Phoenix Academy

at Lake View Terrace, California:

Clinical Manual and Program Description of

an Adolescent Therapeutic Community

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This manual was prepared under funding provided by grant no. KD1 TI11433 from the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). The model and approaches described in this document are those of the authors and do not necessarily reflect views or policies of CSAT or SAMHSA.

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Preface

This document represents a collaboration between the Phoenix Academy staff at Lake View Terrace, the Phoenix House Foundation, and RAND. The following staff members at Lake View Terrace gave time to describe aspects of the program and review portions of the manual: Robin McGrady, Al Clary, Brian Moody, Larry Stallings, Eleanor Shepherd, Gail Myers, Jill Newman, Marsha Obremski, Leilani Burrell, John Fisher, Kirsten Anderson, Tom Stang, and David Blumberg. The residents of the Academy allowed us to watch many of their groups and activities. William Smith, Liz Stanley-Salazar, and Larry Stallings provided valuable input about the manual as it describes the Lake View Terrace Program, and Liliane Drago and Amy Singer provided review and comments at the Phoenix House national level. We would also like to thank Patricia Shane for her helpful review of an earlier draft.

Introduction

This manual seeks to describe the Phoenix Academy residential treatment program for adolescent substance abusers as it was implemented in 1998, 1999, and 2000 at Lake View Terrace. During this period, youths entering the Academy and other group homes through the Los Angeles County juvenile justice system were part of an evaluation study to compare Academy outcomes to those at the other facilities. Therapeutic communities, such as the one described in this manual, are organic, changing systems. Thus, this manual presents a specific window in time of a program that is continually evolving to meet the needs of its clients and the community that they form. It also represents just one such program (Lake View Terrace), and practices differ somewhat across facilities because of differences in the population served, funding and licensing constraints, and local issues. Where practices during the study period differ from current or "ideal" practices, these discrepancies are noted. Anyone wishing to replicate or implement treatment features contained in this manual are advised to seek formal training in this model.

Since an understanding of this program requires familiarity with the therapeutic community model, we begin with an overview of that model, with modifications made for adolescents at Lake View Terrace noted along the way. We then move into a description of the flow of services and progress of adolescent residents during their treatment, followed by a description of the various treatment components. At the end of the manual, we describe staff training and supervision, funding for the program, and empirical support for the efficacy of this particular program.

I. PHOENIX ACADEMY MODEL: AN OVERVIEW

A. The Therapeutic Community Perspective

The fundamental assumption underlying Phoenix Academy is that recovery from substance abuse requires change of the whole person—psychologically, socially, and behaviorally. This holistic view of substance abuse contrasts with other common approaches to treatment, which may focus more narrowly on physiologic dependency or on identification of emotional conflicts from which drug abuse may stem. Like other programs based on the therapeutic community model, Phoenix Academy regards substance use as the outward manifestation of a much broader set of problems and adopts a holistic view, seeking to promote change in virtually all aspects of an adolescent's life. Because of this focus on all-encompassing self-regeneration, Phoenix Academy has drawn its name from the mythological bird that burned itself to ashes on a funeral pyre from which it rose to live anew.

1. Mission Statement

The Phoenix Academy is a therapeutic community for adolescents that combines residential treatment for substance use with academic instruction. In conjunction with substance abuse, participants may experience a wide range of co-morbid mental disorders. Each adolescent's therapeutic needs are addressed in a safe and supportive environment. The objective is to promote global changes in lifestyle, identity, and behavior.

2. Elements of the Therapeutic Community Perspective

Phoenix Academy adheres to the basic principles followed by all therapeutic programs based on the therapeutic community (TC) model. Historically, therapeutic communities have two unique features. The sine qua non of the TC model is its view that the therapeutic milieu provides the basis for all psychological and behavioral change. Second, as described below, the Phoenix Academy model is based on an explicit and unique set of views concerning the nature of both drug abuse and the drug abuser; the process of recovery; and fundamental precepts, beliefs, and values required of persons who commit to self-help.

a. View of the Disorder. Substance abuse is considered to be a disorder of the whole person, affecting values, beliefs, mood, and behavior. Though substance abuse is seen as primary (e.g., drug abuse must stop before any other changes can be made), the problem is not the drug, but the person. The person needs to address the issues and problems that contributed to and resulted from his or her substance abuse. Thus, the aim of recovery is to change virtually all aspects of a member's life to promote a more positive lifestyle. Within the TC framework, physical detoxification is only an antecedent to treatment.

b. View of the Person. Within the conceptual model provided by the TC, individuals are differentiated along dimensions of psychological and social dysfunction, rather than substance abuse patterns. Substance abusers are regarded as sharing certain characteristics that contribute to their proclivity to abuse substances. These characteristics include poor tolerance for frustration, difficulty controlling impulses, low self-esteem, problems with authority, inability to cope with feelings, an absence of personal accountability, guilt, poor interpersonal and communication skills, unrealistic beliefs, manipulativeness and dishonesty, and pervasive life-skill deficits.

c. View of Recovery Process. The foregoing views of the disorder and the person give rise to the position that recovery requires a fundamental, but gradual, transformation of one's lifestyle, personality, and identity. In other words, recovery involves making changes to negative thinking, feeling, values, and behavior that are consistent with drug use. Recovery itself is viewed as a self-help process in which people with a common problem help one another. Therefore, they must play an active role in their recovery, as opposed to a passive one in which a "professional" administers treatment. Self-help recovery involves a social learning process, in which residents learn new appropriate behaviors and lifestyles from peers and staff members who are successful in recovery and who serve as role models.

d. View of Right Living. The TC model holds that successful recovery hinges on adopting a new life orientation that embraces certain essential precepts, beliefs, and values. This orientation, termed "right living," emphasizes honesty, living in the present moment (i.e., the here and now) rather than focusing on the past, and acceptance of personal responsibility for one's own destiny. This view encourages members to lead a mature, responsible lifestyle characterized by adherence to a strict moral code of ethics and behavior. The value of work (work ethics and pride in work) and the earning process is epitomized by

the concept of "no free lunch." Concern for the welfare of others and community involvement are stressed and are opposed to the anti-social, self-serving ethics of the drug subculture. This concern is epitomized by the concept of "being your brother's/sister's keeper." Residents are encouraged to actively challenge their own and others' negative behavior. From the perspective of right living, human beings are regarded as essentially good, even though specific actions may be negative. By emphasizing innate goodness and the possibility of personal change, members of the community are encouraged to pursue their full potential. This view enables residents to be accepting of their own shortcomings and mistakes, as well as those of others.

3. Elements of the Therapeutic Community Method

The cornerstone of the TC model is the view of the community as both the primary agent of change as well as the context in which recovery occurs. As described by De Leon (1997), the TC is distinguishable from other therapeutic approaches in "the purposive use of the peer community to facilitate social and psychological change in individuals (p. 5)." All activities within the community are designed to promote therapeutic and educational change. Peers and TC staff members act as role models for change and serve as guides to the recovery process. As described by De Leon (1997), key elements that characterize the TC community include

- Use of participant roles. Residents are expected to contribute directly to all activities conducted within the TC. Thus, each resident assumes an active and prescribed role in the maintenance of community functions. Assumption of social roles provides learning opportunities for residents. These roles are targeted at the developmental stage of each member of the community, and new roles, requiring more responsibility, are awarded as participants make therapeutic progress.

- Use of membership feedback. The primary source of therapeutic change is feedback provided by other members of the community. All members of the community are expected to provide responsible concern for other members. This concern is manifested by providing honest, authentic reactions to others.

- Use of members as role models. In addition to providing feedback to others, members are also expected to serve as a role model of the change process for others in the community.

- Use of collective formats for guiding individual change. All learning occurs in a social context. Education, training, and therapeutic activities take place in group settings.

- Use of shared norms and values. The successful functioning of the TC requires that all members adhere to a shared set of beliefs and standards of behavior regarding self-help recovery and right living. These consensually accepted standards are expressed in the language of the TC and are mutually reinforced by members.

- Use of structure and systems. The recovery process is predicated on recognition of community procedures and structures as legitimate sources of social influence. The attainment of status, responsibility, and privileges depends upon accepting supervision from others, abiding by consensually accepted rules, and behaving as a responsible member of the community.

- Use of open communication. The sharing of experiences of all community members is regarded as essential to the therapeutic process. The use of public forums in which members discuss feelings, experiences, and behavior and its consequences promotes social learning and self-help.

- Use of relationships. Engagement in the therapeutic change process is facilitated by development of positive relationships with peers and staff members. Peer relationships also provide the core social support network on which recovery can be maintained upon return to the broader community.

- Shared terminology. The concepts and values of the TC are often expressed by means of a special terminology. The use of special terms, especially in discussions of

recovery and principles of right living, serves to strengthen the bonds among members of the community. Thus, the use of this terminology reflects the degree of integration into the community.

4. Elements of the Therapeutic Community Program Model

Phoenix Academy at Lake View Terrace follows the TC model as described by De Leon (1997), with a few modifications for the adolescent population. The basic components of TC method include the following:

- Community separateness. TCs are generally housed in a living space that is separated from other agencies or programs and/or the greater community to facilitate development of a distinctive identity. Members of residential TCs remain apart from outside influence, immersed in the TC experience around the clock for weeks before receiving privileges to leave the TC for a short time. This period of isolation separates members from drug-use triggers at a time when drug cravings are at their strongest.

- A community environment. The environment of the TC contains ample shared living space to promote affiliation and a sense of common purpose. Community walls are adorned with simple messages conveying shared norms and values. Visual displays of the organization of the TC are posted to facilitate identification with the community.

- Community activities. With few exceptions (e.g., individual therapy), all therapeutic and educational services are offered in group settings. Daily meetings, groups, and seminars are held. Job functions and recreational activities are also programmed to occur collectively. At least one meal each day is prepared, served, and shared by all members.

- Peers as role models. All TC members, including staff members, are expected to serve as role models. As conceived within the TC model, the efficacy of the TC is directly related to the number and quality of these role models.

- Staff as community members. The TC staff is composed of both traditional professionals (e.g., health providers) and recovered members. All staff members receive training in the TC model to become integrated into the TC community. Irrespective of their training or function within the community, the role of all staff is that of community member. As such, they serve as role models and guides within the TC model.

- A structured day. In accordance with the TC view of the individual and the recovery process, each day has a formal schedule of activities. This structure counters the lack of order and discipline characteristic of most substance abusers. The structured day promotes self-regulation, discipline, responsibility, and personal accountability.

- Work as therapy. All activities required for the successful day-to-day functioning of the community (e.g., meal preparation, cleaning, meetings) are performed by members. All members contribute to these functions in accordance with their prescribed roles. Involvement in these activities is regarded as central to therapeutic change inasmuch as participation enables acquisition of new skills, promotes self-awareness, and contributes to the assumption of personal responsibility. The specific roles played by a member at any given time are a function of the needs of the community and the personal resources of the member, as well as a reflection of that member's progress in treatment. Members who demonstrate positive attitudes, values, behavior, and responsibility in meeting work requirements are rewarded with higher level job functions, which entail greater status, authority, and privilege.

- Phase format. All aspects of therapeutic and educational process (i.e., all community activities) are organized around the principle that recovery proceeds in stages. When

members meet the expectations associated with a given stage of recovery, they advance to the next stage.

