# The Bradley Center

# The Blue Print for Change
# Comprehensive Mental Health Treatment Services for Children and Adolescents

## 2010

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## Focus on the Therapeutic Milieu

The Bradley Center is committed to the treatment of children with complex trauma. The active treatment component is Cognitive Behavioral Therapy (CBT), primarily because it interfaces well with the Trauma Model of Care. The comprehensive intervention framework addresses vulnerabilities created by exposure to overwhelming life circumstances that have interfered with healthy development. Through building skills, stabilizing internal distress and strengthening the security of the care giving system, interventions guided by this framework seek to provide children with tools that will generalize, and thereupon enhance resilient outcomes. To this end, the treatment milieu relies heavily on the approaches of *The Sanctuary Model (Bloom 2005)* and *The Attachment, Self-Regulation and Competency Model (Kinneburgh, Blaustein & Spinazzola, 2005).*

Following the Pennsylvania Child and Adolescent Service System Program (CASSP) principles, the interdisciplinary team works diligently to help the child and family reach their greatest potential. In addition to The Bradley Center Team, including Education staff, the referral sources and State or local agencies, are all included in this team approach to treatment.

In order for any treatment intervention to be successful, effective staff training is critical. At The Bradley Center, challenging behaviors are safely managed through the use of the Cornell University Model of Therapeutic Crisis Intervention (TCI). These interventions are completely consistent with the principles of Trauma Informed Care. Further, clinical education for staff goes beyond the basics as is required, and delves into the specific treatment modalities designed for each Clinical Program within The Bradley Center.

Residential programs at The Bradley Center provide a safe and therapeutic treatment milieu that creates a structured and predictable environment by establishing rituals and routines. Therapeutic activities, activities of daily living and recreational activities take place

according to a predictable and thoughtfully planned schedule. The schedule, as well as each particular treatment modality, is presented in a clear, concrete and concise fashion to residents and their families. Individuals are empowered, as they are expected to take responsibility for their own behaviors and participate in therapeutic activities (i.e., psycho-educational groups, recreational activities, activities of daily living, etc.) as is detailed in each resident's treatment plan.

## The Sanctuary Program

All programming emphasizes a strength-based approach to treatment. Given that commitment, The Bradley Center has woven the concept of establishing physical, psychological, social and ethical safety within its milieus. Research has shown that young people, particularly those that have failed in traditional treatment settings, develop pro-social behaviors best by practicing and reinforcing them. The human task of internalizing limits or developing healthy boundaries, pro-social behaviors and using good judgment is best fostered by experiential means. The Sanctuary program, as developed by Dr. Sandra Bloom, teaches young people how to manage their emotional responses to internal conditions and their external experiences. Within the safe treatment milieu, children become able to directly deal with issues of loss and change.

The Bradley Center will seek full Sanctuary accreditation in October 2010.

## Family relationships

At the time of admission, a therapist is assigned to the child and her family to serve as the primary contact and provide case management services. Family members are encouraged to become active members of the interdisciplinary team. Family members have a major impact early in their child's treatment as the therapist seeks their input in the development of the initial treatment plan. Family members attend regular interagency conferences and must be in concert with the psychiatrist's recommendations regarding pharmacological interventions.

Family members are involved with the therapist and the child in family counseling sessions on a weekly basis. Sessions occur over the telephone for the child whose family lives a considerable distance from The Bradley Center. The therapist may have direct contact with this family should they be able to visit the child and stay at the apartment that The Bradley Center maintains on campus. For the child whose family lives locally, counseling sessions take place on campus or in the family home. A multi-system family focused approach supports the CASSP principles as services are planned in collaboration with the family as the primary support system for the child and that services are planned with all of the child-serving systems involved in the child's life.

## Discharge Planning and Preparation

Disposition planning for the child begins just following the completion of the admission assessment. During this process, the treatment team identifies the core issues that will impact the child's eventual discharge from the program. Family members and the child are active members of the team and their wishes and capabilities are given serious consideration when disposition planning is discussed. External agencies that have been or following discharge will be involved in the child's care, are also actively involved in the process.

Representatives from these agencies join family members and the child in regularly scheduled treatment reviews. These reviews may include reports on the child's behavior during any therapeutic leaves that occurred during the review period and/or any visits the child made with family members to the family apartment that is located on campus. This type of planning and preparation helps the child with progress towards maturation and development of the ability to self-regulate. The child will then be able to successfully reintegrate back into her family, school and community and will not need to revert to the antisocial behaviors that lead to placement in a residential treatment facility. A functional assessment, such as the *Vineland Adaptive Behavior Scales (VABS)*, is completed at the time of discharge. This is often requested when the child is moving to a less structured setting, such as a group home. Group home staff will utilize the results of the assessment to establish a baseline with which to determine the course of future training.

