   Young people who develop social competence are more likely to experience a sense of personal power (Eccles and Gootman).

e. He/she will be given age-appropriate choices, including consequences for behavior.
   i. Adults will help _____ reflect on his/her choices in daily 1-1 conversation, in therapy, and in weekly group.
   ii. He/she will be challenged to distinguish between what he/she controls and what he/she does not. (He/she does not control anyone else.)
   iii. Adults will be willing to let _____ be miserable if he/she chooses to engage adults in power struggles. However, the choices he/she is making will be made clear before _____ is held accountable for his/her behavior.

C. Helping adults and parents will provide _____ with clear expectations and accountabilities to use good **decision-making skills**.

Measurable Indicator:

A. Complete pre/post asset measure, survey I found in Appendix
B. Percent of time student takes initiative to be accountable (tells adults where he will be, is responsible to follow through).
   Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Involve _____ in regular reviews of family/group rules and boundaries. Adjust as mature and responsible behavior indicate, but be aware that even 18 year olds need boundaries.
   Boundaries are essential to allowing kids to be kids. They should only need to make choices within their capabilities and only experience consequences they can live with (Keim, seminar, 1996).

b. Develop and model an expectation that all family members, including adults, communicate where they will be and when.
c. Develop a parent network with the parents of _____ friends. Have an agreement with adults and your child that youth will only be allowed in each other's homes with adult supervision.
d. _____'s parents (with support from his probation officer or social worker) will develop a list of acceptable out-of-school activities from which he can choose. He will be expected to abide by this structure which establishes where he is, with whom, doing what, until when, and how his follow through can be checked.

REACTIVE ATTACHMENT DISORDER, 313.89

Symptoms: Markedly disturbed and developmentally inappropriate social relatedness in most contexts evident before age 5 and evidenced by either excessively inhibited, hypervigilant, and/or highly ambivalent and contradictory responses; or by indiscriminate sociability with diffuse attachments such as excessive familiarity with strangers.

Presenting problems: Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interaction, may be excessively inhibited or indiscriminately sociable,

"love-hate" relationships with adults, possible experience with abuse or neglect, depressive symptoms negatively impacting adult relationships, often uses misconduct to push adults away.

Discharge goal: _____ will reduce symptoms of [*identify one*: inhibition or indiscriminate sociability], anxiety and emotional dysregulation by developing improved capacity to elicit **support** from his/her [*identify available support system*: parents, supportive adults, and/or healthy peers].

Objectives:

1. _____ will participate in daily family communication with adults.

   Measurable Indicator:

   A. Complete pre/post asset measure, survey A found in Appendix
   B. Completion of daily conference, including completed journal.
   C. Reduction in targeted conduct problems.

   Expected level: ___ Objective accomplished: yes: ___ no ___

   Possible Interventions:

   a. _____ will engage in daily conversation at the table and during group.
   b. _____ will keep a daily journal explaining why bad things happen.
      According to Becker-Weidman (2006) DBT is effective with trauma related attachment disorders. Counseling staff familiar with DBT and working in partnership with the therapist can serve as point of performance coaches.

   c. Adults will spend focused, individual time with _____ daily. During this time they will review the journal entries with _____ and help him/her reflect on whether his/her problems are:
      i. Internally or externally caused
      ii. Global (effect everything else) or specific
      iii. Stable (will always be like this) or instable (is likely to be different soon)

      According to Seligman and his associates (1999) individuals can learn optimism by learning to explain bad things as external, specific, and instable. Optimistic people believe the future will be better than the past.

d. _____'s caregivers will contact him/her at least weekly to visit.
e. _____ will write home weekly. Staff will provide a photo of an activity that week to include in the letter.

2. _____ will participate in a weekly activity with a **mentor**.

Measurable Indicator:

A. Complete pre/post asset measure, survey F found in Appendix
B. Completion of scheduled mentoring activity weekly.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. _____'s mentor will focus on activities of interest to _____.
b. The purpose of mentoring will be to provide personalized adult support. *According to Minnis, Marwick, Arthur & McLaughlin (2006) concordant intersubjectivity is the key to attachment, i.e. the experience and affirmation of emotionally being "on the same page" as someone else.*

c. Mentoring time will not be cancelled due to behavior problems. If there are safety concerns or accountability issues activities will be planned on campus. *Welsh, Vianna, Petrill & Mathias (2007) found conduct problems were not clearly linked to attachment difficulties. RAD youth should not be isolated when disciplined for acting out. Holding "therapies" lack support and are potentially harmful.*

3. _____ will regularly participate in structured and supervised **youth programs**. *According to Olmsted (seminar, 2002) treatment focus for children with attachment problems should be to build attachments with adults. Adolescents with histories of attachment problems should be encouraged to build relationships with healthy peers.*

Measurable Indicator:

A. Complete pre/post asset measure, survey G found in Appendix
B. Number of times per week student participates in program activities.
C. Increased interactions with responsible friends (versus strangers or anti-social peers).
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Regularly interact with pro-social peers who model age-appropriate self-control and decision-making skills.
    i. Staff will encourage responsible peers to help facilitate and/or lead activities.
b. Unsupervised peer activities limited to peers who model pro-social values and self-control.

MOOD DISORDERS

Symptoms: The severity and duration of depressive symptoms as well as cyclical patterns of mood, if any, are described by the following diagnosis. Mood Disorder NOS is used only when a distinction between depressive and bi-polar disorders is unclear.

Relevant Diagnosis: Dysthymia, Major Depressive Disorder, Depressive Disorder NOS, Bi-polar disorders I & II, Cyclothymic Disorder, Mood Disorder NOS

Presenting Problems: In children: hyperactive behavior, significant conflict with primary parent, excessive worrying, tearfulness, unprovoked hostility, poor communication, running away

In adolescents: Irritable, isolated from family and friends, sudden deterioration in academic performance, loss of interest in previous activities, sad, hopeless, changes in sleep patterns, suicidal thoughts

NOTE: Review case with consulting psychiatrist to insure appropriate medication therapy. Also review asset building interventions for anger management.