- TC concepts. The TC view of recovery and right living are embodied by a framework of concepts, taught as part of an organized curriculum. Members are repeatedly exposed to these concepts in various groups, meetings, and seminars, as well as in conversations and personal writings. They include "honesty," "responsibility," "no free lunch," "you are your brother's/sister's keeper," "what goes around comes around," and others (to be described in "Orientation of Youth Into the TC" in Section III).

- Peer encounter groups. The core community group is the peer encounter. The aim of the peer encounter group is to promote awareness of specific beliefs, attitudes, and behaviors that must be changed. Members ventilate and explore feelings in the encounter group, gaining personal insight and emotional management skills. The encounter group process also promotes interpersonal skills and positive relationships among members, as they resolve personal differences constructively and share common feelings and experiences.

- Awareness training. The TC model holds that awareness of one's attitudes and behavior and their personal and social impact must precede change. Therapeutic and educational activities are aimed at bringing about this self-awareness.

- Emotional growth training. One aspect of personal development is emotional growth. Emotional growth requires that members learn to identify, express, and manage emotions effectively. Opportunities for emotional growth are provided by the interpersonal and social demands of community life and are facilitated by therapeutic activities, such as encounter groups.

- Planned duration of treatment. The ambitious goals of treatment—which include internalization of a new set of living standards—require a period of intensive

involvement in the TC. Although the precise length of involvement may vary, duration of treatment must be consistent with individual treatment objectives. At Lake View Terrace, the goal is to keep adolescents in treatment for 1 year.

- Continuity of care. Aftercare involvement with the TC is essential for maintaining treatment gains. Effective aftercare sustains a TC and self-help perspective and approach, though in a less intensive, ambulatory modality. Aftercare continues until the member makes a successful adjustment to the greater community.

In addition to De Leon's description (1997) of the general TC elements, adolescent Phoenix Academy models include the following education element, which is one of the key components for adolescents:

- Educational process. The emphasis on education within the adolescent TC makes it a crucial part of the therapeutic process. Like work for the adult in a TC, school performance is seen as an important clinical issue for the adolescent, though adolescents hold jobs as well. Behavior in the classroom is monitored and used as a barometer of clinical progress. Progress in the educational program is encouraged through the use of privileges and phase advancements. Educational staff and therapeutic staff members communicate frequently and work together to integrate the educational process into the therapeutic experience. In addition to being a part of the therapy itself and an important part of recovery, the educational process helps residents make up for prior school failures and accelerates their progress towards graduation (e.g., by filling in missing requirements). In this way, the educational process helps to prepare them for the transition back into the community after leaving the Academy.

B. Phoenix Academy Compared to Adult Therapeutic Communities

Although the therapeutic community model is composed of a core set of philosophical and therapeutic underpinnings, certain modifications to the basic model are

made to address the unique needs and circumstances of adolescents. The major modifications are summarized below:

- Treatment stages reflect progress along age-appropriate behavioral, emotional, and developmental dimensions.

- Adolescent programs, including Phoenix Academy, are generally less confrontational than adult programs.

- For adolescents, there is less emphasis on job functions and more emphasis on school. Nonetheless, work skills, habits, and ethics are taught and are considered important in the development of adolescents.

- Adolescents participate somewhat less than adults in certain daily operations of the Academy (e.g., driving). However, they are expected to get involved in running departments and working with staff members to make decisions, and thus, they have influence in the management of the Academy, just as participants in adult programs.

- Staff members provide more supervision and evaluation than would be typical of an adult program.

- Neurological impairments, particularly learning disabilities and related disorders (e.g., attention deficit/hyperactivity disorder) are assessed.

- Greater emphasis is placed on education, including schoolwork, in adolescent programs.

- The family plays a greater role in the treatment process.

- Greater emphasis is put on recreation and social activities in adolescent programs, in recognition of the need to teach adolescents how to have fun without drugs and alcohol.

- Psychotropic medications may be prescribed and taken for the treatment of psychological disorders, unlike the policy characterizing many TCs for adults.

- The duration of stay for adolescents is variable and often depends upon funding considerations rather than adolescent needs.

C. Physical Setting and Facilities

Phoenix Academy at Lake View Terrace is housed in a large, modern building surrounded by parking areas and recreational fields and is located in a middle-class residential neighborhood. The campus is 17 acres, and the building has several wings broken up by courtyards filled with gardens and trees. The overall size of the building is 167,000 square feet, but the Academy leases 10,000 square feet to the Training Division of the Los Angeles County Office of Education, the alternative school agency for the county. This arrangement in part reflects the close partnerships between Phoenix Academy and this agency. As one enters the building, one passes a reception desk where residents and guests sign in and out. Nearby are the admissions and administrative offices. Beyond the reception desk is a large atrium that serves as a waiting area. As in all public areas, residents' colorful artwork is displayed on the walls. The hallways throughout the facility are wide and uncarpeted. The classrooms (including art room and computer stations) are located in one part of the building, near large kitchen facilities and a cafeteria. There are four different dormitory areas, each containing a series of double dorm rooms, a lounge area, and a meeting room. Dorm rooms are large, with minimal decorations or personal belongings, and are kept neatly: beds are made with hospital corners, blankets are rolled at the end of the bed, shoes are neatly lined up, etc. A suite of staff offices is located in one section of the building, but staff offices are also interspersed throughout the building. Some administrator and supervisor offices are located in dormitory areas to allow maximum contact with residents. Several large group rooms are used for special events, community meetings that include

family members, and house-wide meetings. The grounds contain recreational areas (pool, playing fields, basketball courts).

D. Clinical Approach and Staffing Patterns

Counselors at Phoenix Academy work to demonstrate the qualities of honesty and consistency in order to build a trusting therapeutic relationship. They provide residents with frequent feedback about their behaviors. Whereas some aspects of the treatment are confrontational (e.g. the encounter groups), counselors maintain a supportive stance with youths. Many of the staff members are TC graduates in recovery and serve as positive role models for the residents.

Primary counselors, who act as "parents," are responsible for most aspects of the residents' day-to-day experiences, including privileges, personal needs, communication with family, outings, and one-on-one counseling sessions. Primary counselors try to embody a "good" parent: one who consistently enforces rules and provides structure, but at the same time is empathic, listens, and shows care and concern for the resident.

Family therapists, who see residents in individual and family counseling, maintain a more traditional therapeutic role, but they too are involved in many aspects of the case and spend a lot of time on the units with the residents. Thus, they get to know the residents informally as well as in sessions.

Finally, all staff members work as a team, to provide a uniform approach and consistency within the TC. Much communication between staff members about residents occurs informally, but communication is also formalized in regularly scheduled case reviews and team meetings. Residents learn quickly that staff members work as a team. Although they can trust individual staff members to keep private the details that they discuss with them, they know that the entire staff will be kept apprised of their progress in treatment. Thus, residents are accountable to the entire staff and can expect all staff members to help them progress through treatment.

II. PHASES OF TREATMENT AND CRITERIA FOR ADVANCEMENT

A. Privileges and Sanctions

A basic concept of the TC is that individual change can be facilitated by teaching the consequences of behavior. This position holds that desirable behavior can be stimulated by providing positive consequences and removing negative ones. By contrast, unacceptable behavior can be discouraged by introducing negative consequences or removing positive ones (e.g., revoking rewards like status promotions or other privileges). Behavior that deviates from accepted practices of the community is met with disciplinary consequences or "sanctions." Decisions regarding privileges and sanctions are made by staff members at weekly meetings and are announced at house meetings when the entire community convenes. This public sharing of information regarding privileges and sanctions has an important function in the TC. Members learn desirable behavior not only through the consequences of their own behavior, but also through the observation of others' behavior. This social learning process occurs as members adopt behaviors they have observed to be effective in the attainment of rewards and avoid those that result in negative outcomes.

Within the TC, earned privileges are believed to instill pride and self-regard, whereas unearned positive consequences are regarded as stimulating an unwarranted sense of entitlement. For this reason, no privileges are granted to a resident without being earned. Although basic entitlements such as sufficient food, sleep, clean clothing, personal hygiene, and educational opportunities are provided to members of the community unconditionally, virtually all other resources are regarded as privileges that must be earned.

As residents spend more time in the program and meet program goals, they advance through the phases of the program. With each phase advancement comes the opportunity to earn additional privileges. These include more frequent communication with persons outside of the TC, greater access to personal property (e.g., radios, jewelry), more free time, and enhancements to a resident's responsibility or status within the community (e.g., more responsible job, assignment to a more desirable room, being asked to conduct seminars, being allowed to take special trips).

The TC imposes sanctions on residents whose actions run counter to approved standards. Sanctions are not used merely to punish a resident for negative behavior.

Sanctions are intended to serve as a learning experience for the resident, stimulating individual growth. Sanctions are imposed in proportion to the severity of the infraction and length of time in the program. For violation of most house rules or regulations, relatively mild sanctions are imposed; for example, if a resident refuses to accept instructions from authority or is late for a meeting, then the resident may be verbally reprimanded. The most common form of sanction is termed a "learning experience." During the learning experience, a privilege that had been previously earned by the resident can be taken away; for example, the resident may be demoted from their current job to one of lesser status within the community. Other types of learning experiences include writing assignments, cleaning, or other assigned activities, and generally last between 1 and 5 days. During a learning experience, residents may also be excluded from participation in planned program activities that are not regarded as primarily educational or therapeutic in nature. Residents may also be required to perform additional assignments related to their treatment plan.

B. Phases of Treatment

1. Phase I: Orientation

The treatment program consists of four phases. Phase I consists of both an orientation and a stabilization component. The orientation phase, which typically lasts 2 to 3 months, is devoted to orienting participants to the basic philosophy, concepts, and rules of the TC. The orientation class is conducted three times a week by senior program staff members. The primary goals of the orientation phase are to prepare the participant to progress optimally through the treatment program and to observe and assess participants as they immerse themselves in community life.

During the orientation phase, the new residents are introduced to a number of responsibilities. They learn program terminology and begin to use these terms in their daily activities. Residents at Phoenix Academy are grouped into "clans" or families. Each clan has 6 to 15 residents and a clan leader or primary counselor. Each resident is assigned to a clan and to a big brother or sister to guide them through the program. They are also given their first job function within the community. Job functions require adherence to community rules and acceptance of authority; they also emphasize teamwork. Attendance at school begins during this phase as well. Weekly family therapy sessions may also take place,

focusing on issues that were occurring before the resident's entry into the program. New residents attend clan meetings and receive individual counseling sessions with the clan leader, as well as individual treatment. During the orientation phases, members are required to complete an autobiography, write a paper describing their reaction to the orientation process, and pass a written examination.

During the orientation phase, new residents have fairly limited privileges (e.g., no makeup, jewelry, books), as all privileges must be earned. In this early phase of treatment, contact with the outside world is very restricted. Going out of the program is a privilege that increases as members progress through the program and demonstrate commitment to their recovery. Isolating members from outside influences helps them adjust to treatment and minimizes exposure to drug triggers. In recognition of the importance of family for adolescents, new residents are allowed to receive mail from immediate family members, to visit with family members at scheduled functions, or to make phone calls to their immediate family members.

2. Phase I: Stabilization

Following successful completion of orientation, the stabilization period begins. Over the next 4 months (months 2 to 6), the residents begin to participate as fully integrated members of the community, engaging in a broadening range of community activities. The objective of this phase of the program is to become fully engaged in the treatment process and to comply with program rules. During this period, residents are expected to begin establishing positive relationships with their peers and to assume responsibility as a big brother/big sister for newer residents. Control of impulses, management of frustration and other feelings, and responsible behavior (e.g., relating to work, hygiene, order in rooms) are emphasized. Residents also are eligible to earn passes to leave the facility once they complete orientation.