# The Bradley Center
# Campus Overview

Each Unit has a capacity of 25 Residents

| Unit | Description | Gender | Age Range |
| --- | --- | --- | --- |
| **Intellectual Disability/ Autism Spectrum Disorder** | Moderate to Mild Intellectual Disability/ Autism Spectrum | Male & Female | 12 – 17.5 |
| **Female Trauma** | Diverse diagnostic composition, mood disorders with history of trauma | Female | 13 – 17.5 |
| **Adolescent Male** | Diverse diagnostic composition, mood disorders, History of impulse discontrol | Male | 12 – 17.5 |
| **Children's Unit** | Diverse diagnostic composition, mood disorders, ADHD | Male & Female | 6 - 14 |

## Description of Treatment Modalities

Specialized Residential Treatment Services:

The Intellectual Disability/Autism Spectrum Disorder (ID/ASD) Residential Treatment Facility (RTF) is one of the specialized programs at The Bradley Center. The ID/ASD program serves both males and females aged 12 – 17.5 years of age, with a dual diagnosis of a primary Axis I psychiatric diagnosis and an Intellectual Disability or Autism Spectrum Disorder.

## Independent Living Skills

Emphasis is placed on community readiness beginning at the time of admission into the ID/ASD RTF Program. Skills that are considered critical to independent living are identified and taught. In order to maximize learning, teaching takes place in the environment in which the skill is to be performed. As the child acquires the skill, she is closely supervised in a structured situation; The primary goal is to help the child gain the confidence she needs to assume the responsibility and be able to initiate performing the skill appropriately in the context of daily living circumstances.

The *Skills to Achieve Independent Living* (SAIL) program is utilized to address the teaching of daily living skills in the ID/ASD RTF Program. The program consists of skills within four major areas: Personal Management, Home Management, Applied Academics and Community Access. Within each area, skills are further grouped into sections. The area of Community Access, for example, contains four sections. They are: Leisure Time, Community Resources, Prevocational and Mobility. The SAIL curriculum is a teaching program consisting of: (1) Behavioral objectives (life skills); (2) Strategies (to be taught in a normalized setting); and (3) Mastery criteria on two levels – (a) skill acquisition and (b) self-initiation. A Skills Inventory, an annotated checklist, is maintained for each child and provides a record of the child's ability on each skill. The inventory can be utilized in planning for disposition and can help

determine whether the child possesses entry-level skills for a group home placement. The inventory can then again act as a baseline from which group home staff can develop their treatment planning.

## Individual and Group Therapies

Individuals with an intellectual disability benefit from the same individual and group treatment modalities that are made available through all of the programs at The Bradley Center. A child residing with the ID/ASD RTF is striving toward similar therapy goals. However, the manner in which these treatment modalities are structured, presented and measured is specialized for the child with an intellectual disability.

Group members are often presented with handouts that provide each member with an outline of the group (i.e., the structure of the group, the rules of the group and the group goals). Similar handouts are distributed in a group of children with an intellectual disability. However, it is understood that many of these children have limitations in reading, significant receptive and expressive language problems and short and long-term memory problems. Therefore, handouts and verbal instructions are concise, simple and concrete. Complex sentences and abstract words are avoided. Written statements are read aloud and each group member may be asked to repeat the statement or direction in his own words. Each component or step in a group presentation has a discrete ending and each group member should be able to repeat the instruction before proceeding to the next component or step. Each group member brings her handouts with her when she returns to the next session, so that they can frequently be reviewed and referenced.

In implementing group approaches in the ID/ASD program at The Bradley Center, a purposeful effort is made to keep the group size as small as possible. This is important because it offers each child more opportunities to practice the particular skill or behavior being taught within the safe and supportive environment of the group. Numerous repetitions in this context strengthen the possibility that the child will attempt to incorporate the skill or behavior into her daily routine. Because of the limitations in language skills as discussed above, group approaches with children with intellectual disabilities most often

rely heavily on a modeling component. Modeling is an illustration or dramatization of "how" the specific skill or behavior is to be performed. It incorporates all of the essential verbal and non-verbal components of the skill or behavior. To this end, the use of co-leaders in a group of children with intellectual disabilities is a very valuable asset. It is essential that the skill or behavior being taught is modeled correctly from the outset and every time that it is being demonstrated.

It has been demonstrated that children with intellectual disabilities respond positively to a highly structured, repetitious and concrete group approach. This same structure and routine is equally beneficial with children with complex trauma and issues related to attachment. In many instances, the child begins to experience success for the first time in her life through this type of group experience. She understands what is expected of her and correctly anticipates what is to take place next on the agenda. She actually knows the correct answer or appropriate response and is eager to demonstrate it. She gains confidence and finds herself in a role that she may not before have experienced, as she assumes a position of leadership contributing constructively to the group process and in support of her peers.

Following is a more detailed description of some of the treatment modalities that are offered. All are cognitive-behaviorally based.

## Pre-Therapy (Teaching About Feelings)

Sex education, relationship training, anger management training and social skills training have all been used to deal with feelings but most begin with an assumption that the child has a basic understanding of feelings. In developing a curriculum for the active treatment of a child with mental retardation, it should not be assumed that the individual is able to effectively recognize, acknowledge and express his emotions or can clearly identify and label emotional/psychological states in others. Children with complex trauma or a pervasive developmental disorder have significant difficulty in identifying and understanding their feelings and the feelings of others, as well as managing their

own feelings. They struggle to learn how they feel and what is causing them to feel that way and how to handle their feelings safely.