Discharge goal: _____ will report reduced stress related to symptoms of his/her [*specify*] *mood disorder* by learning to practice **healthy choices**.

*Healthy choices are a related to the asset of **decision-making skills**. Steps toward this goal may include any of the following objective statements which can build on student strengths. Use the asset measure following the chosen objective:*

Objectives:

1. _____ will demonstrate **healthy choices** by practicing coping skills and healthy lifestyle choices.

Measurable Indicator:

A. Complete pre/post asset measure, survey D found in Appendix
B. Percent of time student practices the specific coping skills listed above.
C. Reduction in targeted symptoms as measured by the RADS.

Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. _____ will practice four elements of a healthy lifestyle to aid coping with depression:
    i. Follow through on his/her doctor's prescription for medication therapy.
    ii. Eat regular, healthy meals.
    iii. Get daily exercise.
    iv. Get at least 8 hours of sleep on a regular schedule.
b. Adults will teach _____ the basis for depression and help him/her distinguish depression from situational problems.
    A comparison between the cause and treatment of diabetes and depression is often helpful to older children and adolescents.
c. _____ will read about historical/famous people who have coped with depression (or Bi-polar disorder) and contributed much to others.
    NOTE (b) and(c) can be good group therapy projects.

2. _____ will choose healthy (artistic, physical, verbal) outlets for expression of negative feelings.

Jongsma and associates (2003) recommend teaching aggressive youth to express anger through respectful verbalizations, art mediums, and healthy physical outlets.

Measurable Indicator:

A. Complete pre/post asset measure, survey I found in Appendix D
B. Number of times each week student participates in planned activities.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Participate in creative arts activities, including in-school and after-school programs, at least three hours a week.
    i. Regularly share creations with adults.
b. Participate in games and sports which provide a controlled and safe context for aggressive behavior (e.g. kicking balls or throwing foam balls at opponents).
c. Engage in aerobic exercise for 30 minutes or more daily.
d. Talk to adults daily about emotions (adults coach student in skill-building during teaching conferences).
e. Journal daily about emotions and share with adults during daily conferences as well as in therapy sessions.

3. _____ will participate in daily **family communication** with adults.

Measurable Indicator:

A. Complete pre/post asset measure, survey A found in Appendix
B. Completion of daily conference, including completed journal.
C. Reduction in targeted conduct problems.

Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

e. _____ will engage in daily conversation at the table and during group.
f. _____ will keep a daily journal explaining why bad things happen.

g. Adults will spend focused, individual time with _____ daily. During this time they will review the journal entries with _____ and help him/her reflect on whether his/her problems are:
    1. Internally or externally caused
    2. Global (effect everything else) or specific
    3. Stable (will always be like this) or instable (is likely to be different soon)

According to Seligman (1999) individuals can learn optimism by learning to explain bad things as external, specific, and instable. Optimistic people believe the future will be better than the past.

h. _____'s caregivers will contact him/her at least weekly to visit.
i. _____ will write home weekly. Staff will provide a photo of an activity that week to include in the letter.

4. _____ will participate in a weekly activity with a **mentor**.

Measurable Indicator:

A. Complete pre/post asset measure, survey F found in Appendix
B. Completion of scheduled mentoring activity weekly.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

d. _____'s mentor will focus on activities of interest to _____.
e. The purpose of mentoring will be to provide personalized adult support.
f. Mentoring time will not be cancelled due to behavior problems. If there are safety concerns or accountability issues activities will be planned on campus.

5. _____ will regularly participate in structured and supervised **youth programs**.

Measurable Indicator:

A. Complete pre/post asset measure, survey I found in Appendix
B. Number of times per week student participates in program activities.
C. Increased interactions with responsible friends (versus strangers or anti-social peers).
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Regularly interact with pro-social peers who model age-appropriate self-control and decision-making skills.
    i. Staff will encourage responsible peers to help facilitate and/or lead activities.
b. Unsupervised peer activities limited to peers who model pro-social values and self-control.

6. _____ will build the asset of **achievement motivation** by completing assigned school work on a daily basis.

Achievement motivation *is an internal asset resulting from external structures and which challenge and support the student to discover their capacity for success. The following interventions are advocated by Jongsma and his associates (2003).*

Measurable Indicator:

A. Complete pre/post asset measure, survey B found in Appendix
B. Daily completion of assigned school work.
C. Improvement in grade average.

Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. _____ will receive individualized instruction.
b. Time for homework is provided daily.
c. _____ is responsible to maintain a homework log and have all materials available. Adults will pre-teach students about their responsibilities.
d. Adults will check with teachers daily to insure accountability.
e. Adults will discuss school (learning, progress, and value of) daily with the student at or near the supper hour.
    i. Plans are made for completion of homework.
    ii. Homework is a priority over social and recreational activities.
    iii. Adults will arrange "breaks" as appropriate, based on progress toward completion of assigned work.
f. Adult assistance is available each school day evening.

C. Pre/post asset measure, Appendix: survey F

g. Adults will set challenging goals for academic achievement with commensurate rewards.
    i. Goals/contracts can be with individual student or student group.

7. _____ will strengthen the asset of **achievement motivation** by regularly engaging in school community.
   A study by Huang and associates (2000) found a strong affiliation with the school community contributes significantly to motivation to learn and improved standardized test scores. No other educational intervention has been found to achieve similar improvements except teaching to the test.

Measurable Indicator:

A. Complete pre/post asset measure, survey I found in Appendix
B. Participation in planned activities.
C. Improved grade average.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Participate in after-school program activities.
b. Participate in student council.
c. Participate in student community service projects. (E.g. tutoring younger students, contributing art work for food shelf fund raiser, musical performances for senior citizens, etc.)
d. Participate in Junior Achievement club.