During this period, residents gradually assume more responsible job functions designed to teach skills and improved work habits. Basic education classes are supplemented with seminars on life skills, hygiene, sex education, and minority studies. TC seminars help members examine previous lifestyles and values, and teach the TC "view of right living." Recovery and treatment issues are explored, and the "how's" and "why's" involved in

changing lifestyles are examined. The primary aim of seminars is to provide intellectual challenges, helping the residents to develop interpersonal and conceptual skills. Speaking in front of a group is seen as a way to bolster self-esteem. Involvement in treatment and counseling activities continues during this phase, as does participation in clan meetings, peer group meetings, and individual counseling with the clan leader. By the end of this phase, members may move from compliance for fear of sanctions to conformity in the desire to gain social rewards in the community.

As residents progress in this phase of treatment, they begin to earn an expanding range of privileges. Residents earn the privilege to communicate with approved friends by mail. After a minimum of 90 days in the community, residents may receive an allowance and become eligible for small group outings (e.g., to the movies), accompanied by staff members. Residents also earn privileges in the form of personal freedoms. These include the use of small personal items, eligibility to decorate their personal living area with items from home, and permission to use makeup and jewelry. Successful progression through this phase of the program is marked by compliance with the core principles of the programs, connections with peers, social assimilation into the community, adjustment to work, and insights into personal value systems.

3. Phase II: Primary Treatment

Phase II of the treatment process takes place during residents' sixth through ninth month in the program. Internalization of values and intrinsic motivation for drug-free living and personal growth is accomplished in this phase. Leadership roles of members in the community facilitate this process, as members start to act as role models for others in the program, modeling acquired skills and sharing insights with newer residents. By the end of this phase, the member is expected to have adopted a new social identity: that of a drug-free person in recovery.

An aim of this phase is to make initial preparations for residents' eventual re-entry to the community. During this period, residents are expected to implement vocational and educational plans in preparation for school or work in the community. They are encouraged to continue to work on interpersonal relationships, in general, and family relationship conflicts, in particular. Residents also are expected to work on improving their social and

assertiveness skills and are given opportunities to practice speaking in public, such as the preparation of seminars or workshops for other residents. Residents assume more responsible job functions of higher status within the community and also assume some leadership responsibility. The treatment team develops a re-entry plan in collaboration with social service workers and parents, when applicable. Residents participate in advanced educational and vocational counseling as well as workshops and seminars to prepare them to meet the demands of re-entry. Residents who will not be returning to live with family members receive training in independent living skills and related issues that they will face outside the Academy. A major thrust of the re-entry plan is to encourage greater involvement in activities in the larger community, in which they can make a contribution to the outside community.

During this period, residents may earn the privilege of hosting guest tours of the facility, may represent Phoenix House in public speaking engagements with the staff, and begin to participate in cultural enrichment activities. Residents continue to participate actively in clan meetings and to receive individual counseling sessions with their clan leader. Family and/or individual therapy takes place, as appropriate. Individual and group counseling place emphasis on building skills, instilling positive attitudes, and addressing community re-entry concerns. During this period, residents may also participate in marathons (described below) or multiple family group sessions.

Other privileges that can be earned during Phase II include making and receiving more telephone calls from immediate family members or approved friends, visiting with family or friends during Family Tea and Recreational Days, and expanded privilege to have personal items (e.g., radios). During this period, residents may earn the privilege to participate in social outings with other Phase II residents and may receive additional free time.

4. Phase III: Re-Entry

Phase III of the treatment process takes place during months 9 through 12 of the program. The objective of this phase is to complete final preparation for residents to return to their communities. Residents are expected to make a weekly itinerary schedule and to develop realistic plans for returning to the community, including identification of life goals.

They are responsible for initiating and following through on efforts to integrate into the community. These efforts include managing personal finances, opening a bank account, and using public transportation. Responsibilities may also include obtaining a driver's license, looking for employment, preparing for job interviews, and registering to vote. During Phase III, residents are expected to continue to serve as positive role models for others in the community and to maintain interpersonal relationships with peers and younger members of the community. Demonstration of satisfactory performance in school is also required.

During this period, residents participate in individual and group counseling with their clan leaders. They also attend seminars, workshops, and tutorials and participate in the re-entry classes. They also participate in group sessions with other members of the community who have reached Phase III, in which they can focus on specific re-entry issues. Residents participate in community service projects to contribute to the broader society to which they are about to return. Individual and family therapy continue, and residents also participate in multiple family group therapy sessions. The focus of family therapy is on preparation for the transition to the greater community. Other counseling and therapy sessions are used to address practical issues in preparation for the residents' move to the community, dealing with separation anxiety and the fear of failure, and encouraging application of new skills. Residents who will move into independent living situations or foster homes receive special counseling to address their specific needs.

During this phase of the treatment program, residents receive an expanded range of privileges. They become eligible for individual rooms and may make and receive phone calls, they receive a stipend, they are allowed to possess personal transportation, and they are eligible for home passes of up to 72 hours.

5. Aftercare: 1 Year

After completion of Phase III, residents have finished the residential portion of the program. All residents who have successfully completed Phase III move out of the facility and enter into a 1-year program of aftercare activities. Weekly groups are continued on-site for the first 6 months following completion of Phase III. For the remaining 6 months, groups are available twice monthly. Counseling is provided, including home visits by aftercare counselors. Family therapy, if appropriate, is offered twice a month for the first 6 months

and monthly thereafter, unless more intensive family therapy is needed. “Live-outs” are expected to visit and give seminars for 8 hours a month and to act as role models for residents. They sign a contract agreeing to the possibility of being drug-tested and agree to comply with consequences suggested by the staff. Quarterly activities, including picnics and sporting events, are held to keep aftercare participants and their families engaged in the program. Aftercare participants are encouraged to remain involved in social and recreational activities with residential members of the community. After one full year of living drug- and crime-free and after completion of all other TC requirements, program participants are considered for formal graduation

III. DESCRIPTION OF THE MAJOR COMPONENTS OF PHOENIX ACADEMY

A. The Admissions Process

1. Referrals Into the Program

Referrals to Phoenix Academy at Lake View Terrace generally come from the following sources: Juvenile Probation (about 90%); Department of Children and Family Services (DCFS) (about 5%); and the Department of Mental Health (DMH), self-referrals, or other county agencies (about 5%). Preliminary information about the patient is gathered over the phone, and if suitable, an intake interview is scheduled. Many times this first assessment occurs in Juvenile Hall, but other times the potential resident is brought to Phoenix House for the assessment.

2. Intake Assessment

The intake assessment begins with a review of the probation packet or records from DMH or DCFS. An interview with the potential resident is conducted using CIS-I, a computer-driven contact interview, including assessment of the following areas: basic demographics, education, placement history, legal information, medical history, behavioral/conduct problems, substance abuse, psychiatric history, financial information, and current physical health status. On the basis of this interview, it is determined whether or not the adolescent is eligible for Phoenix Academy admission.

More detailed information is gathered at intake in each of the areas described above on a computer-driven admissions interview, called CIS-II. Data from CIS-I and CIS-II are linked so that all of the prior information is also available. If they are available, family members can be included in the intake assessment and oriented to the program and family components. If questions regarding the suitability of an applicant are raised during the intake process, a second interview is conducted by a psychologist to evaluate whether the youth would be likely to benefit from Phoenix Academy. Once the assessment is complete, the admissions coordinator submits the paperwork to the admissions director for approval. If the youth is accepted into treatment, an admissions appointment is set up to complete the intake process. CIS-II data become part of the adolescent's chart.

Phoenix House maintains a waiting list that operates on a first-come, first-served basis. For instance, they hold eight beds for their contract with the Los Angeles County Alcohol and Drug Program. If a youth comes to them from this source, he or she will be admitted if one of those eight beds is open or will wait for one to open up.

3. Inclusion/Exclusion Criteria

Youths with a history of behavioral problems and substance abuse and who demonstrate a need for treatment in a long-term, highly structured residential treatment program are candidates for Phoenix Academy if they meet the following criteria. They must be 13 to 17.5 years old, able to function in the TC in a voluntary and open setting, speak English, and have undergone detoxification (if necessary). Those with co-occurring mental health and substance abuse problems may be accepted, as may those with histories of severe trauma or those who have been stabilized on psychotropic medications. There are several different reasons for exclusion from the program, though there are no hard-and-fast rules. These include fire-setting, active self-mutilation or active suicidal ideation, history of suicide attempts, serious violent behavior, sexual predatory behavior, severe psychotic symptoms, active homicidal ideation, severe impulse control problems, untreated tuberculosis or other infectious disease, being gravely disabled, or having an IQ below 70 (moderately mentally challenged). The presence or absence of any of these problems does not necessarily preclude admission to the program. Rather, they are considered in light of the recency of such behavior, as well as contributing factors such as substance abuse, remorse, behavior during the interview, and placement history. Youths who have a history of leaving other programs without permission (AWOLs) and those with very minimal drug use history are generally accepted, though these factors are considerations in the admissions process. In some cases, additional information (e.g., mental health records) is required before the admissions director can reach a decision.

4. Receptivity of Youth and Family

The receptivity of the youths and their parents to Phoenix Academy treatment differs by the referral source. In general, youths in the probation system are eager to go to the Phoenix Academy. They tend to view it favorably, in comparison to Juvenile Hall, even

when staff members are careful to describe the program honestly and to highlight the structure and rules. Parents of these children are mixed in terms of their enthusiasm and can be split into three groups. Some parents are engaged and involved in the program, some are disengaged and participate minimally, and the rest are hostile towards the program staff. About 80% of youths have family members involved in their treatment, but it is sometimes a more distant relative (e.g., an aunt or grandmother) rather than a parent. Barriers to engagement in the program for parents include language barriers and cultural norms that stigmatize treatment. Among DCFS referrals and self-referrals, the youths are generally not receptive to the idea of beginning the program. They are usually in a less structured home or home-like setting and do not wish to be in a highly structured environment for an extended period of time. In such cases, current residents are sometimes brought into the interview to talk about the program and to help encourage the youth to sign in. Parents of self-referred youths are generally highly committed, and Phoenix Academy staff often helps them prepare for the admission process. For instance, Phoenix Academy staff makes it clear to parents that if they want the youth to enter the program, they should make it the only option available to the youth. DCFS youth generally do not have parents who participate in the program, since they are already separated from their natural parents and motivation for foster parents tends to be low.

B. Treatment Planning

1. Client–Staff Matching

The admissions interviewer assigns the new client to a clan. Clans are led by a staff member (known as the clan leader) who serves as primary counselor for each member of his or her clan. There is no formal procedure for assigning a new client to a particular clan, although the admissions interviewer does attempt to match the youth with an appropriate clan leader within the constraints of available beds. For instance, a young man with impulse control problems might be deemed to need a strong male figure as his primary counselor, or a young woman with a history of sexual acting out might be deemed to need a female counselor. All youths in a particular clan work with the family therapists assigned to that clan.

2. Assessments and Evaluations

The clan leader (or "primary counselor") immediately conducts a clothing inventory, a needs assessment (socialization, emotional, mental, physical, and functional skills) within 2 weeks, and develops an individual treatment plan within 30 days (see table below). In addition, the family therapist conducts a family assessment, a case plan in which goals for treatment are defined, and a psychosocial assessment. A psychologist completes a psychological assessment within 2 weeks of admission, including psychological testing (e.g. cognitive testing, MMPI, Rorschach) and a structured diagnostic interview. Educational testing and credits review are also done during the first few days of school.