A pre-therapy, or teaching about feelings, group is taught in a group format so that the child has the opportunity to hear that many others have the same feeling experiences. It is a natural beginning for group counseling. The format and teaching materials are structured so that children with varying skills can participate. Face drawings of five basic feelings states (happy, sad, mad, scared and “just okay”) are utilized and various feeling labels are translated back into these five basic feelings (e.g. I feel all of the five feelings, sometimes one at a time, sometimes together), are taught and repeatedly referred to as the group analyses differences and similarities in each child’s emotional response(s) to common situations. Simple and enjoyable games such as “The Special Chair”, “The Fan Game”, and “Go Fish” are utilized to teach and practice these important core concepts and enable the child to better respond to further counseling.

The concepts outlined in the discussion of teaching about feelings in a group format are reinforced on an individual basis. Each child is involved in the self-monitoring of her daily mood. A weekly mood monitoring form shows five face drawings next to each day of the week; happy, sad, mad, scared and “just okay.” With the aid of a staff member, the child marks one face each day to represent her general mood. The child utilizes the weekly mood monitoring form in the completion of her weekly journal entry and brings these items with her when meeting with the therapist for individual counseling.

A great deal of space is dedicated in the program description to the discussion of pre-therapy or teaching about feelings. Central to the overall clinical philosophy of treatment at The Bradley Center is the Therapeutic Crisis Intervention System (TCI). TCI is a crisis prevention and intervention model for residential childcare facilities. It assists in preventing crises from occurring, de-escalating potential crises, managing acute physical behavior, reducing potential and actual injury to the child and staff, and teaching the child adaptive coping skills. The TCI model offers a framework for implementing a crisis prevention and management system that reduces the need to rely on high-risk interventions. It provides direct care staff with the skills, knowledge and attitudes to help the individual when she is at

her most destructive. It also provides care workers with an appreciation of the influence that adults have with children who are troubled, and the sensitivity to respond to both the feelings and behavior of an upset child in crisis. Strategies in the TCI model emphasize helping the child to explore her feelings, summarize her feelings and the content of the situation and connect behavior to feelings. Therefore, it is important that early treatment interventions through the ID/ASD RTF focus on assessing and enhancing the child's ability to accurately identify and label her feelings in order to better understand and benefit from TCI strategies.

## Anger Management Training

The outline for a traditional anger management-training group can be viewed as perhaps too ambitious for an individual with mental retardation. Over a twelve-week period, relaxation training, the identification of problem situations, the introduction and discrimination of coping and trouble statements, role-play, the steps of problem solving and other concepts are introduced at various points and integrated into the approach. However, the goal of self-control is maintained as the various components of anger management are addressed separately through other group experiences. For example, an initial focus of anger management training, the recognition and identification of emotions, is dealt with in the pre-therapy group presented above.

Anger management with the more advanced child with complex trauma recognizes that traumatized children frequently are disconnected from their own emotional experiences. Difficulty expressing emotion may lead the traumatized child to be explosive. Following the onset of intense emotional states, she may have difficulty calming down and either remain in a negative affective state for an extended period of time or rely on maladaptive coping methods (Kinniburgh et al.). For this child, treatment will follow the approach developed by Millicent H. Kellner in *In Control: A Skill-Building Program for Teaching Young Adolescents to Manage Anger.* The program is based on cognitive-behavioral principles with its main goal "to help youngsters gain the awareness and skills to manage the unique, yet malleable dimensions of their anger (physiology,

thoughts, emotion, behavior) so they can achieve self-control and develop a repertoire of prosocial behavior."

The *In Control* Program is made up of a total of ten anger management sessions with a "connecting activity" to be completed between sessions. One of the strengths of the program is that each session follows a similar format that consists of: Goals; Objectives; Materials; Overview; Leader Script (Review, Session Content and Closing); and Connecting Activity. The structure is such that co-leaders of the group can vary throughout the program but consistency is relatively assured. Because of the consistent approach, the child may quickly become comfortable with it and better understand what is being expected of her. In this manner, she can focus more effectively on the content of the sessions. Review sheets are utilized at the beginning of the next session to act as a bridge and demonstrate to the child that there is a "connectedness" to her treatment. The anger log is introduced in Session #2 and is the focal point of the program. It is a self-monitoring device and a teaching tool to reinforce skill development. The log grows in length and scope as each new topic is introduced until a full version; the "Final Anger Log" emerges in Session #7. After the anger management group is terminated, the "Final Anger Log" becomes part of the routine on the unit and in the classroom. Copies of the anger log should be kept in clearly designated places. Should an anger-related incident occur, the staff member would direct the child to take a few minutes to complete an anger log. This would help with recall and reinforce key concepts of the program. The log could be utilized in any debriefing that might be indicated. In addition, the child's therapist should receive any completed logs. The therapist may wish to incorporate them into the agenda of the next individual counseling session.