8. _____ will increase positive interactions with peers and adults, including parents.
Eisenberg, et al. (2006) found asset development increased efforts to control externalized behavior problems and reduced internalizing symptoms of mental illness.

Measurable Indicator:

A. Complete pre/post asset measure, survey I found in Appendix
B. Participation in planned activities.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. _____ will participate in organized or community-based **program activities** on a regular basis (at least three times a week).
b. _____ will participate in a **friendship skills** course focused on teaching engagement skills, empathy, and conflict resolution.

c. _____ will participate in all family-oriented activities, including social activities, recreation, work, meals, and group meetings.
d. _____ will participate in **community service** projects.
e. _____ will be encouraged to participate in youth ministry activities provided his/her guardian is supportive.

ANXIETY DISORDERS

Symptoms: Criteria for Anxiety Disorder include excessive worry and anxiety more days than not for a period of 6 months or more about a number of events or activities. Student finds it hard to control the worry and experiences three or more of the following symptoms: restlessness, easily fatigued, difficulty concentrating, irritability, muscle tension and/or sleep disturbance.

Relevant Diagnosis: Social Anxiety Disorder, Generalized Anxiety Disorder, Panic Disorder, Phobias, Obsessive Compulsive Disorder, PTSD

Presenting Problems: Level of anxiety or fear markedly exceed the level typical of developmental stage, high motor tension, autonomic hyperactivity (high heartrate, breathing, nausea, diarrhea), hypervigilant, phobias, excessive worry about abandonment, excessive guilt

Discharge goal: _____ will learn to manage the symptoms of his/her anxiety by practicing the necessary **decision-making skills**.

Note: Review appropriateness of medication therapy with consulting psychiatrist.

The following interventions are based in part on studies by Stewart & Watt (2008); Gralton, Muchatuta, Morey-Canellas & Lopez (2008); and Mueser & Tanb (2008).

Objectives:

1. _____ will learn to identify anxious feelings and causes.

   Measurable Indicator:

   A. Complete pre/post asset measure, survey C found in Appendix

   B. Completion of daily conference, including completed journal.

   C. Reduction in targeted behaviors.

   Expected level: ___ Objective accomplished: yes: ___ no ___

   Possible interventions:

   a. Talk to adults daily about connection between events, feelings, and behavior (adults coach student in skill-building during teaching conferences).
   b. Journal daily about emotions and share with adults during daily conferences as well as in therapy sessions (*CBT effective with many adolescents according to Canadian Psychiatric Association, 2006).*
   c. Discuss efforts to express feelings and maintain self-control with group members at least weekly.

2. _____ will regularly practice recreational and relaxation activities to reduce stress.

   Measurable indicator:

   A. Complete pre/post asset measure, survey D found in Appendix
   B. Follow through on wellness plan.
   Expected level: ___ Objective accomplished: yes: ___ no ___

   Possible interventions:

   _____ will develop a personal wellness plan including:

   a. Engage in creative arts activities at least three hours a week.
      i. Regularly share creations with adults.
   b. Engage in 30 minutes of aerobic activity daily (walking, running, biking, swimming). *Numerous studies identify the therapeutic benefits of regular exercise in the treatment of anxiety disorder: Orwin (1973); Broocks, et al. (1998); Sabourin, et al. (2008); Smits, et al. (2008).*

c. Practice behaviors which help reduce stress daily, such as talking, listening to music, playing music, reading, etc.
d. With supportive adults, _____ develop his/her own "stress recovery plan" of helpful steps which adults will encourage him/her to take when he/she becomes anxious. *According to Abram, et al. (2006) PTSD is frequently co-morbid with chemical dependency and other mental health disorders.*

3. _____ will resolve key issues that are the source of his/her anxiety.

Measurable indicator:

A. Complete pre/post asset measure, survey C found in Appendix
B. Percentage of time _____ responsibly accepts consequences for choices.
C. Reduction in identified symptom of anxiety (e.g. reports of panic, hyperventilation, nausea, etc.)

Expected level: ___ Objective accomplished: yes: ___ no ___

Possible interventions:

a. Adults will help _____ connect patterns of thoughts, feelings and behaviors.
b. _____ will participate in experiences which build self-efficacy (*Bandura, 1994)* such as adventure counseling activities.
c. _____ will practice positive self-talk.
d. Adults will reduce efforts to control _____, affirming his/her ability to make choices and be responsible for consequences.

BORDERLINE PERSONALITY DISORDER

Symptoms: a pervasive pattern of instability of interpersonal relationships, self-image and affect as well as marked impulsivity.

Presenting Problems: Emotional dysregulation, intense negative emotions, identity confusion, impulsive behavior, interpersonal instability, non-suicidal self injury, suicidal attempts, aggression related to past abuse.

Discharge goal: _____ will reduce the severity of her emotional dysregulation and improve stress tolerance by practicing critical **decision-making skills**.

Steps to achieve this goal will include:

a) Improve emotional regulation
b) Increase stress tolerance
c) Improve interpersonal skills
d) Develop a more positive self-identity

Current studies (Oldershaw, Grima, Jollant, Richards, et al., 2009) find that the capacity to improve executive functioning (the ability to integrate thoughts and feelings) improves through adolescence into young adulthood, consequently improved decision-making skills can be developed into adulthood.

Dialectic Behavior Therapy has been found to be an effective therapeutic intervention with Borderline Personality Disorder. Staff should be familiar with the basic concepts of Dialectic Behavior Therapy and regularly consult with the student's therapist in order to be able to coach

the student to apply skills taught in therapy. The following interventions are based in part on work by Domes, Schulze & Herpetz (2009); Glenn & Klonsky (2009; Stepp, Epler, Jahng & Trull (2008).

Objectives:

1. _____ will practice "mindfulness" by attending to interpersonal interactions and their impact on her/his emotions.