Staff Person	**Assessment Responsibilities**	**Role With Resident**	**Activities With Resident**
Primary counselor or "clan leader"	• Individual treatment plan • Appraisal/needs and services plan • Clothing inventory • Progress reports to referring agencies • Educational assessment • Progress notes	• Advocate and "parent" • Responsible for all elements of the case	• Encounter groups • Workshops • Liaison with school • One-on-one meetings • Mediator with family • Enforcement of disciplinary actions • Discharge planning • Decisions about phase advancement and job functions • Outings and activities
Family therapist or case manager	• Psychosocial history • Individual case plan • Educational assessment with family	• Individual and family therapy • Specialized group therapist	• Encounter groups • Workshops • Individual therapy • Family therapy • Parent education • "Family Tea" • Crisis intervention
Psychologist	• Psychological testing	• Evaluator and specialty counselor	• Specialized group therapy • Individual or family therapy (when needed) • Crisis intervention
Psychiatrist	• Psychiatric evaluation (if needed)	• Specialist	• Medication interventions and management • Crisis intervention

The admissions coordinator informs the senior staff about relevant issues for each new resident and attends weekly staff meetings to present new residents to the clinical team. A multi-disciplinary treatment team meeting is held weekly to discuss cases and make modifications to treatment plans. This team includes the consulting psychologist, primary counselor, family therapist, and someone from the education department. If there is a medical issue, then someone from the medical department is also present.

C. Orientation of Youth Into the TC

Youths advance through phases in the program, described in Section II. This begins with orientation, which follows a structured curriculum.

Orientation Curriculum

- Week 1: Philosophy and history
- Week 2: Cardinal rules and basic rules
- Week 3: Basic concepts, terminology
- Week 4: Dress code and room procedure
- Week 5: Morning meeting schedule and rationale
- Week 6: Family gathering, seminar, chain of command
- Week 7: Encounter and tools; encounter video
- Week 8: Encounter and tools; mock encounter
- Final test

Youths are given an orientation packet and taught the basic rules of the Academy. The cardinal rules include no physical violence, no threats of physical violence, no drugs or alcoholic beverages, and no destruction of Phoenix House property. Basic rules include acceptance of instructions from authority, punctuality, maintaining a neat appearance, curbing impulsive behavior, good manners, no stealing, no lending or borrowing, no receiving gifts without staff approval, no leaving the facility without permission, no walking out of encounter groups, no going to bed during the day without staff permission, no smoking, no making or receiving phone calls without permission, leaving the facility by the front door only, signing in and out of the facility, no personal money except stipends earned at the Academy, and no visits from family or friends unless approved by the primary

counselor. Violation of any of these rules or the refusal to accept appropriate disciplinary actions may lead to expulsion (see "Disciplinary Procedures" in Section IV).

Youths are taught 13 basic concepts:

1. Honesty: This is the key to being successful in treatment and recovery. Members are taught to be honest in word, deed, and in lifestyle.

2. Blind faith: Members are encouraged to trust that the process will work, though they may not completely understand or accept it initially.

3. No free lunch: This concept teaches work ethic—nothing is free, and all good things in life require work and effort.

4. It's better to understand than to be understood: This concept reinforces the importance of the community and in listening and attempting to understand other community members' perspectives and issues.

5. Nothing is constant but change: Your feelings, your surroundings, and all the events in life are changing constantly. Things won't always happen the way you want them to; it is important to learn to be flexible.

6. Act as if/become as if: This concept holds that changing behavior will lead to emotional and attitudinal change. It encourages positive behavior regardless of negative feelings or poor motivation. The importance of this concept is its use as a change strategy. Positive behavior is thought to lead to positive outcomes, improved feeling states, overcoming fears, and thus the acquisition of new behaviors and skills.

7. You are your brother's/sister's keeper: This is the cornerstone of the self-help process—the support that members give one another. This concept stresses that all members have a responsibility to help their "brothers" and "sisters." This social support is a foundation of a stable recovery during and after treatment.

8. You can't keep it unless you give it away: Members are taught to reinforce what they have learned about recovery by teaching and helping others. This promotes self-help, maturity, and the internalization of values.

9. You get out what you put in: This concept teaches that effort is related to outcomes. The harder a member works, the more he/she benefits.

10. Different strokes for different folks: This concept teaches members not to compare themselves to others, as everyone is different. Drug abusers often use perceived injustices as an excuse for poor behavior.

11. Hang tough: Members are taught not to give up, no matter how hard things get.

12. Guilt kills: This concept holds that dishonesty will lead back to drug use and, literally, death.

13. Be careful what you ask for, you just might get it: This helps members understand that they must be prepared to handle the things they want.

Residents must take a test at the end of the curriculum to show that they have learned the material; the test can be taken several times until the resident passes it.

D. Family Involvement

The program strives to involve family members effectively in the youth's treatment. The goal is to get parents actively involved, not just in their child's treatment, but also in the community as a whole; for instance, parents are encouraged to participate in a Parent Network, help to plan holiday celebrations, and participate in career day activities. Family involvement begins with a 2-hour parent orientation meeting, in which an overview of the program is presented. Family members are invited to participate, on the basis of information in the admissions interview; addicted parents are excluded from participation. Though this

meeting is framed as mandatory, some family members never become involved in the program, despite staff efforts to engage them.

After orientation, the therapist invites family members to a family assessment meeting (often a series of a few meetings) to engage the family members in the treatment process, to develop a list of permissible phone and mail contacts for the youth, and to complete necessary paperwork. Senior staff members interview parents to determine if they can participate in treatment. Parents who are criminally active or obviously using substances are not permitted to participate. If parents tell staff members that they are getting into recovery, they are asked to sign an agreement allowing random drug testing when they come onto the property. Parents are also invited to attend Parent Education, on a broad range of topics (e.g., drug education, enforcing house rules, parenting styles, talking to kids about sex). This curriculum was developed at Phoenix House and is taught by a range of staff members. These classes last an hour and are followed by a "Family Tea," or informal social hour for visiting with the youths in an unstructured format. Family members must attend the Education seminar in order to attend the Family Tea afterwards.

Sample Parent Education Seminar Topics

- Developing and reinforcing house rules
- Nurturing self-esteem
- Coping with peer pressure
- Handling parties
- Finding alternatives to drugs
- Recognizing signs of drug use
- Effects of divorce on teens
- Understanding misbehavior
- Co-dependency
- Parenting styles

A Family Recreation Day is planned every 6 to 8 weeks on a weekend day for about 4 hours. Activities include softball games, relay races, contests, and potluck dinners. Family members are expected to help plan and run the event. These events often center on a theme (a holiday or cultural event, for instance). The purpose is to encourage socialization and interaction among family members in a sober environment. All family members who are involved in family therapy, as well as two or three additional family members, are invited to

attend. These family members are approved by the clinical team, to ensure that only sober supports are included. Girlfriends and boyfriends do not generally attend, unless the resident is at least at Phase II and the staff approves this plan. Each family member contributes food to a barbecue. Certain rules apply to these events, including a ban on smoking or bringing cigarettes into the facility, residents not being allowed into the family car, restrictions on the food or gifts family members may bring to the resident, a ban on the use of cellular phones by residents, and a requirement that families stay in designated areas.

Parents also attend regular family therapy sessions on a weekly basis. These sessions are arranged by the therapist and are used to facilitate reunification by improving trust and communication and by clarifying parental roles and responsibilities.

Family Network meetings are held once a month, and all parents are invited to attend. These meetings provide a forum for parents to meet with staff members (family therapists, counselors from each unit, and senior management staff) in which they can air concerns about the program, make plans for events, and volunteer to participate in upcoming events. Parents are encouraged to attend these meetings, but they tend to be underutilized, with fewer than 10 families attending most meetings.

Residents are eligible for passes to go home once they complete orientation, but passes are contingent upon progress in the program and are earned as a privilege. Residents submit proposals for passes for as often as every other weekend, and these usually progress from short time periods to longer ones. Clinical staff members work closely with parents to develop a specific itinerary for the time outside the program, including activities, locations, and companions. This ensures that the youth doesn't encounter friends or family members who are using drugs, have too much unstructured time, or retrieve drugs or paraphernalia from stashes at home or in the community. In addition, both residents and parents are informed of and expected to adhere to standard pass policies (see below). When youths return to Phoenix Academy, the primary counselor checks in with them and usually has a one-on-one session within a day of returning to process any issues that arose during the pass. Youths understand that they may be asked to submit urine for a drug screen upon their return.

Standard Pass and Family Involvement Policies

1. Family members shall give the residents no money unless the primary counselor approves it.
2. Parents must sign in and out at the front desk, even if they are just picking up their child for a pass or appointment.
3. Parents must follow residents' planned itinerary (no shopping, lunches, etc., unless approved by the primary counselor).
4. No cigarette smoking in the presence of residents.
5. No expensive jewelry or clothing. Please do not buy or bring any expensive items for your child.
6. No gifts without approval of the primary counselor.
7. Phoenix Academy celebrates birthdays. Please bring cards only, no gifts or cakes.
8. No drug or alcohol consumption prior to attending a Phoenix Academy event. If there is suspicion that you might be under the influence, you will be asked to leave the property, and you will not be allowed to return until you meet with the managing director.

Multi-family groups can be conducted throughout the program but are seen as especially important during the re-entry phase of treatment. Though these groups have not been instituted recently at Phoenix Academy at Lake View Terrace, there are plans to begin implementing them again soon (multi-family groups are part of other Phoenix Academy programs). These groups consist of several youths and their family members and are used for processing issues related to family relationships, discipline, communication, and planning for the return home after treatment.

E. Community Structure and Typical Schedule

1. Unit and Clan Structure

The Phoenix Academy is divided into four units (based on the physical location of dorm rooms) with inspirational names (e.g., Ascension), and youths perform many activities within their units. There are 20, 30, 50, and 50 residents on each respective unit, and they sleep in single or double dormitory rooms. The 20-bed unit is the Induction Unit, for new residents, and the 30-bed unit is the Mental Health Unit, which provides more intensive treatment (staff-to-client ratio of 1:6 during waking hours). The staff-to-client-ratio on the other units is 1:10 during waking hours. Functions such as the Family Tea and meals are

often done with youths in their own unit and one other unit, so that the community is divided roughly in half for many activities.

Within each unit, the residents are further divided into clans or families. Clan members meet in family gatherings after each meal; spend most of 1 day per week together ("clan day"), including special activities and an encounter group; and plan outings and set goals as a group. Since clans are based within units, clan members also eat at the same time and sleep in the same dorm area.

The unit structure at Phoenix Academy is somewhat based on the physical layout of the building and the census. Thus, different structures are used in locations other than Lake View Terrace.