## Relaxation Training

Relaxation training at The Bradley Center will follow the model developed by Cautela and Groden (1978). This is a flexible model for teaching relaxation as a self-control procedure for adaptive behavior. Evidence indicates that it has been shown to be a benefit in decreasing disruptive and aggressive behaviors; as well as being effective in developing attentional skills which results in a decrease in social isolation and an increase in self-help, motor and academic skills. Cautela and Groden's model also formalizes the adaptation of the relaxation procedures for the child with special needs. A primary concern is developing in the child with mental retardation the ability to generalize learned coping and self-management strategies. To this end, once the children are proficient in some of the relaxation techniques in the group setting, training is moved to the vacant classroom where each child can practice the same techniques while seated at her desk. In this controlled environment, images of stressful academic related situations are introduced as relaxation techniques are being implemented. Other strategies related to anger management, such as coping statements (e.g. "Be cool", "Stay calm," and "Think first") are taught and mastered in a similar fashion.

## Social Skills Training

Social skills deficits have been frequently identified as critical reasons for failure of individuals with mental retardation in competitive employment, sheltered workshops and community living arrangements. Children with complex trauma tend to be attracted to abusive relationships. It is non-abusive relationships that are anxiety producing, confusing, unpredictable and frightening. Children who grow up in abusive relationships tend to treat others with the same callous disregard that they have experienced themselves (Bloom). Any discussions of effective social skills refers to repertoires of social behaviors that, when used in social interaction, tend to evoke positive reinforcement and generally result in positive outcomes. The acquisition of social skills enables the child to competently and effectively participate in diverse aspects of human interaction (e.g. conversational skills, assertive behaviors and leisure-time social interactions skills). Social skills training can also be effective in

decreasing the aggressive behaviors associated with arguments and fights. The importance of social skills for interpersonal adjustment, community living and vocational success cannot be overstated.

The Bradley Center's ID/ASD RTF employs a social skills training approach that adheres to the model of instruction, modeling, practice, feedback and coaching. This model relies heavily on the role-play and all social learning revolves around it. Basically, the format of a role play is described as follows: an interpersonal vignette is described to the child, a role model utters a prompt line and then the child responds to the role model as if the interaction was actually taking place. The role-play is a very versatile technique that easily engages children of varying skills and functioning levels. It can be limited to a single prompt and response, as described above, or extended by having the role model offer one or several counter-responses. Complex interpersonal interactions are broken down into more easily understood and manageable components. Social skills training sessions easily incorporate simple props, videotape and audiotape.

As in relaxation training and other modalities, the issue of generalization is a primary concern. With social skills training, it is approached in a similar fashion as described above. The task is somewhat more difficult in a group setting, as responses to the role model prompt are inclined to be more generic in nature. However, in an individual counseling setting, social skills training is closely tied to the child's specific deficits and needs. A role-play re-enacts the particular situation in which the child has reported difficulty. A response is formulated to fit the individual child's particular needs and personality. In this manner, the child may find the response more natural and may be more likely to adopt it into her repertoire and utilize it in an actual situation.

## Group Therapy

**MISSION**: Group therapy is a process in which residents gain self-awareness through interactions with others thus facilitating change in behaviors and improved relationships. The group therapy sessions are conducted in accordance with all seven commitments in the Sanctuary Model.

The Bradley Center is committed to the treatment of children with various mental health diagnoses, behavioral issues and past life experiences. The residents are placed at The Bradley Center through the mental health, child welfare and juvenile probation system. Most will have diagnoses but are not limited to mood disorders, posttraumatic stress disorder, or dual diagnosis of pervasive developmental disorders and/or mental retardation. The Bradley Center serves 100 children assigned to four units based on their developmental needs and diagnosis.

The residents attend five group therapy sessions a week. The group format and topics will address goals and objectives from the individualized treatment plan. All residents will receive a combination of expressive arts groups, Adventure Based Programming groups, skill based groups and prescriptive groups. The clinical team and psychiatrist, family/guardian and referral sources will prescribe specialized groups for each resident based on their clinical needs and treatment plan goals and objectives. A master's level certified art therapist, a certified music therapist and two masters' level mental health therapists will facilitate the groups. Each of the groups is run with two facilitators and a small group of 4 to 12 residents. The child development specialists also attend groups to model appropriate group behaviors; provide proximity control, hurdle help, positive reinforcement, and assist the therapist in facilitating the group. The child development specialist can assist the resident in transferring any new skills discussed in the group sessions into the milieu and community.