   Measurable indicator:

   A. Complete pre/post asset measure, survey E found in Appendix
   B. Completion of daily journal and conference.
   C. Reduction in frequency _____ assigns negative motives to others.
   Expected level: ___ Objective accomplished: yes: ___ no ___

   Possible interventions:

   a. _____ will participate in group and individual therapy to learn the skills taught in DBT.
   b. _____ will practice behavioral descriptions of her interactions without ascribing motivation or intention, or using jargon to describe what happened ("she was acting like a jerk").
   c. _____ will record a satisfying and dissatisfying interaction in her journal each day.
   d. _____ will review responsible choices she made in her responses to others during a daily conference with staff.

2. _____ will practice **friendship skills**.

   Measurable indicator:

   A. Complete pre/post asset measure, survey H found in Appendix
   B. Completion of journal assignment
   C. Reduction in frequency of interpersonal conflicts per week
   Expected level: ___ Objective accomplished: yes: ___ no ___

   Possible interventions:

   a. _____ will participate in family/group activities.

b. _____ will practice problem-solving skills with adults and peers.
c. _____ will record daily examples of living out family/group values with her/his peers. The values must be agreed with staff, such as respect, kindness, responsibility.

3. _____ will match her/his emotional response to the situation.

Measurable indicators:

A. Complete pre/post asset measure, survey E found in Appendix
B. Completion of journal assignment.
C. Reduction of targeted behaviors such as self-injury or suicidal ideation.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible interventions:

a. _____ will describe the situation or interaction (including memories) she/he is responding to in behavioral terms and then express her emotion.
b. _____ will practice accepting feedback about the level (rather than the validity) of her emotion.
c. _____ will keep a daily journal recording the connection between her/his thoughts, feelings, and choices, including the consequences of her/his **decision making skills**.

4. _____ will allow staff to help her/him with her wellness recovery action plan (WRAP) when she/he feels stressed.

Measurable indicators:

A. Complete pre/post asset measure, survey F found in Appendix
B. Percent of time _____ responds to staff support as described in her/his WRAP (or risk management plan).
C. Reduction in targeted acting out behavior associated with stress.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible interventions:

a. _____ will develop and regularly update a wellness recovery plan outlining steps she/he requests staff take when she/he is experiencing a high level of stress or a crisis.
    i. The WRAP will include coaching steps for staff to help _____ with mindfulness, interpersonal effectiveness, and emotional response.
    ii. Staff will coach _____ to practice the skill needed to cope with the particular stress she is experiencing.
b. _____ will accept staff support, per her plan, when offered.

PERVASIVE DEVELOPMENTAL DISABILITIES/AUTISM SPECTRUM DISORDERS

Symptoms: (Asperger's Disorder) Impairment in social interaction manifested by at least two of the following: inability to understand or effectively use multiple nonverbal behaviors, failure to develop peer relations at an appropriate developmental level, fails to spontaneously share interests and achievements with others, lack of social or emotional reciprocity. Restricted and stereotyped patterns of behavior, interests and activities evidenced by at least one of the

following: an encompassing preoccupation with restricted pattern of interest that is abnormal in intensity or interest, inflexible adherence to specific, nonfunctional routines or rituals, repetitive motor mannerisms, persistent preoccupation with parts of an object.

Relevant diagnosis: Asperger's Disorder, PDD-NOS, High functioning Autism

Presenting problems: Unable to take another's perspective, inability to "read" people, inflexible about shifting attention or changing activities, difficulty deciding which stimuli to attend to, difficulty organizing and prioritizing, gets stuck on tangents and off topic, has difficulty generalizing skills to new settings, highly sensitive to certain sensory stimulus (sight, smell, sound, feeling).

Discharge Goal: _____ will display reduced levels of anxiety and frustration (manifested by acting out) as a result of building assets of **adult and peer support**.

The following interventions are based on Burton (seminar, 2007) and Bauer (2006).

Objectives:

1. _____ will strengthen the asset of **adult support**.

Measurable Indicator:

A. Complete pre/post asset measure, survey F found in Appendix
B. Percent of time student accepts adult support when experiencing a problem. (A follow-up goal can measure the percent of time the student seeks adult help rather than act out.)

Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. _____ will seek adult help when he has a problem.
    i. Adults will encourage _____ to let them help him solve the problem.
    ii. Adults will encourage _____ to join them in a quiet, relaxing place to talk (his bedroom, an empty lounge or office, etc.)
    iii. Adults will assume _____ does not fully understand what caused the problem and is therefore unable to resolve it. (For example, it is likely _____ does not understand the other person's perspective.)

iv. Adults will praise _____ for seeking help before the problem gets worse (as _____ learns to trust adults to help he will be encouraged to seek help before he acts out).
v. Adults will speak softly and calmly to _____ about what happened and how the problem can be resolved.

Note: Adults will often need to "play detective" in trying to understand the seemingly tangential associations made by students with PDD. Try to understand how seemingly disjointed topics are connected in the students experience.

vi. Adults will remind _____ that having a problem does not mean he is "in trouble" and encourage him to seek help if he is confused or frustrated, before he acts out.

2. _____ will practice attending and organizing skills.

Measurable Indicator:

A. Complete pre/post asset measure, survey C found in Appendix
B. Completion of daily tasks and routines as recorded in student chart.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. Teach attending skills:
    i. Adults will ask _____ to be the group recorder by writing the decisions made in group meetings on a flipchart for everyone to see. This will help _____ focus on the main points communicated in the group setting.
    ii. Adults will calmly redirect _____ to the topic when he/she moves on to a tangent. Adults will recognize that tangential associations are typical for students with PDD and do not indicate an effort to derail conversation.
b. Teach age-appropriate organizational strategies
    i. Adults will help _____ develop a daily calendar with his schedule of activities for each day. They will review the calendar with him each evening to make adjustments for changes in his schedule.
    ii. Adults will regularly ask _____ to remind them or the group of upcoming activities.
c. Use visual schedules and prompts
    i. Adults will develop picture guides (age appropriate photos or drawings) to help _____ complete daily routines and tasks.
    ii. They will teach him rhymes or raps to remember how to cope with stressful situations.