2. Typical Schedule

A typical schedule is presented below. The daytime activities are highly structured, with little free time. Each unit follows a somewhat different schedule, but all follow the general scheme presented below.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
5:30		Wake-Up	Wake-Up	Wake-Up	Wake-Up	Wake-Up	
6–6:45		Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	
6:45–7		Community Clean-Up	Community Clean-Up	Community Clean-Up	Community Clean-Up	Community Clean-Up	
7–7:30		Tighten Rooms	Tighten Rooms	Tighten Rooms	Tighten Rooms	Tighten Rooms	Wake-Up
7:30–8:30	8:00 Breakfast	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	8:00 Breakfast
8:30–11:40	9:30 Wake-Up	School	School	School	School	School	Room General Inspection (GI)
11:40–12:25	10:30 Narcotics Anonymous Speaker	Seminar or Activity	Seminar or Activity	Seminar or Activity	Seminar or Activity	Seminar or Activity	Family Gathering: House GI
12:25–12:50	12:00 Brunch	Lunch	Lunch	Lunch	Lunch	Lunch	12:00 Lunch
1:00–2:45	Outside Activities	School	School	School	School	School	GI Common Areas
3:00–3:15	Weekly School Detention	Personal Needs	Re-Entry	Personal Needs	Speaker's Bureau	Personal Needs	Family Gathering
3:15–3:30			Family Gathering		Personal Needs		Outside Activities
3:30–5:00	Personal Needs	Job Functions	Clan Day Encounter Groups	Outside Activities	Study Time	Family Gathering	4:15 Personal Needs
5:00–5:40	Dinner	Dinner		Dinner	Dinner	Dinner	Dinner
5:40–6:15	Community Clean-Up	Community Clean-Up	6:00 Dinner	Community Clean-Up	Community Clean-Up	Community Clean-Up	Community Clean-Up
6:15–6:30	6:15–7:15 Orientation or Family Gathering	Family Gathering	6:30 Community Clean-Up	Community Clean-Up	Personal Needs	Watch movie and process	Family Gathering
6:30–8:00	7:15–8:30 Female or Male Encounter Groups	Passenger Activity and Family Gathering	7–8 Clan Day	Family Gathering/ Parent Education	Encounter Groups		Constructive Free Time
8:00–8:30		Relating	Complex Meeting	Family Tea			
8:30	Snacks	Snacks	Snacks		Snacks	Snacks	Snacks
8:45	Tighten Up House	Tighten Up House	Tighten Up House	Tighten Up House	Tighten Up House	Tighten Up House	Tighten Up House
9:30	Lights Out	Lights Out	Lights Out	Lights Out	Lights Out	Lights Out	
10:00							Lights Out

F. Job Functions

Work has an important clinical function in the TC related to many of the psychological, social, ethical, and behavioral issues presented by the substance abuser. The ability to successfully hold a job in mainstream society is seen as an important part of a stable recovery. All residents have a job, or a job function, in the community. These jobs are expected to help the resident build up good work habits, skills and ethics, and a sense of responsibility. Job functions are thought to help counteract the disorganized lifestyle, rebelliousness towards authority, poor impulse control, and need for immediate gratification that often characterizes substance abusers.

The structure of the job functions in the TC closely parallel the occupational hierarchy in our society. Residents begin with jobs that require little responsibility, more physical labor, few rewards, and little status. As they prove themselves at these jobs, they advance to higher job functions, requiring more skill, responsibility, coordination and cooperation with others, and leadership. Advancement is based on good job performance as well as psychological growth and attainment of treatment goals. Attaining a higher position is expected to improve self-esteem and sense of competence. By learning to negotiate the world of work in the TC, members acquire the skills needed for employment in society.

Job functions can be described in six levels:

- Entry level: Service and kitchen crews. This category involves assisting with the preparation of meals for the community, such as peeling potatoes and setting tables, or with janitorial work. The major goals of working in these job functions is to conform to community rules and to accept authority. Residents are introduced to the concept of "pride in quality" and urged to do their very best work on every job. Work is seen as an extension of themselves, with no job being too menial to be done well.

- Second level: Office positions and facility maintenance. These job functions include recordkeeping and clerical work, or painting, plumbing, carpentry, or other skilled maintenance work. At this level, residents are expected to develop better work motivation and to begin working for internalized rewards.

- Third level: Crew chiefs. At this level, residents begin to assume leadership roles and assume responsibility for the work done by the workers they supervise. Residents must improve skills in planning, problem-solving, organization, and interpersonal skills (especially assertiveness) in order to work at these job functions. Many adolescents lack the maturity and skills to go beyond this level but are offered merit badges or other rewards to be able to still see progress made within this level.

- Fourth level: Motivators. Motivators are the "eyes" and "ears" of the community, who monitor and direct resident activities and enforce community rules. This level requires an even greater capability to balance various demands from supervisors and supervisees, as well as more responsibility. Through the process of enforcing the community norms and rules, residents are thought to internalize the norms of the TC. The "act as if" concept is very important at this level, since motivators must be able to carry out this task or negative behavior will be provoked in others. Motivators must also relinquish lingering negative attitudes and values and shed their street image if they are to be effective in this role.

- Fifth level: Department heads and chief motivator. Residents at this level supervise the crews and crew chiefs, and the chief motivator supervises the other motivators. This level requires managerial skills, such as giving directions, accepting and delegating responsibility, managing systems and people, and coping with conflicting demands. Residents who achieve this level are expected to serve as role models for the newer residents, embodying the behavior and attitudes of substance-free people. They are also expected to be able to withstand the peer pressure and negative opinions of some residents, which is seen as a critical task for people in recovery.

- Sixth level: Coordinator. Coordinators supervise the department heads and chief motivator, and report directly to the clinical staff. Residents who get to this level are consistently demonstrating the abilities necessary in the lower levels, have strong motivation and leadership skills, and are resilient in their ability to handle a variety of stressors and challenges.

G. Groups and Meetings

1. Daily Meetings

Daily meetings take different forms, but all have the goals of fostering the following goals ("the 4 A's"):

- To take *attendance*—to ensure that all residents are on-site, for control and accountability.

- To *assemble* the community—physically gathering residents allows them to see that they are part of a whole community.

- To *assimilate* residents into the order of the environment at Phoenix House and to facilitate information-sharing to help members feel connected to each other and the community.

- To *affirm* the importance of the community itself as a "family" and healing force.

a. Morning Meetings. Every morning after breakfast, a morning meeting that includes the entire community is held for about 30 minutes. During this meeting, the goal is to provide motivation to get through the day and to establish an upbeat mood, as substance abusers often find morning very difficult. Members of the community are chosen to plan and present material for about a week prior to a specific meeting, and the material is approved by staff members prior to presentation. Elements that are commonly included are a concept of the day, predicted weather, skits, jokes, mock awards, announcements, games, and upbeat songs. In addition to providing motivation for the day, the morning meeting is expected to increase community unity and cohesion.

b. Seminars. Seminars are held three to five times per week and cover concepts central to TC philosophy and recovery precepts; seminars are organized by unit directors. There are several types of seminars. Concept seminars are often in the format of writing a key phrase (e.g., "You are your brother's keeper") on the blackboard and then discussing this phrase and its meaning in the group. These are usually held within residential units. In "pro

and con" seminars, the community is divided into two groups and assigned the position of pro or con in a current controversy. Halfway through the seminar, the sides switch positions, so that members of each group get the opportunity to argue both sides. This exercise is seen as a way to build perspective-taking skills and to prepare group members for encounter groups, in which they must be objective and able to listen to the opposite side. Guest speaker seminars include an outside speaker on various topics and encourage an exchange of ideas between group members and the speaker; for instance, the medical nurse might arrange for an outside speaker on a health topic, with the director's approval. Finally, some seminars include educational games, such as charades, spelling bees, and trivia. These games are intended to foster community awareness and provide intellectual stimulation, while being entertaining. All residents on the unit at the time of the seminar attend it.

Sample Seminar Topics

- Concept seminars on each of the TC basic concepts
- Self-awareness
- Change
- The disease model of addiction
- Stress management
- Goal-setting
- Drug education
- Loneliness
- Relapse prevention
- Triggers to relapse
- Aggressive versus assertive communication
- Symptoms of stress
- Hitting bottom

c. Mock Speaking: The "Speaker's Bureau." This group is available to residents who are in the program for at least 6 months and display good behavior, school grades, and community involvement. Residents first attend a four-session training course on public speaking, then do a mock presentation for the facility. The groups are led by the community outreach coordinator. Group members talk in front of a simulated public forum and take turns acting as moderator or making testimonials about their lives before they entered the TC and/or since they entered the TC. Testimonial is most important as a self-help tool. It allows

the community to hear about people like themselves who are successful in changing their lives. It also allows the speaker to obtain perspective on their lives. Presenting themselves publicly as a person successful in recovery reinforces a change in identity. This format is also helpful in preparing residents for public self-disclosure, participating in house tours, and improving public speaking skills.

d. House Meetings/Family Gatherings. These meetings are held at least once a day, every evening after dinner, and are used to conduct community business. They are run by senior residents and staff members, and they include announcements about trips, job changes (promotions and demotions), tours and visitors, and night work crews. These gatherings follow a certain ritual, and are facilitated by the coordinator. Residents usually begin by giving each other “strokes,” or compliments about things they admire in one another or positive behaviors they see in each other. This is followed by “pull-ups,” or calling one another on negative behaviors, poor attitudes, or rules infractions, with a request that the problem be addressed. Accused residents are expected to accept the “pull-up,” rather than denying it or saying “no.” Residents are also invited to talk about their day (“plug-ins”) in general and to say anything that they want to share with the group. Participation in the family gatherings can be integrated with treatment plan goals; for example, in an individual treatment plan, a resident might be asked to identify emotions she experienced during the day via the “plug-ins” at least three times a week in the family gathering. After the residents have finished, staff members take the floor and make announcements and give feedback to the group members. These meetings are used to discuss all behaviors in the community and their consequences, including privileges earned and sanctions dispensed since the previous meeting and commitments made by residents to change their behavior. The family gathering is thought to promote a sense of belonging and connectedness through the sharing of personal information and to encourage positive behavior through social and vicarious learning. As much as possible, focus is put on the positive changes that individuals have committed to as a result of receiving a sanction for negative behaviors. Family gatherings can last anywhere from 10 minutes to 2 hours or more.

2. Workshops

Workshops are a series of didactic/experiential meetings that cover special topics relevant to treatment and/or recovery for many Phoenix Academy youths. The director approves workshops and takes responsibility for ensuring a well-rounded treatment experience for residents. The workshops are developed by staff members according to their expertise or through curricula brought in from other sources. Topics include the development of morals and values, relapse prevention, and recognition of triggers; topics are relevant to all residents. Workshops are usually operated within clans and include about 12 youths. Other topics are more specialized, and in these cases, the staff members who will be running the workshops interview potential candidates for participation and select those who they think might benefit. Such topics include grief and loss, self-esteem, anger, and sexual abuse. The 2-hour workshops run at a scheduled time (after the school day) for 8 to 12 weeks, and youth leave their other activities to attend them.

3. Tutorials

Tutorials are extended experiential groups that focus on a particular life theme, such as the need to belong/unity, trust, change, being a man or woman, and racism. Staff members attempt to set a mood in the tutorials that is conducive to talking and thus bring snack food, music, and the like to make residents comfortable. The goal of the group is to teach residents through their own experience. Tutorials typically have two parts: The first uses exercises to symbolize the theme, and in the second, the group processes or relates about what occurred. These groups avoid psychological jargon and try to focus on everyday issues that residents will encounter in their lives. They are typically held on the weekend, when the schedule can more easily accommodate a 4- to 6-hour group. A series of tutorials prepares residents for a marathon (described below) and helps to follow up common themes explored within the marathons. Senior staff members, including therapists, plan and arrange the tutorials, with approval from the director. Usually, about 12 to 15 residents participate.