### Expressive Arts Groups

1. Art Therapy
    a. To include displays at the awards assemblies if resident wishes
    b. Purpose/Goal
        i. Safety (from destructiveness to self and others)

ii. Symptom Relief
iii. Assessment (strengths and weaknesses)
iv. Social Support (Engagement to support, adherence to treatment
v. Therapy/Education (around behavior, treatment collaboration, adherence)
vi. Exploration of self concept and family dynamics

2. Music Therapy
    a. The prescriptive use of music in a therapeutic fashion to address issues of communication, academics, music, physical, social, and emotional well-being in a holistic sense.
3. Psychodrama
    a. Residents can write and perform their own skits or stories in a variety show or play.
    b. Residents will prepare scenery, advertising, marketing, and other productions.
    c. Provides an opportunity to express and process feelings and experiences from their own perspectives and those of others
4. Journey
    a. David Oldfield program
    b. A creative approach to the necessary crisis of adolescence
5. Creative Dramatics
    a. Expressing feelings through drama
    b. Focus on younger and lower functioning residents

**Skill Based Groups**

1. Dialectical Behavioral Therapy Group
    a. Mindfulness
    b. Emotion Regulation
    c. Distress Tolerance
    d. Interpersonal Effectiveness

2. Cognitive Behavioral Therapy
    a. Coping Techniques
    b. Problem Solving
    c. CBT-Event, Thoughts, Feelings, Behaviors

    d. Thought Distortions

3. Social Skills
    a. Social Skills Training
    b. Skill Building
    c. Interaction Skills
4. Conflict Resolution
    a. Peaceworks approach to teaching conflict resolution to children
5. Anger Management
    a. Anger styles
    b. Triggers
    c. Symptoms/effects
    d. Coping techniques
6. Life Skills/Citizenship
    a. Learning about how to be a good citizen
    b. Focusing on independent living skills such as cooking, shopping, budgeting, transportation, etc.

## Prescriptive Group Therapy

1. Drug and Alcohol Education Group
    a. Educate residents who have experimented with drugs and alcohol.
    b. Focus on the various types for drugs and their effects on the body, brain, behaviors, relationships and overall functioning in life.

2. Solution Focused Process Group
    a. Strengths based approach to identifying behaviors that are not helpful and focusing on what does work.
    b. Explore roadblocks to change and focus on overcoming challenges

3. Trauma Recovery Group
    a. SELF – Sanctuary Model
    b. Utilize group process to learn to manage symptoms of traumatic experiences
    c. Indirect use of Dialectical Behavioral Therapy

4. Family Support Group (for residents without identified families and are up for adoption)
    a. The group focused on the interactions, relationships, responsibilities, discipline, and roles within a family setting.
    b. The group members participate in family type activities such as playing board games, celebrating holidays and birthdays, off campus outings, etc.
    c. The group would then examine the different roles within a family in the above mentioned situations.
5. Relaxation
    a. Relaxation exercises
    b. Guided imagery
    c. Self soothing techniques
6. Grief and Loss
    a. Identify types of loss
    b. Stages
    c. Feelings related to grief and loss
    d. Recovering from loss
7. Sanctuary Psycho-Education Groups
    a. Use the Sanctuary Psycho-Education Curriculum
    b. Using SELF model (Safety, Emotion Management, Loss, Future)
8. Spirituality
    a. What does spirituality mean to me?
    b. The belief in a higher power
    c. Explore the beliefs of various world religions and their practices
9. Play Groups
    a. Small groups meeting in the play room, outside or the gym.
    b. Directed and non-directed play
9. Resident Internships
    a. Residents can be prescribed internships on and off campus based on their abilities and emotional stability. The internships will focus on learning positive job habits and exploring new skills and experiences.

b. On campus internships consist of working with the different departments within the facility such as house keeping, dietary, maintenance, and clerical.
c. The on campus internships assist residents in preparing for the world of work. The assigned tasks can be modified to fit the residents' strengths and needs.
d. The internships will focus on developing the following skills:
    i. Ability to stay focused and complete tasks
    ii. Initiative – motivation to complete assigned tasks and take on newly assigned tasks
    iii. Ability to cooperate with directions from authority and accept constructive criticism
    iv. Interactions with co-workers (peers/adults)
    v. Quality of work, done correctly, able to correct mistakes, ability to learn from mistakes
e. Residents will be observed and rated on the above objective by the internship supervisor. Each resident will also evaluate their own skills using a Likert scale. Each resident will be provided supervision on a monthly basis to discuss progress, strengths and needs. A performance improvement plan will be developed to assist resident in addressing problem areas.
f. The off campus internships will take place in local businesses such as the Holiday Inn in Moon Township. Residents will "shadow" employees to learn job skills. Residents must be able to demonstrate safe behaviors in order to participate in this part of the internship program.
g. All residents will be supervised by a group therapist, who will remain with the groups as they are working whether on or off campus.

## Adventure Based Therapy

Adventure Based Therapy

a. Goal – Team Building, cooperation, communication, relationships, trust, process experiences, self-awareness.
b. Group initiatives and activities to help develop the above skills and many more
c. Climbing Wall

# Program Description:

## Intellectual Disability/ Autism Spectrum Disorder (ID/ASD) Unit

The Intellectual Disability/Autism Spectrum Disorder (ID/ASD) Residential Treatment Facility (RTF) is one of the specialized programs at The Bradley Center. The ID/ASD program serves 25 male and female youth, ages 12 – 17.5 years of age, with a dual diagnosis of a primary Axis I psychiatric diagnosis and an Intellectual Disability or Autism Spectrum Disorder.