3. _____ will strengthen **peer relations** by sharing his skills or knowledge with other students at least once a week (e.g. role play card games, superhero comics, paper airplane design, model airplanes, etc.).

Measurable indicator:

d. Complete pre/post asset measure, survey G found in Appendix

A. Completion of planned activity weekly as recorded in Life Skills database. Expected level: ___ Objective accomplished: yes: ___ no ___

Possible interventions:

a. Adults will organize an activity around one of _____'s interests or skills.
    i. _____ will be encouraged to share or teach peers about one of his interests. If age-mates are not interested in the activity _____ will be encouraged to teach younger students the activity.
    ii. _____ will be encouraged to try new activities that play to his interests and strengths as a way to expand positive interactions with others.

FETAL ALCOHOL SPECTRUM DISORDER

Presenting Problems: Irreversible brain trauma secondary to prenatal alcohol abuse. Treatment focuses on secondary diagnoses and disabilities which commonly include ADHD acquired, speech and language deficits (particularly pragmatic and social communication), visual/motor and sensory deficits, mental retardation, oppositional behavior, conduct problems, attachment disorder, posttraumatic stress, and/or depression.

Discharge Goal: _____ will reduce behavior problems, anxiety and frustration by learning **decision-making skills** to improve:

- Emotional regulation,
- Self-control, and/or
- Social competencies

Note: According to Orsak (seminar, 2009), treatment is most effective when adults focus on doing basic behavioral interventions well.

- *Point of performance coaching is essential to learning behavior change.*
- *Teach new skills in small steps. If student is confused, give less information. Slow down and match the pace of cognitive processing.*
- *Do not delay correction.*
- *Emphasis should be on simplicity: Clearly define a few target behaviors in a way the student can understand and insure that all adults use the same language.*
- *Consequences (both rewards and punishments) must occur immediately. Any delay, even brief, may diminish effectiveness.*
- *Maintain a 3:1 ratio of positive to negative consequences for learning to occur.*

Objectives:

1. _____ will improve his/her capacity for emotional regulation.

Measurable indicators:

A. Complete pre/post asset measure, survey E found in Appendix
B. Percent of time _____ practices problem solving skills when prompted by staff (in response to expressions of frustration or anger).
C. Percent of time _____ continues to engage in misconduct after being prompted to use problem solving skills (including the use of time out or other relaxation techniques included in recovery plan).
D. Expected level: ___ Objective accomplished: yes: ___ no ___

Possible interventions:

a. _____ will practice step-wise problem solving skills.
b. Staff will preteach expected behavior prior to transitions, previously problematic situations, and/or new situations.
    a. Check for understanding.
    b. Practice new skills.
    c. Provide student with a signal to check his/her behavior.
c. Staff will agree on a recovery plan which uses interventions that have previously been useful when _____ is dealing with stress (a risk management plan).
    a. For example: _____ will be rewarded for choosing to take a time out when frustrated.

2. _____ will develop self-control skills.

Measurable indicators:

A. Complete pre/post asset measure, survey C found in Appendix
B. Percent of time _____ demonstrates self-control when prompted by adults to make good choices.
C. Percent of time _____ continues to engage in misconduct after being reminded of consequences and encouraged to use coping skills outlined in his/her recovery plan.

Expected level: ___ Objective accomplished: yes: ___ no ___

Possible interventions:

a. _____ will practice "if-then" thinking by learning to make "good choices".
    i. Staff will use the "80/20 rule" to reinforce self-control and to teach consequences.

b. Staff will teach _____ sexual safety skills to reduce the risk of exploitation or impulsive sexual behavior.

i. In consultation with _____'s family, staff and parents will teach and reinforce _____ rules for sexual behavior that best apply to all circumstances at home and in the community (e.g. "always use a condom when having sex" – do not attempt to distinguish between intercourse, oral sex, or masturbation).

3. _____ will develop functional social skills.

Measurable Indicator:

A. Complete pre/post asset measure, survey I found in Appendix
B. Participation in planned activities.
Expected level: ___ Objective accomplished: yes: ___ no ___

Possible Interventions:

a. _____ will participate in a **friendship skills** course focused on teaching engagement skills, empathy, and conflict resolution.
b. _____ will participate in all planned **youth programs**, including social activities, recreation, work, meals, and group meetings.
c. _____ will participate in **community service** projects.
d. _____ will be encouraged to participate in youth ministry activities provided his/her guardian is supportive.

References For the Treatment Planning Guide

Abrams, K., Washburn, J., Teplin, L., Emanuel, K., Romero, E., & McClelland, G.

(2007). Posttraumatic stress disorder and psychiatric comorbidity among detained youth.

Psychiatric Services, 58(10), 1311-1316.

Allison, D., Faith, M., & Franklin, R. (1995). Antecedent exercise in the treatment of

disruptive behavior : A meta-analytic review. *Clinical Psychology: Science and Practice, 2(3), 279-303.*

Bauer, S. (2006). Asperger syndrome. *Online Asperger Syndrome Information and Support.* http://www.udel.edu/bkirby/asperger/.

Becker-Weidman, A. (2006). Treatment for children with trauma-attachment disorders: Dyadic developmental psychotherapy. *Child and Adolescent Social Work Journal, 23(2),* 147-171.

Broocks, A., Bandelow, B., Pekrun, G. George, A., Meyer, T., Bartmann, U., et al. (1998). Comparison of aerobic exercise, clomipramine, and placebo in the treatment of panic disorder. *American Journal of Psychiatry, 155,* 603-609.