Case Example

A tutorial on unity begins with team-building exercises. The group is challenged to build a machine with at least one moving part, using common household objects as parts. The group members must work together towards this goal. After they build their machine, they reconvene as a group and talk about the process—how people worked together, issues of trust and team decision-making, authority, and communication.

4. Peer Support Groups/Peer Process Groups

Peer support groups are designed to get residents who are working on the same phase (e.g., orientation) together to support one another around the special issues of that phase. For instance, a new resident in orientation may be the only one at that phase within his or her clan, and therefore the peer support group would help him or her address the unique issues of orientation with peers in that same phase who are in other clans or other units.

Peer process groups are used to process significant issues elicited in other program activities and are routinely scheduled for this purpose. The goal of process groups is to learn to talk about feelings. For instance, if a seminar is held on the topic of sexual abuse, a peer process group would be scheduled afterward in order to help residents express the feelings that arose during the seminar. For example, after an outing in which residents are likely to encounter many homeless individuals (which might highlight for them the negative consequences of drug use), a process group would be scheduled to occur upon return to the Academy.

5. Encounter Groups

a. General Information. Encounter groups are seen as a primary mechanism of improving negative attitudes and behavior. They use confrontation by peers to increase individual self-awareness. Each encounter group includes 12 to 15 community members and is facilitated by one to three staff members and more senior residents. They are held three times a week so that they can be used to address negative behaviors within a few days. The goals of the encounter are to (1) confront negative behavior, (2) help the confronted person admit responsibility for (or "own") the behavior, (3) help the confronted person identify feelings that underlie the negative behavior, (4) have the confronted person make a commitment to change the behavior in the future, and (5) have the person accept the support

of the group in setting realistic goals for altering his or her attitude and/or behavior. Examples of negative behavior include the following: being rude to others, disobeying house rules (e.g., playing a radio when this is not allowed, possessing contraband, stealing food from the cafeteria), deviating from a plan when out on pass, manipulating staff or other residents, not expressing feelings (or "stuffing it"), not working the program (or "jailing it"), getting involved in gang-related activities in the program, flirting (or "tipping") or spending too much time with a member of the opposite sex, and other such problems. Encounter groups serve to reduce friction in the community and maintain rule conformity and psychological safety in the community.

There are several kinds of encounter groups. The most common, usually held once or twice a week, are "slip encounters." A box labeled "encounter slips" sits prominently in each unit, and residents can "drop a slip" describing any kind of negative behavior into the box, to be used at an encounter in the near future (see example below). For these groups, participants include those who dropped the slip and those who are named on it.

Example of an Encounter Slip

Encounter Slip　　　　Date: 9/30/99
On: Johnny R.

Re: When I pulled him up for cursing he didn't adhere and it bothered me.

W/B (written by):
Rick R.

A second kind of encounter group is a clan encounter, which occurs at some point during "clan day," once a week. This allows residents to interact with those residents they know the best. Finally, there are "special needs" group encounters that bring together various subgroups of residents: girls or boys, a particular racial or ethnic group, a particular unit, a particular job function, or a particular age group. These groups allow for the exploration of topics that particular subgroups of members have in common and thus foster identification with peers who are similar to them. In addition, they ensure that there are no

members in collusion so that behaviors are not being confronted. These special needs encounters normally replace one of the slip encounters and are scheduled as needed.

What members accomplish in the encounter depends on their emotional maturity and developmental phase in recovery and the treatment process. Although staff members are continually working with residents to progress in the groups, newer clients may only be able to acknowledge the negative behavior. Commitment to changing the behavior in the future is expected of clients who are further along in treatment, and the ability to identify feelings underlying the behavior is expected of residents who have been in the program for about 6 months.

Expectations of residents during the encounter group differ from those for the client during the course of the rest of the day. In work, at school, and during other daily activities, youths are expected to restrict spontaneous outbursts of emotion so that they can learn to behave appropriately and manage their emotions. In contrast, the encounter group is a forum in which angry feelings can be expressed, providing the opportunity to learn to cope constructively and appropriately with such feelings. There are few restrictions on language, so the newer members may use a lot of profanity and slang, in a barrage of loud, angry words. This style is expected to decrease with time in the program, as residents learn to express themselves and control their anger more effectively.

The group encounter is intended to channel community friction by settling personality conflicts and disputes that arise in the youths' daily lives and by providing a venue for offering support and showing concern for one another. The encounter process itself is not thought to resolve disputes, but rather to remove the hostility from them so that residents can talk to each other later on. This is usually accomplished immediately after the group, during the "relating time."

Encounters should be planned in advance by staff members and senior residents, especially slip encounters. The "encounter master" is the staff member who develops an agenda, determines the group composition, and convenes a planning meeting with facilitators. The encounter master can also designate a senior resident to act as "encounter strength." In this role, the resident helps to guide the encounter process under supervision from the staff member. The agenda includes who will be confronted and about what behaviors. The planning meeting can be used to anticipate problems on the basis of the staff

members' and senior residents' knowledge of individual clients and group dynamics. Alternatively, they can be run so that the group members themselves decide whom to confront. Group members sit in a circle, and their places are sometimes arranged by the facilitator (e.g., to separate close friends, to balance gender or ethnicity, to place adversaries across the circle from one another so that they can easily confront one another). The group begins with one resident reciting the rules and the announcement, "the game is open," after which the first planned confrontation begins. Ideally, the most pressing issues should be addressed first, but in some cases the group members clamor to begin the confrontation, and the facilitator helps guide the choice of the first confrontation.

b. Rules and Guidelines of the Encounter. Encounters are structured by clearly defined rules and enforced by the facilitators and other participants. At the beginning of each group, one participant recites the rules. These include

- No physical violence or threats of violence
- No collective assault on any individual ("rat-packing")
- No leaving your seat for any reason
- No offering of aid to the confronted person ("red-crossing")
- No revealing of disclosures from the encounter outside the group ("leaking")
- No invoking status privileges. All members of the encounter, including staff, are on an equal plane and can be confronted.

There are also some guidelines of things to be avoided during the encounters. These include

- Attacking a person's "inner self," a characteristic that cannot be changed rather than a behavior
- Interpreting or "therapizing" a person's behaviors, feelings, or motives
- Confusing what is being said with who is saying it
- Dwelling on a person's past history, except to highlight current actions
- Spending too much time on the confrontation phase of the encounter
- Lying by omission

- Forming negative contracts with other group members in order to avoid confrontation
- Excessive defensiveness, even against invalid charges
- Trying to look good.

c. Structure and Components of the Encounter. The structure of the encounter ideally is to focus on six group members for about 15 to 20 minutes each, during a 2-hour meeting, followed by 30 minutes of relating time. If not all encounters on the agenda are covered, it is important that the facilitator at least acknowledge the issues that were not covered and attempt to cover them in the next meeting.

There are three phases to each encounter—the 3 C's—confrontation, conversation, and closure.

During the confrontation phase, one group member confronts another by describing a specific negative behavior or other behavior they are concerned about, and how they felt about the behavior. The feelings of the resident initiating the confrontation are especially important, because although a resident could potentially deny some aspect of the behavior, they cannot deny the other's feelings. Other participants who witnessed the negative behavior are encouraged to describe this behavior from their own perspectives. The group makes the confrontation with specific examples and is expected to demonstrate a willingness to hold a member accountable for behavior while still showing care for his or her well-being. The confronted person can deny the confrontation; it is up to the group to help the member accept the confrontation or to withdraw it. The key question asked during this phase is, "What really happened?" This phase is completed when the confronted individual admits to the behavior and accepts the confrontation. If the confronted individual is unable or unwilling to accept the confrontation, after having tried to use the tools of the encounter (see below), then the facilitator can decide to move on to the next confrontation.

The purpose of this phase is to provide social feedback to an individual, with more objectivity than the individual has. This forces the confronted person to see himself or herself honestly, in spite of the pain that might ensue. The goal is for the confronted person to accept the confrontation and turn the process into self-confrontation. In fact, it is possible for individuals to use the group for self-confrontation from the outset. Under these circumstances, the individual raises the behavior himself or herself, and then uses the group

to explore it. Here the group is quiet, and the confronted individual is allowed some time to talk to the group, with prompting from the group facilitator.

The second phase is the conversation phase. Here the individual gets the opportunity to talk about the behavior and to explore the feelings underlying it. Group members are expected to use active listening during this phase and to share their own experiences and feelings. It is important that the confronted individual not try to explain or rationalize the behavior or shift blame to others, but instead engage in an honest and concise (within 5 minutes) effort to discuss the behavior. The key question during this phase is, "Why did this happen?" and it draws to a close when the confronted person relates to his or her feelings. The facilitator can be helpful here in assisting the confronted individual to articulate his or her feelings.

Finally, during the closure phase, the confronted person must make a commitment to change his or her behavior. Group members also offer suggestions for changing the behavior and for setting behavioral goals, though ideally the confronted person takes the first step. The confronted person is expected to try to make a commitment to change his or her behavior, and group members are expected to offer specific ways that they will support those efforts at change. The key question during this phase is, "How will you change?" and it draws to a close when the confronted person commits to a specific change.

Case Example 1

K. is a Phase III resident who is the crew chief for the service crew. In a job-function encounter, she is in a group with other advanced members of the community, such as other crew chiefs, motivators, and coordinators in her unit. One begins by confronting her about how she is doing her job. He tells her that the house is a mess, that she's not getting her crew to keep things clean. She responds with anger and yells back, telling him that he can clean it himself if he is not happy with it. This response is not typical of an advanced group member, so the group facilitator checks in with her, and she says she wants to continue, that "she's boxing." Another group member echoes the first, and she again responds with anger. A few more try to get through to her, but she continues her angry response. The rest back down, showing obvious discomfort with the intensity of her response. (Comment: Ideally, the facilitator and group members would have tried other tools of the encounter, such as compassion or empathy, to help K. own the behavior before moving on.) The group facilitator shifts gears to the conversation phase, and asks her to tell the group what is going on for her. She quiets down and begins by saying everything is "cool," but then adds that she has some family members' birthdays around the corner. She adds that last year at the same time she went AWOL from the program she was in then, after learning that her brother was killed a few days before his birthday, and that her mother's birthday is also coming up, and that that "always f---s me up." She is crying now, and the other group members are listening carefully to her. The facilitator asks for feedback from the group, and several suggest that she talk to them about it, that she use them as supports. K. specifically asks one female group member for feedback, and when she also offers support, K. looks relieved. For closure, K. says she will work harder to keep the service crew in line and will talk to some of them later on about her issues. During relating time, K. would be expected to talk to those who offered her support in more depth.

After the group, the facilitator plans to meet with her to talk more about the issues she raised. He also plans to inform her counselors, so that they can focus on them as needed.

Case Example 2

R. is a Phase I boy who is confronted by peers in a slip encounter. The slip confronts him for stealing clothing from a peer who had been rumored to have gone AWOL (but was in reality only contemplating it and talking to a counselor in another part of the building). Several group members confront him about this behavior, pointing out that it's not right to be going in other people's rooms, even if you think they went AWOL, and definitely wrong to be stealing. After this confrontation comes from five or six people, the facilitator asks R. to talk about it. He shrugs it off at first, saying he knows others would take his stuff too. The facilitator presses, asking him why he did it. He says he was "bored," that he misses his family and is bored all the time. The facilitator asks if that's what he was doing before he came in the program—getting in trouble when he felt bored. R. acknowledges that this is true and shows the first glimmer of responsibility and "owning" of his behavior. The facilitator asks the group for feedback, and other group members talk about how he should do something positive when he is bored, like work on his program or socialize with the other kids. He is asked to make a commitment, and says he won't go in others' rooms anymore. This is accepted, and the encounter moves on to another slip.