Individuals with intellectual disabilities benefit from the same individual and group treatment modalities that are made available through all of the programs at The Bradley Center. A youth residing in the ID/ASD RTF is striving toward similar therapy goals. However, the manner in which these treatment modalities are structured, presented and measured is specialized for the youth with an intellectual disability.

A Stop, Think, and Go program is utilized on the ID/ASD Unit. The objective of the program is to provide the youth with concrete, immediate feedback so that the child can understand the structure and expectations of the unit in order to help the child develop the ability to better self-regulate. This program utilizes a stop light system allowing the youth to move between the colors at different intervals during the day. Each color of the stop light describes the activities available to the child at each light on the signal, as well as the behaviors the child should consider and be made aware of at each signal.

Elements of the SELF Model are included in this program. Safety issues (physical, psychological and social) are clearly detailed throughout the program. Handling feelings without becoming destructive to oneself or others (Emotions) is underscored. The child has ample opportunities to learn how to prepare for change (Loss)

and re-establish the capacity for choice (Future). In addition, the program is cognitive-behaviorally based (CBT) as it emphasizes steps to get the child to STOP AND THINK before he/she ACTS.

Emphasis is placed on community readiness beginning at the time of admission into the Program. Skills that are considered critical to independent living are identified and taught. In order to maximize learning, teaching takes place in the environment in which the skill is to be performed. As the child acquires the skill, he/she is closely supervised in a structured situation. The primary goal is to help the child gain the confidence he/she needs to assume the responsibility and be able to initiate performing the skill appropriately in the context of daily living circumstances. The Skills to Achieve Independent Living (SAIL) program will be utilized to achieve this goal.

In implementing group approaches in the ID/ASD program, a purposeful effort is made to keep the group size as small as possible. Because of limitations in reading skills, receptive and expressive language skills and short and long-term memory, group approaches with youth with having intellectual disabilities most often rely heavily on modeling and role-play. Group approaches are cognitively based and include; pre-therapy, social skills training, anger management and relaxation.

## Program Description:

## Female Trauma Unit

The Female Trauma Unit at The Bradley Center is a unit of 25 adolescent girls who have experienced some type of trauma in their lives. The girls are placed at The Bradley Center through the mental health, child welfare or juvenile probation system. Most have diagnoses of mood disorders with a history of physical or sexual trauma.

The girls will be involved in milieu therapy focusing on building a safe community where they go about completing activities of daily living, psycho-educational groups and structured activities. The girls will attend five psychotherapy groups a week. These are small groups that will utilize the Sanctuary Model and The Westmoreland Posttraumatic Stress Disorder Project. Each girl will be assigned a therapist for family and individual therapy. Family therapy will occur one time per week either in person at the Bradley Center, on speakerphone or if appropriate, in the home. Family therapy will take a systems, structural, or communications theoretical approach. Individual therapy will focus on Cognitive Behavioral therapy, Dialectical Behavior Therapy, relaxation therapy, sexual reactivity, and grief and loss issues. All therapists are trained in the above approaches. The staff is trained to manage behaviors that are triggered by internal or external stimuli as well how to deal with self-injurious behaviors. Structured activities will be leisure based and growth oriented. Participation in activities will be based on whether or not the girls are maintaining safe behaviors. All staff and residents will be taught how to utilize the sensory room.

An incentive program is used on the Female Trauma Unit. Individual treatment goals are developed each week along with daily expectations. Each daily expectation is incorporated with the Seven Commitments of the Sanctuary Model. The incentive program's week runs from Monday through Sunday and is tracked by each staff member at the end of each shift. Each individual goal and daily

expectations are worth one credit point. The residents can earn a total of 194 credits. Each Sunday a percentage will be totaled for each resident and this percentage determines what incentive plateau they will be assigned. There are four different categories depending on the percentage points: Garage Band, One-hit wonder, Platinum and ICON. Each plateau has different incentives and each individual and has the opportunity move to a different plateau weekly.

In conjunction with the incentives program, a contract that incorporates the Sanctuary SELF model will be developed with each resident, their primary staff and their therapist. The goal of the contract will be measurable and therapeutically based to meet the needs of the resident. The contract will provide the resident an opportunity to work towards the goal of remaining safe and continue this goal upon discharge.

Each resident, upon entry into the program will complete assessments prescribed by the treatment team. The assessments will be repeated as necessary to determine progress and needs. Other indicators of progress may include the Child and Adolescent Functional Assessment Scale (CAFAS) and baseline comparisons of the number of passive physical restraints, self-injurious behaviors, elopement attempts, and other maladaptive behaviors.

# Program Description:

## Adolescent Male Unit

The Adolescent Male Unit at the Bradley Center serves a total of 25 pre-teen and teenage males from 12 to 17.5 years of age. Although the diagnostic composition is diverse, the diagnoses of mood disorders and impulse control disorder are most prevalent.