Caldwell, C., Wright, J., Zimmerman, M., Walsemann, K., Williams, D., & Isichei, P. (2004). Enhancing adolescent health behaviors through strengthening non-resident father-son relationships: A model for intervention with African-American families. *Health Education Research, 19*(6), 644-656. Retrieved July 5, 2006 from ProQuest database.

Domes, G., Schulze, L., & Herpertz, S. (2009). Emotional recognition in borderline personality disorder: A review of the literature. *Journal of Personality Disorders, 23(1),* 6-20. Retrieved March 31, 2009, from ProQuest database.

Eccles, J., & Gootman, J. (2002). *Community programs to promote youth development.* Washington, D.C.: National Academy Press.

Glasser, W. (1976). *Positive addiction*. New York: Harper & Row.

Glenn, C. & Klonsky, E. (2009). Emotional disregulation as a core feature of borderline personality disorder. *Journal of Personality Disorders, 23(1),* 20-29. Retrieved March 31, 2009 from ProQuest database.

Grace, D. (2008). *Building developmental assets in at-risk youth: A quasi-experimental study*. Published dissertation. ProQuest database, Publication #3320265.

Gralton, E., Muchatuta, A., Morey-Canellas, J., & Lopez, C. (2008). Developmental traumatology: Its relevance to forensic adolescent settings. *British Journal of Forensic Practice, 10(2).*

Huang, D., Gribbons, B., Kim, K., Lee, C., & Baker, E. (2000). *A decade of results: The impact of the LA's BEST after school enrichment program on subsequent student achievement and performance.* UCLA Center for Learning. Retrieved February 10, from http://www.lasbest.org.

Jongsma, A., Peterson, M., McInnis, W. Peterson, B. (2006). *Adolescent Psychotherapy Treatment Planner.* San Francisco: Wiley, John & Sons.

Minnis, H., Marwick, H., Arthur, J., & McLaughlin, A. (2006). Reactive attachment disorder: A theoretical model beyond attachment. *European Child & Adolescent Psychiatry, 15(6),* 336-342.

Mueser, K. & Taub, J. (2008). Trauma and PTSD among adolescents with severe

emotional disorders involved in multiple service systems. *Psychiatric Services, 59(6),* 627-634.

Oldershaw, A., Grima, E., Jollant, F., Richards, C. et al. (2009). Decision making and problem solving in adolescents who deliberately self-harm. *Psychological Medicine, 39(1),* 95-105. Retrieved March 31, 2009 from ProQuest database.

Oman, R., Vesely, S., McLeroy, K., Harris-Wyatt, V., Aspy, C., Rodine, S., et al. (2002). Reliability and validity of the youth asset survey. *Journal of Adolescent Health, 31*(3), 247-255. Retrieved January 17, 2005, from EBSCO database.

Orwin, A. (1973). The running treatment: A preliminary communication on a new use for an old therapy (physical activity) in the agoraphobic syndrome. *British Journal of Psychiatry, 122,* 175-179.

Paris, J., editor-in-chief. (2006). Clinical practice guidelines: Management of anxiety disorders. *Canadian Journal of Psychiatry, 51(8),* Supplement 2. Retrieved from ProQuest database.

Poulin, F., Dishion, T. & Haas, E. (1999). The peer influence paradox: Friendship quality and deviancy training within male adolescent friendships. *Merrill-Palmer Quarterly, 45,* 42-61.

Premack, D. (1965). Reinforcement theory. In D. Levine (Ed.), *Nebraska symposium on motivation,* (123-188). Lincoln: University of Nebraska Press.

Sabourin, B.,Stewart, S., Sherry, S., Watt, M., Wald, J., & Grant, V. (2008). Physical exercise as interoceptive exposure within a brief cognitive-behavioral treatment for anxiety-sensitive women. *Journal of Cognitive Psychotherapy, 22(4),* 303-320.

Seligman, M., Schulman, P., & DeRubeis, R. (1999). The prevention of depression and anxiety. *Prevention & Treatment, 2,* Article 0008a. Retrieved Feb. 26, 2008 from http://journals.apa.org/prevention/volumne2/pre0020008a.html.

Smits, J., Berry, A., Rosenfield, D., Powers, M., Behar, E., & Otto, M. (2008). Reducing anxiety sensitivity with exercise. *Depression and Anxiety, 25,* 689-699.

Stepp, S., Epler, A., Jahng, S. & Trull, T. (2008). The effect of dialectical behavior therapy skills use on borderline personality disorder features. *Journal of Personality Disorders. 22(6),* 549-564. Retrieved March 31, 2009 from ProQuest database.

Stewart, S. & Watt, M. (2008). Introduction to the special issue on interceptive exposure in the treatment of anxiety and related disorders: Novel applications and mechanisms of action. *Journal of Cognitive Psychotherapy: An International Quarterly. 22(4),* 291-302.

Welsh, J., Viana, A., Petrill, S., & Mathias, M. (2007). Interventions for internationally adopted children and families: a review of the literature. *Child and Adolescent Social Work Journal, 24(3),* 285-311.

Zayas, L., & Lewis, B. (1986). Fantasy role-playing for mutual aid in children's groups: A case illustration. *Social Work with Groups, 9*(1), 53-66.

References

American Academy of Child & Adolescent Psychiatry. (2010). *Practice Information-CASII.* Retrieved from http://www.aacap.org/cs/root/member_information/practice_information/casii

Anderson, R.L., Lyons, J.S., Giles, D.M., Price, J.A., Estle, G. (2003). Reliability of the child and adolescent needs and strengths-Mental health (CANS-MH) scale. *Journal of Child and Family Studies. 12* (3), 279-289.

Barth, D. F. (2008). Hidden eating disorders: Attachment and affect regulation in the therapeutic relationship. *Clinical Social Work Journal*, *36*(4), 355-365.

Bressi, S. K. (n.d). Social Work Research and Evaluation: Quantitative and qualitative approaches. *Psychiatric Rehabilitation Journal*, *29*(1), 83-84.