Case Example 3

The group angrily confronts S., an 18-year-old boy who is a "re-tread," meaning that he had gone AWOL before and is now at the Academy for a second time. (This is the boy whose things were stolen in the example above, while he considered a second AWOL.) They confront him about not working on the program, not doing anything productive, and also about his thoughts about going AWOL. There is obviously a lot of anger in the group towards S., and he shrugs off the confrontation. A few times the facilitator has to step in to calm things down, since several people are talking angrily at once. When the facilitator turns to the conversation phase, S. says he hates it here, that he hates all of them and doesn't care what they think. He says he is 18 now, and he will be leaving soon enough. He declares that there is no need to work on any of these things. The group members are still angry, and tell him that they are tired of spending their energy on him, when he has no desire to do anything for himself. A couple of group members tell him that they are finished with him and that he shouldn't bother to try to talk to them again. The facilitator says that they will skip the closure phase, since S. is unwilling to own his behaviors or respond to the group feedback. (Comment: Ideally, the group would have tried other encounter tools to help S. own his behavior, since the angry approach was clearly not effective. However, there will be many other opportunities to do this in subsequent encounters, and the facilitator will be mindful of the need to try other encounter tools in the future.)

The encounter group concludes with an unstructured period of about 30 minutes in which the group members have "relating time" to finish discussions or socialize with one another. People who confronted others are encouraged to talk with them during this period, under staff supervision. This time is used to build camaraderie and support for each other, as well as to provide additional feedback and support to confronted persons. Group members are reminded to keep the information from the encounter within the group.

After the groups, a summary of what transpired is put in a book, so that all staff members who work with the individual can review it and make sure to focus on the issues raised, as well as to help them keep the commitments they made.

d. Tools of the Encounter. Three main types of tools are used in the encounter: provocative tools, evocative tools, and neutral tools.

Provocative tools are used most during the confrontation phase of the encounter. These tools challenge or push the individual to react and reflect on his or her behavior, and they must be used with caution with adolescents. In particular, they should be accompanied by responsible concern. They include hostility, engrossment, and humor. Hostility is useful in getting past the defenses of an individual that is being confronted, and forces him or her to experience the anger that his or her behavior generates. Hostility may help the accuser more than the confronted individual, by venting destructive anger. Newer, less experienced members tend to rely on hostility when they confront others, and it is expected that the use of hostility will decrease as they progress through the program. Facilitators will allow some hostility to be expressed, but they are careful to curb it, as it can be very destructive. Engrossment magnifies or exaggerates the behavior to make it more clear to the confronted person. It too is used to get past defenses such as denial and rationalization. Humor, or poking fun at a specific behavior, helps group members get past false images and defenses. Humor can help the confronted person take himself or herself less seriously and can also dissipate some of the hurt that confrontation causes.

Evocative tools include identification, compassion, and empathy. Identification, when a member reveals a similar experience or feeling, is the most commonly used method, and it breaks down barriers and status differences between group members. When the group member uses identification, it helps him or her to contribute to the process and helps the confronted individual feel less alone or alienated, thereby being therapeutic for both

individuals. Identification facilitates self-disclosure and self-acceptance. Compassion, showing concern for another person's feelings, promotes group cohesion. This tool is most useful during the conversation and closure phases of the encounter, but it can also be used during the confrontation phase. Empathy, being able to put oneself in another's position, involves not only compassion but also the ability to identify with the confronted person's feelings. Empathy encourages the conversation phase by demonstrating active listening by group members, and it helps the confronted member feel safe enough to self-disclose.

Neutral tools include projection and the carom shot. Projection involves the recognition of your own behaviors in the confronted person. A resident who recently went AWOL is encouraged to confront a resident who deviated from the plan on a recent pass home, even though their incidents are similar. Even though his or her behavior is no better, his or her confrontation is still valid and can be beneficial to the confronted individual. The carom shot is used to indirectly confront a person who is especially defensive or unresponsive to direct confrontation. Here, the group member addresses a behavior in one person that is similar to the behavior of the person to be confronted, and the confrontation bounces from the first person to the targeted person. Often, this facilitates later confrontation with the targeted member, as he or she has time to contemplate the issues and can become less defensive by witnessing the problem in someone else. This technique requires skill and practice and is used cautiously by experienced group members.

e. Role of the Facilitator. The role of the facilitator is likened to the motor oil in an automobile, ensuring a smooth acceleration and ride, but not steering or fueling the voyage. The facilitator serves as a role model for the group and participates actively but does not dominate the group, and sets the tone of the group through questions and requests for clarifying information. He or she must be skilled in all the encounter tools, in active listening, and interpretation of body language. The facilitator also must be open to feedback and criticism and be flexible enough to alter the encounter according to the needs and limitations of a particular group. Most important, the facilitator must be able to create an atmosphere of trust, enabling the group members to be honest about owning their negative behavior and to feel that they are making worthwhile contributions to the encounter process.

6. Marathons

Marathons are extended therapeutic groups that are held periodically (a few times a year) to work through clients' major issues. During the 1998–2000 time period, three marathons were held at Lake View Terrace. Ideally, each resident should participate in two marathons before finishing the program: once as a "passenger" (or participant) and once as a "shepherd" (or helper). Typically, residents have been in the program at least 5 months before participating in a marathon, and they are selected carefully to make sure that they are ready for the intense emotional experience. They should have some peers also participating, and they should be ready to examine themselves and their past experiences. Marathons ideally include 20 to 30 residents, around 10 staff members, and 5 to 10 shepherds. Staff members are trained through experience, by participating in marathons as support staff before they begin to take on an active role. Individual work includes resolving past traumatic experiences; examining fears of intimacy, aloneness, and responsibility; and increasing trust between participants. It consists of several months of preparation, in which plans and permission for each participant are developed, a group process lasting from 24 to 36 hours, and then weeks of processing the work done in the marathon. The goal of the marathon is to "open a window of opportunity for effective treatment" or "get a foothold" on an individual resident's issues. It is a cathartic experience that allows peers to show love for one another, and it gets the message across that each resident is not unique in the issues he or she deals with and is not alone, but is rather a member of a community that can offer support and part of a shared treatment process. Thus, the marathon experience tends to increase commitment to treatment. In addition, the marathon helps to give the resident words for his or her pain, so that he or she is better able to talk about feelings after the marathon. It marks a shift from a more behavioral focus in the encounter groups, to a focus on feelings, insight, and historical events. Much of the "real" work is left for after the marathon, once the issues are exposed and the resident is more ready to deal with them.

Each marathon is unique, but marathons can contain the following elements: (1) an element of mystery, so that details about when the marathon is planned or what it will contain are kept secret; (2) venting of anger towards peers or staff before the marathon, so that lingering anger does not interfere with the process; (3) some kind of activity to "break the ice," such as games, dancing, and the like; (4) group activities designed to encourage

bonding and to start off the marathon, such as lighting candles; (5) trust exercises to increase unity and trust among participants; (6) messages from family members, taped and played to the group, offering encouragement and messages of love; (7) theme music and inspirational music, used throughout the marathon to help clients get in touch with their feelings; (8) journaling about experiences in the marathon between activities and to augment feelings about the work being done; (9) confrontation with triggers related to drugs, violence, and sexual acting out, in which residents are encouraged to think about the impact that these things had on their lives and the lives of their family members; (10) psychodramatic work to highlight themes of hurt that the clients have experienced in their pasts (violence, sexual abuse, gang and drug initiation, drug use, jail, and death); (11) "working," the culmination of the marathon for each individual (described below); (12) a "working circle," periodically or at the end of the marathon, in which those participants who have completed the working are able to acknowledge their success; (13) "prescriptions," or suggestions about how to work on the issues after the marathon is over, that are translated into treatment plans; and (14) joint artwork, group pictures, t-shirts, and the like to bond at the end of the marathon and to solidify the sense of accomplishment at having completed it.

The marathon culminates in a process called "working," which attempts to resolve or ameliorate past traumatic experiences. This part of the marathon takes considerable training and planning. Marathon staff members initiate this process by role-playing or otherwise initiating a trauma narrative. Participants are encouraged to speak freely and honestly about their trauma and, most importantly, to express their feelings. This usually begins with a statement like "it hurts," since most residents have difficulty at first expressing their feelings more clearly. This process is repeated several times, with more emphasis on the feelings each time.

After the focus on the trauma, the participant is brought back to the present by being asked to talk about the way they have handled their feelings through substance abuse and/or violence. They then (1) express how they will get rid of those negative behaviors (e.g., no more substance abuse), (2) express their desire to change, (3) express their needs (e.g., for help, love, trust, honesty), (4) say who can meet those needs (including Phoenix House staff or peers), and (5) call out to those people. For those with low self-esteem, marathon staff

members lead them through positive self-affirmations as well. Those participants who feel enraged are offered ways to vent anger non-destructively.

The follow-up from the marathon is seen as the time that change actually occurs. "Prescriptions" are translated into treatment plan goals, and therapists and primary counselors work with residents to resolve or accept issues explored during the marathon. Follow-up group sessions are held a few times a month for at least 3 months afterwards, and common themes are explored via tutorials and other groups.

Since the marathon includes many, but not all, members of the TC, non-participating residents are given alternative activities and participate in the marathon by supporting the actual participants.

H. Individual or Family Counseling

Therapeutic work on the individual and family level occurs chiefly through two mechanisms: one-on-one meetings with the clan leader (primary counselor) and individual or family sessions with the family therapist (case manager).

1. Individual and Family Therapy

Residents participate in at least 1 hour of therapy per week—either in a family format when parents can be involved or in an individual format if there are obstacles to family involvement. The family therapist can also pull the primary counselor into sessions as needed. In some cases, the resident will receive both family and individual therapy weekly. The family therapist carries a caseload of 12 to 15 residents. Since the resident is experiencing a lot of personal growth as a function of the TC, one primary task of the family therapist is to try to blend this progress with the family functioning, so that the family can accommodate the changes in the adolescent and family members can grow themselves. This task involves education of the parents, increasing communication with the parents, helping the family talk about traumatic or stressful life events together, helping the adolescent make amends for past behavior, helping the parents with the shame they are experiencing as failed parents, setting boundaries and limits, and teaching parents to enforce rules and structure within the family.

2. One-on-One Counseling

One-on-one counseling occurs frequently: at least once a week, always after passes and encounter groups if the youth was confronted in group, following a crisis, and whenever the youth seeks it out. Sessions generally last about 1 hour and are used to process feelings about new events, to listen to the youth, and to help him or her feel in control. Counselors point out that the first few months in the program are used to build trust with these youths who all have difficulty trusting others, especially adults. This trust building is done through careful listening, consistency, and keeping their private information confidential. (Though counselors are required to tell parents about certain risky behaviors, they are usually able to convince the youth to tell the parents themselves, with support from the counselor.) Counselors are careful that when they confront youths about their behavior, they also reinforce the youth for positive behaviors. Since the primary counselor has multiple responsibilities with the youth and acts as their "parent" on the unit, the youth begins to come to the counselor with difficulties and to request one-on-one meetings when needed.

I. Vocational and Pre-Vocational Training

Each resident works with a vocational counselor, who helps the resident identify higher educational goals and career aspirations. Contacts with the vocational counselor can be in individual, group, or family format. During the orientation phase, the vocational counselor gathers educational materials such as school transcripts and Individual Educational Plans (IEPs), if applicable. Aptitudes and interests are explored with the aim of developing goals for the future, often using commercial computer software (e.g., "Choices"). After orientation, the vocational counselor meets individually with residents to help them develop a "5-year plan," which may concern educational or vocational goals.