Treatment interventions follow the cognitive-behavioral model and Glasser's Choice/Reality Therapy emphasizing appropriate social behavior and individual responsibility and problem-solving skills. Having developed a strong internal locus of control with the ability to identify and solve the mundane problems of daily living in a prosocial manner, the child will be able to successfully reintegrate back into his family, school and community and will not need to revert to the antisocial behaviors that lead to placement in a residential treatment facility. Social skills training, relaxation, problem solving, anger management and reality therapy are included in the approaches that are thoughtfully presented on both an individual as well as a group setting.

The Adolescent Male Unit places a great deal of emphasis on staff development and their ability to manage intense affect. Staff recognizes that in order to improve caregiver-child attunement they must respond to the child's affect, rather that react to the behavioral manifestation. A structured and predictable environment is created by establishing routine and the use of praise and reinforcement are increased to facilitate the child's ability to identify with competencies rather than with deficits.

The Adolescent Male Unit utilizes a Trust-Based Incentive Program to assist staff in teaching new skills that help each resident to identify, establish an internal locus of control and to change maladaptive behaviors. It will help the resident better understand the relationship between thoughts, emotions and actions. The incentive program will utilize positive privileges to motivate the young person and encourage positive choices, behaviors, responsibility and respect.

# Program Description:

## Children's Unit

The Children's Unit at The Bradley Center is comprised of male and female youths, ages 6 to 14. The unit is divided into two sections, dependent upon age range and level of functioning. One group is co-ed, with the other being male only.

The diagnostic composition being diverse, the Children's Unit does specialize in the treatment of Mood Disorders and Attention Deficit Hyperactivity Disorder (ADHD).

The underpinnings of therapeutic interventions will incorporate trauma informed principles as well as cognitive behavioral therapy. In light of the age group, play therapy and social skills training will be incorporated into individual, group as well as family treatment sessions.

A Stop, Think, and Go program is utilized on the Children's Unit. The objective of the program is to provide the child with concrete, immediate feedback so they can understand the structure and expectations of the unit in order to help the child develop the ability to better self-regulate. This program utilizes a stop light system allowing the child to move between the colors at different intervals during the day. Each color of the stop light describes the activities available to the child at each light on the signal, as well as the behaviors the child should consider and be made aware of at each signal.

All residents and staff will receive ongoing education as to the beneficial and therapeutic use of the diversion room. Relaxation techniques, Anger Management training, as well as Adventure Based Therapy will facilitate the treatment needs of this age and diagnostic group.

## A Safe and Comfortable Living Environment

At The Bradley Center the young people are permitted to decorate their bedrooms with child friendly items. These items can be from their home, or can be provided and purchased by The Bradley Center. Items that are permitted are: appropriate family photos, appropriate drawings that the child has completed, arts and crafts projects, posters that are child friendly, incentives posters, Sanctuary Safety Plans and Unit expectations.

Items that are not permitted are those depicting pornography, violence, drugs/alcohol or those with demeaning or degrading messages.

Decorative items may be secured to the wall with the use of masking tape, blue poster tack, double sided tape or removable mounting squares. Items may not be attached to the walls with staples, duct tape, nails or push pins.

# Assessment Tools

## Clinical Assessments:

The ***AD/HD Rating Scale IV*** uses the actual diagnostic criteria for Attention-Deficit/Hyperactivity Disorder as listed in the DSM-IV-TR as the basis for the scale. It is used for both younger children and adolescents. The Bradley Center will utilize the teacher version of the rating scale.

There are a total of 18 items to be evaluated by the teacher, with a scale range of "never" to "very often." Items on the questionnaire include: organization, activity level, disruption to classroom, listening and inattention.

Administration Schedule: Baseline and then every two weeks during the school year.

The ***Child Depression Inventory (CDI****)* is a 27-item self-rated symptom oriented scale suitable for children and adolescents aged 7 to 17 years. The scale discriminates children with the psychiatric diagnosis of major depressive or dysthymic disorder as opposed to those with other psychiatric conditions or non-selected "normal" school children. It is sensitive to changes in depression over time and is an acceptable index of the severity of the depressive disorder. The *CDI* quantifies a range of depressive symptoms including disturbed mood, hedonic capacity, vegetative functions, self-evaluation, and interpersonal behaviors. It can be completed in 15 minutes or less. The *CDI* can be scored and profiled in less than 10 minutes.

Administration Schedule: Baseline and then monthly.

The ***Obsessive-Compulsive Disorder Checklist (OCDC)*** includes elements of checklists/inventories developed by Vitiello (1989), Gedye (1992) and Leyton (2001). It is understood that compulsive behaviors tend to occur in categories and this checklist contains categories of ordering, completeness/incompleteness, cleaning/tidiness, checking/touching and deviant grooming. The content of a compulsion may change over time, although the type of category tends to persist. This checklist also recognizes the difficulty that children and adolescents have in describing the underlying anxiety and subjective discomfort related to an obsession and the repetitive behavior.