Bruyere, E.B. (2010). Child participation and positive youth development. *Child Welfare. 89* (5), 205-220.

Bullis, M., D'Ambrosio, R., Schultz, R. Todis, B., & Waintrup, M. (2001). Overcoming the odds: Qualitative examination of resilience among formerly incarcerated adolescents. *Exceptional Children. 68* (1), 119.

Burns, B.J. Phillips, S.D. Wagner, R., Barth, R.P., Kolko, D.J., Campbell, Y., Landsverk, J. (2004). Mental health need and access to mental health services by youth involved with child welfare: A national survey.

Butler, L.S. & McPherson, P.M. (2006). Is residential treatment misunderstood? *Journal of Child Family Studies. 16,* 465-472. doi: 10.1007/s10826-006-9101-6

Caldwell, C., Wright, J., Zimmerman, M., Walsemann, K., Williams, D., & Isichei, P. (2004). Enhancing adolescent health behaviors through strengthening non-resident father-son relationships: A model for intervention with African-American families. *Health Education Research, 19* (6), 644-656.

Children's Mental Health Division Minnesota Department of Human Services. (2008). *Outcome measures pilot: SDQ and CASII. Report for Minnesota mental health action group (MMHAG).*

Clark, M.D. (1998). Strength-based practice: The ABC's of working with adolescents who don't want to work with you. *Federal Probation. 62,* (46), 46-53.

Clemmons, V., Dannenfelser, P.L., & Newman, B.S. (2007). The diagnostic and statistical manual of mental disorders in graduate social work education: Then and now. *Journal of Social Work Education. 43* (2), 297-307.

Collins, K. (2005). Search Institute-The organization that helps communities help kids. *Pediatric Nursing*. *31*(6), 496-497 & 507.

Council on Social Work Education. (2010). *Advanced social work practice in clinical social work.* Retrieved at http://www.cswe.org/File.aspx?id=26685

Cox, K. (2008). Tools for building on youth strengths. *Reclaiming Children and Youth. 16* (4), 19-24.

Cosgrave, E.M., Yung, A.R., Killackey, E.J., Buckby, J.A., Godfrey, K.A., Stanford, C.A. & Mcgorry, P.D.(2008). Met and umnet need in youth mental health. *Journal of Mental Health. 17* (6), 618-628.

Crew, S.D., Bender, H., Cook, C.R. (2007). Risk and protective factors of emotional and/or behavioral disorders in children and adolescents: A mega-analytic synthesis. *Behavioral Disorders. 32* (2), 64-77.

Curtis, W.J., & Cicchetti, D. (2003). Moving research on resilience into the 21st century: Theoretical and methodological considerations in examining the biological contributors to resilience. *Devleopment and Psychopathology, 15* (3), 773-810.

Eagle, M. (2011). Interpretation and the therapeutic Relationship: An attempt at integration. *Clinical Social Work Journal*, *39*(2), 139-150.

Fallon, T., Pumariega, A., Sowers, W., Klaehn, R., Huffine, C., Vaughan, T., Winters, N., Chenven, M., Marx, L., Zachik, A., Heffron, W., Grimes, K. (2006). A level of care instrument for children's systems of care: Construction, reliability and validity. *Journal of Child and Family Studies. 15* (2), 143-155. DOI: 10.1007/s10826-005-9012-y

Fergus, S., & Zimmerman, M. (2005). Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annual Review of Public Health, 26*, 399-419.doi: 10.1146/annurev.publhealth.26.021304.144357

Garbarino, J. (2001). Lost boys: Why our sons turn violent and how we can save them. *Smith College Studies in Social Work. 71* (2), 169.

Grace, D. (2008). Building developmental assets in at-risk youth: A quasi-experimental study. *Doctor of Education Dissertation.*

Gresham, F.M., Kern, L., Vanderwood, M. (2007). Risk and protective factors of emotional and/or behavioral disorders in children and adolescents: A mega-analytic Synthesis. *Behavioral Disorders, 32,* (2), 64-77.

Harvey, J. & Delfabbro, P.H. (2004). Psychological resilience in disadvantaged youth: A critical overview. *Australian Psychologist. 39* (1), 3-13.

Heller, S.S., Larrieu, J.A., D'Imperio R., & Boris, N.W. (1999). Research on resilience to child maltreatment: Emperical considerations. *Child Abuse & Neglect, 23* (4), 321-338.

Henggeler, S. W. (1999). Multisystemic Therapy: An Overview of Clinical Procedures, Outcomes, and Policy Implications. *Child & Adolescent Mental Health*, *4*(1), 2-10.

Herrenkohl, T.I., Maguin, E., Hill, K.G., Hawkins, J.D., Abbott, R.D. & Catalano, R.F. (2000). Developmental risk factors for youth violence. *Journal of Adolescent Health. 26* (3), 176-186. http://dx.doi.org.ezproxy.stthomas.edu/10.1016/S1054-139X(99)00065-8

Holstead, J., Dalton, J., Horne, A., & Lamond, D. (2010). Modernizing residential treatment centers for children and youth-An informed approach to improve long-term outcomes: The Damar Pilot. *Child Welfare League of America, Inc. 89,* (2), 115-130.

Horwitz, S.M., Hurlburt, M.S., Heneghan, A., Zhang, J., Rolls-Reutz, J., Ficher, E., Landsverk, J., Stein, R.E.K. (2012). Mental health problems in young children investigated by U.S.

child welfare agencies. *Journal of American Academy of Child & Adolescent Psychiatry. 51* (6), 572-581.