The *Obsessive-Compulsive Disorder Checklist* utilizes traditional DSM-IV criteria but places emphasis on objective, observable behavior and practical daily consequences, rather than on inner conflicts and anxiety. Compulsive behavior and its severity are described from an external, objective point of view that could be filled out by an observer. The checklist should be suitable for children unable to read, articulate thoughts or even speak. The severity scale should be useful in evaluating effectiveness of any treatment tried.

Administration Schedule: Baseline and then monthly.

The ***Revised Children's Manifest Anxiety Scale (RCMAS)*** is a 37-item self-report inventory used to measure anxiety in children and adolescents aged 6 to 19 years. Each item is purported to embody a feeling or action that reflects an aspect of anxiety. It is a relatively brief instrument which can be administered and scored in about 20-30 minutes.

Each item is given a score of one for a "yes" response, yielding a Total Anxiety score. Three empirically derived Anxiety Subscales scores (Physiology, Anxiety, Worry/Oversensitivity, and Social Concerns/Concentration) and Lie Scale scores can be calculated. The Lie scale is best thought of as a social desirability scale as it does not directly and conclusively detect "lying."

Administration Schedule: Baseline and then monthly.

The ***Trauma Symptom Checklist for Children (TSCC)*** is utilized to evaluate acute and posttraumatic symptomotology in children and adolescents who have experienced traumatic events (e.g., physical or sexual abuse, major loss, disaster, witness to violence).

The 54-item *TSCC* is a self-report measure that includes two validity scales (Under responsive and Hyper responsive) and six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation and Sexual Concerns). The instrument can be administered in 15-20 minutes and can be scored in just a few minutes. The *TSCC* has been described as probably the most widely used measure of children's PTS symptoms. For many purposes, the *TSCC* sub-scales can be used in the place of additional measures.

Administration Schedule: Baseline and then quarterly (at time of treatment plan review)

***The Vineland Adaptive Behavior Scales (VABS)*** were designed to assess handicapped and non-handicapped persons from birth to adulthood in their personal and social functioning. Following Edgar Doll's original conceptualization of adaptive behavior as multidimensional in structure and his measurement of the behaviors by areas, the *VABS* is organized around four Behavior Domains: Communication, Daily Living Skills, Socialization and Motor Skills.

Administration Schedule: At time of discharge.

***Yale Global Tic Severity Scale (YGTSS)*** is a semi-structured, clinician-rated instrument of motor and phonic tic severity. A separate, one-item impairment rating is also included that captures distress and impairment in interpersonal, academic and occupational realms due to all endorsed tics.

Administration Schedule: Bi-weekly for a period of time specified by the psychiatrist.

3. **Child and Adolescent Functional Assessment Scale (CAFAS)**

Residents are assessed upon admission, toward the end of each rewaiver period but prior to the next interagency team meeting and at discharge through the use of CAFAS. The CAFAS information is documented in the treatment plan as well as the discharge summary. It uses mutually agreeable and reliable measures of the resident's choices, goals, strengths, symptoms, and behavioral patterns.

Administration Schedule: Baseline, 4-months and Discharge

## 4. **Biopsychosocial Assessment**

A biopsychosocial assessment is completed on each resident by an interdisciplinary team including admissions, clinical, nursing, recreation, and education staff. This comprehensive diagnostic procedure is intended to examine all significant areas of the resident's life, including cultural and spiritual, and is used with other assessments for ongoing development of the treatment plan.

Administration Schedule: Baseline

## Aftercare Telepsychiatry Services

In the Spring of 2010, The Bradley Center began to provide Aftercare Telepsychiatry services for a number of youth discharging from our programs. Telepsychiatry aftercare services are available to youth over age 14 in York and Adams counties. This service will allow our psychiatrists the opportunity to provide 3 – 6 months of psychiatric aftercare services to include medication evaluation and psychiatric evaluations and treatment until the youth's care can be transferred to a community psychiatrist. Too often, children and youth are returned to their community after an RTF stay and due to a number of reasons, are not able to get a psychiatric appointment for some time after discharge. Children that are sent to Bradley often are referred by a county program that is more than 2 hours away. Although it is ideal to keep the child in the community, a number of factors prohibit that from occurring.

The Bradley Center provides services post discharge allowing for continuity of care from a more restrictive setting to a less restrictive level of care. We also believe that a transition from one psychiatrist to another will take some time, and psychiatric collaboration as well as a strong case management component will allow for increased positive outcomes when a child is discharged from RTF care.

The Bradley Center also has the capacity to provide family therapy sessions via video conferencing while the child is receiving treatment in the facility to accommodate families that reside a long distance from the point of care.

This is an innovative way to use telemedicine to best meet the needs of youth and their families.

## The Bradley Center
## The Blue Print for Change

“When people are triggered by reminders of past trauma, they become hyper aroused, and only learning gained during past experiences of hyper arousal and danger will be available to them” (Bloom, 1997).

When our residents are fearful, they cannot think clearly, and revert to their well practiced, though maladaptive responses. The Bradley Center provides an environment where the therapeutic influences of the milieu and staff allows for the “calm,” whereupon the resident is in a physical and emotional state that is open to “learning” from crisis.