Howse, R. B., Diehl, D. C., & Trivette, C. M. (2010). An asset-based approach to facilitating positive youth development and adoption. *Child Welfare, 89*(4), 101-16. Retrieved from http://search.proquest.com/docview/865923444?accountid=14756

Huang, D., Gribbons, B. Kim, K.S., Lee, C. & Baker, E. (2000). A decade of results: The impact of the LA's BEST after school enrichment program on subsequent student achievement and performance. *UCLA Center for the Study of Evaluation Graduate School of Education & Information Studies.*

Kegler, M., Rodine, S., Marshall, L., Oman, R., & McLeroy, K. (2003). As asset-based youth development model for preventing teen pregnancy: Illustrations from the HEART of OKC project. *Health Education. 103*(3), 131-144.

Kolassa, I., & Elbert, T. (2007). Structural and Functional Neuroplasticity in Relation to Traumatic Stress. *Current Directions In Psychological Science (Wiley-Blackwell)*, *16*(6), 321-325. doi:10.1111/j.1467-8721.2007.00529.x

Kraemer, H.C. (2007). DSM categories and dimensions in clinical and research contexts. *International Journal of Methods in Psychiatric Research. 16* (S1), S8–S15.

Kuperminc, G.P., Blatt, S.J., Shahar, G., Henrich, C. & Leadbeater, B.J. (2004). Cultural equivalence variance in longitudinal associations of young adolescent self-definition and interpersonal relatedness to psychological and school adjustment. *Journal of Youth and Adolescence. 33* (1), 13-30.

Lechnyr, R. J. (1984). Clinical social work psychotherapy and insurance coverage: information on billing procedures. *Clinical Social Work Journal*, *12*(1), 69-77.

Mahoney, D. (2005). Mental illness common, often goes untreated. *Internal Medicine News. 38* (15), 24.

Mannes, M., Roehlkepartain, E.C., & Peter, L. (2007). Unleashing the power of community to strengthen the well-being of children, youth, and families. *Child Welfare. 84* (2), 233-250.

Minnesota Department of Human Services: Children's Mental Health Division. (2008). *Outcome measures pilot: SDQ and CASII. Report for Minnesota mental health action group (MMHAG).*

Minnesota Department of Human Services. (2012). *Children's Mental Health*. Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000162

Minnesota Department of Human Services. (2012). *Outcome Measures.* Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_144859

Miranda, J., Williams, G. (2011). Youth in recovery. *The Prevention Researcher. 18.2,* 16.

Monette, D.R., Sullivan, T.J. & Dejon, C.R. (2011). *Applied social research: A tool for the human services.* Belmont, CA. Brooks/Cole, Cengage Learning.

Oesterreich, H.A. & Flores, S.M. (2009). Learning to C: Visual arts education as strengths based practice in juvenile correctional facilities. *Journal of Correctional Education. 60,* (2), 146-162.

Oman, R., Vesely, S., Aspy, C., McLeroy, K., Harris-Wyatt, V., Aspy, C.B., Rodine, S., Marshall, L. (2002). Reliability and validity of the youth asset survey (YAS). *Journal of Adolescent Health. 31* (3)*,* 247-255.

Oman, R., Vesely, S., Aspy, C., McLeroy, K. (2004). The potential protective effect of youth assets on adolescent alcohol and drug use. *American Journal of Public Health, 94* (8), 1425-1431.

Paquin, G. (2006). Including narrative concepts in social work practice classes. *Journal of Teaching in Social Work. 26* (1-2), 127-145.

Perry, B.D & Szalavitz, M. (2006). *The boy who was raised as a dog*. New York, NY: Basic Books

Phillips, D. (2000). CSWJ Forum: Is social work a profession? Preliminary considerations. *Clinical Social Work Journal. 28* (2), 213-225.

Probst, B. (2010). Implicit and explicit use of the strengths perspective in social work education. *Journal of Teaching in Social Work, 30* (4), 468-484.

Rapp-Paglicci, L., Stewart, C., & Rowe, W. (2011). Can a self-regulation skills and cultural arts program promote positive outcomes in mental health symptoms and academic achievement for at-risk youth? *Journal of Social Service Research, (37)* 309-319.

Reininger, B., Evans, A., Griffin, S., Sanderson, M., Vincent, M., Valois, R., et al. (2005). Predicting adolescent risk behaviors based on an ecological framework and assets. *American Journal of Public Health, (29)*2, 150-162.

Rew L. & Horner, S.D. (2003). Youth resilience framework for reducing health-risk behaviors in adolescents. *Journal of Pediatric Nursing. 18* (6), 379-388.

Richardson, G. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology, 58*(3), 307-321.

Schorre, B., & Vandvik, I. (2004). Global assessment of psychosocial functioning in child and adolescent psychiatry. *European Child & Adolescent Psychiatry*. *13*(5), 273-286. doi:10.1007/s00787-004-0390-2

Search Institute. (2012). Developmental Assets List. Retrieved from http://www.search-institute.org/developmental-assets/lists

Smith, E. (2006). The strength-based counseling model. *The Counseling Psychologist. 34* (13), 13-79. doi: 10.1177/0011000005277018

Smith, E. (2008). Pitfalls and promises: The use of secondary data Analysis in education research. *British Journal of Educational Studies. 56* (3), 323-339.

Szalavitz, M. & Perry, B.D. (2010). *Born for Love: Why Empathy is Essential and Endangered.* New York, NY: Harper Collins Publishers.

Wharff E, Ginnis K &Ross A. Family-based crisis intervention with suicidal adolescents in the emergency room: A Pilot study. *Social Work*. 57(2):133-143.

Weiss, B. (2007). Can endocrine disrupters influence neuroplasticity in the aging brain? *Neuro Toxicology*. *28,* (5), 938-950.

Weist, M.D., Lowie, A., Flaherty, L.T., & Pruitt, D. (2001). Collaboration among the education, mental health, and public health systems to promote youth mental health. *Psychiatric Services. 52* (10), 1348-1351. doi: 10.1176/appi.ps.52.10.1348

Weisz, J., Sandler, I.N., Durlak, J.A., & Anton, B.S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychological Association. 60* (6), 628-648. doi: 10.1037/0003-066X.60.6.628