Questions Asked in Vocational Career Assessment

- What abilities do you have?
- What are your skills?
- What vocational careers interest you?
- Do you need help with
  - Choosing a career?
  - Getting a job?
  - Keeping a job?
  - Filling out a job application?
  - Preparing a new resume?
  - Answering interview questions?
- What are the best career opportunities for your future?
  - How much training will you need?
  - How much will training cost?
  - Where can you receive the training you need?
  - How much money will you make?

Pre-employment counseling is also offered, such as résumé-writing workshops or mock job interviews; help with interview behavior, attitudes, and dress; and the development of realistic goals (short and long term). Typical short-term goals include completion of high school education (diploma or GED); registering with the Department of Rehabilitation for job training; developing a resume; learning to fill out a job application; learning to be interviewed for jobs; and preparing for independent living by opening a bank account, balancing a checkbook, and applying for apartments. Long-term goals include plans for college, military service, or trade schools and choosing a vocation or career path.

Speakers are brought from outside the Academy to make presentations on some of these subjects. Residents with particular needs are eligible for certain kinds of workshops. For instance, some residents qualify for vocational services through special education programs. Residents over the age of 16 are routinely registered with the State Department of Rehabilitation, which helps them develop a vocational treatment plan, including work at the Academy and in the community afterwards. The Department may pay for the culinary arts

program, described below, or classes at community college. Members who are not eligible for these services through the State are oriented about relevant opportunities by the vocational counselor. Work with residents is individualized, depending on need and phase in treatment. Clinical staff members refer residents to the vocational counselor in order to work on goals for phase advancement, and residents can also seek out the vocational counselor on their own.

The vocational counselor acts as a liaison between the program and school. He or she meets regularly with teachers and with the clinical staff and opens lines of communication about specific residents and about general programmatic issues.

Z. is a young male resident, who came from one of the California Youth Probation Camps with few educational records. After a few months, the vocational counselor had finally received various transcripts and was therefore able to fill out the resident's records and begin to plan goals for phase advancement and a 5-year plan. After about 4 months in the program, Z. reached Phase II of his program and began the culinary arts program. He thrived there, surprising both staff and himself at his interest in food preparation. This helped to build confidence in himself.

Toward the end of the program, Z. decided to join the California Conservation Corps (CCC) for a 2-year commitment. This would enable him to be outdoors and work with his hands, two interests identified while at the Academy. The process for this was at first daunting—Z. had no identification, which was necessary for applying to the CCC, and was anxious about the orientation, several hours upstate. He first needed to get identification from the Department of Motor Vehicles. Then, he worked with the vocational counselor to figure out the bus route. He took public transportation for the first time, with the support of another senior resident. After obtaining identification, a plan for attending the orientation was developed, and Z. successfully completed that step as well.

Thus, in addition to helping Z. develop reasonable goals and building his confidence, the vocational program helped him to carry out the concrete steps required in order to fulfill those goals.

J. Educational Services

Educational services fulfill several functions within the TC, as well as fulfilling the residents' educational needs. Many residents thrive on the positive reinforcement they receive in the academic setting and grow psychologically as well as academically. This can be particularly valuable for those residents who are less comfortable working in encounter

groups, since it provides a way to excel and progress through the program that does not rely as heavily on encounter group participation. Being drug-free enables many residents to perform well academically for the first time since drug use became a significant problem in their lives. Through educational programs tailored to meet individual needs, residents are able to gain a more positive attitude towards academic study and gain a sense of competence and achievement by meeting goals and objectives within their program. In fact, many students are able to accelerate their schooling and make up for time lost prior to entering the TC, since the school operates year-round, with the equivalent of three semesters per year.

Residents attend structured learning activities for 25 hours per week (300 minutes per day, or six 50-minute periods). Phoenix Academy houses an on-site high school (8th to 12th grade) run by the Los Angeles County Office of Education–Court School Program. In this program, certified teachers, tutors, and volunteers teach core subjects and electives (e.g., art, dance), enabling residents to earn credits towards a high school diploma. Special education services are also available to those in need, as determined by the educational assessment that occurs just after intake and in ongoing observation of residents' performance. Many residents need remedial work with the special education specialist (e.g., they cannot read), though they may not have any learning disability, only a lack of education. Ten teachers (including one special education teacher) provide for 150 residents, for a teacher-to-student ratio of about 1:15.

As discussed earlier (see "Treatment Planning"), an educational assessment is conducted at intake. Clinical and educational staff members review educational and testing records to develop a plan for the educational component of the program. Typically, residents have poor or non-existent educational records for the few years prior to entry. Prior to the beginning of each semester, a plan (Individual Learning Plan, or ILP) is drawn up to determine the courses that will best fit each resident's needs, to round out required courses for graduation and minimize the repetition of courses already taken. Phoenix Academy is beginning to implement a new "orientation class" for newly admitted residents, to provide education while they are adjusting to the new environment of the TC, before they are ready to join regular classes. This is being implemented to help diminish the problem of introducing new residents, who are still acting out and learning the rules and structure, to an otherwise stable and productive classroom environment. In established classrooms, teachers

use various methods to teach residents of varying levels of ability and prior training. For instance, in literature classes, all students will read the same text, though some will struggle more with the reading, and others will focus more on the text as literature. In other classes, such as math, the class may be divided into smaller groups on the basis of ability and prior training.

There is a fair amount of integration between the education program and the TC, since education is seen as an integral part of the treatment process. For instance, educational goals are included on the monthly treatment plan, and the teachers and counselors collaborate in developing goals and objectives for each student. Passing grades will help residents to earn more privileges, and tardiness or skipping class results in sanctions. The vocational counselor acts as a liaison between the school and clinical program, facilitating communication and promoting consistency in goals and approach. Homework completion and participation are included in evaluations of the residents' weekly performance for privileges or sanctions. The teachers give points for each youth on a daily basis, ranging from 0 (for the worst) to 4 (for the best) points. At the end of each week, these points are tallied, and a list is created of the "Top 20" and the "Bottom 20." (The number of residents who make the list is not necessarily 20, but averages out to about that amount.) Residents who make the Top 20 list are given positive reinforcement for their excellent behavior and participation, whereas those on the Bottom 20 may get sanctioned or at least have delays in phase advancement. Structured study time is included in the schedule on a daily basis, during time set aside for personal needs. If additional time is needed, residents can request additional study time.

In addition to junior high or high school education, Phoenix Academy operates an on-site culinary arts programs sponsored by Mission College. After residents reach Phase II of their programs (described in Section II), they can begin 360 hours of training in this program and can earn a food handling license and certificate. This program runs for one semester of two periods per day (replacing other electives). There are also college-level classes available through Instruction Television (ITV), which offers a variety of subjects through a combination of videotapes and programmed learning.

During the re-entry phase of the program, residents can attend the Independent Living Program, sponsored by the Department of Child Services at Mission College, and can

register at one of the local high schools or continuation schools. Also at this stage of treatment, the vocational counselor works with re-entry counselors to develop a plan for transition back to school. Staff members contact the school to see if the resident will be allowed back. If so, the counselor arranges to transfer records (typically, a current transcript and the past two report cards). Residents who were expelled from their schools may still be allowed to return with letters of recommendation from counselors at Phoenix Academy and from probation officers, if applicable. If the resident is not allowed to return, attendance at a court school (if on probation), community education center, or alternative school is arranged. Finally, some residents plan to live in a different area when they leave the program. In these cases, attendance at a nearby school is arranged.

K. Medical, Dental, and Legal Services

Medical and dental services are available from consulting physicians, dentists, psychiatrists or psychologists, and staff nurses or licensed psychiatric technicians, or through linkages with community clinics and medical centers. All newly admitted residents are given a physical examination within 30 days of admission, including a tuberculosis (TB) screening test, a review of immunization records, laboratory tests if indicated, and a review of medical history, including all medications. A physician is on-site once a month for physical exams, and residents are transported to the physician's office for all other care. Girls see a female gynecologist for a routine exam, cancer screening, and treatment of any infectious diseases. Special attention is paid to medical issues that might require a referral, that would require clearance by a physician before allowing the youth to participate in the program, or that would interfere with program participation (e.g., ringworm, untreated TB). When immunization records cannot be obtained, residents are offered a tetanus booster and hepatitis B vaccine.

After the initial exam, the nursing staff monitors each resident's health, and non-medical staff members are trained to handle emergency first aid and to help residents with self-administered medications. The nursing staff is responsible for evaluating and making referrals, if necessary, for all medical problems, and psychologists or licensed therapists, in consultation with the psychiatrist, do the same for mental health issues.

A dental van comes to the program once a week to conduct exams and perform dental procedures for residents. Residents have their teeth cleaned every 6 months, and the dental van is equipped for x-rays and procedures such as root canals and simple wisdom tooth extractions

Known medical and mental health issues are put on the resident's treatment plan, and issues of medication management, somatic complaints, and health problems are included in routine entries in the resident's chart.

Under emergency circumstances, appropriate and immediate services are sought. Trained staff provides emergency first aid, and transfers to acute care hospital emergency rooms are made when necessary. Staff members transport residents in non–life-threatening situations, or an ambulance is called. Trips to the emergency room are common for minor illnesses and sports-related injuries.

Psychiatric emergencies, including suicidal gestures, combative behavior, or violence, are handled by staff members, who make every attempt to diffuse the situation and to contain assaultive behavior. Then staff members make an evaluation and appropriate referral. If staff members are unsuccessful in containing the emergency, they will call the local police.

Legal services are arranged on an as-needed basis, through legal aid or pro bono work through the Phoenix House Foundation legal department. In addition, most residents have a public defender, assigned to them through the courts, who acts as their advocate. Legal issues arise particularly as residents begin to transition out of the program, and need help with licensing requirements, expunging juvenile records, and clearing other unresolved legal problems.

L. Community Service

Community service is a requirement of probation for many residents and is seen as important to recovery within the concept, "In order to keep it, you have to give it away." Community service is also a requirement for phase advancement in the program. Residents can be required by the court to complete any number of community service hours (e.g., 60, 90, 120) before they can complete the program. Therefore, Phoenix Academy begins involving residents in such activities beginning in Phase I. Phoenix Academy has relationships with a number of organizations, in which they provide services such as

neighborhood clean-up and restoration, food distribution to senior citizens, gardening, and speaking engagements at schools. The frequency of these activities is about two or three times per week, for 1 to 3 hours per activity. They are set up in the same way as other group outings, when the weekly schedules are set. As residents achieve Phase III in the program and prepare for re-entry, they begin to identify and participate in community service in their own neighborhoods.

The Phoenix Academy staff also participates in community outreach through attendance at meetings of neighborhood associations, chambers of commerce, planning councils and advocacy groups.

M. Recreation

Recreational activities are thought to help the adolescent develop healthy interests and abilities ("clean fun") to replace those related to substance abuse. Residents spend at least 2 hours a day involved in physical education, sports, singing, games, dramatic arts, arts and crafts, and religious activities. Phoenix Academy has equipment and facilities available for swimming, basketball, softball, soccer, and volleyball. Aerobics and community league sports are also offered, to allow adolescents the opportunity to build team skills as well as individual skills. Family recreation days, described earlier, provide the opportunity to learn how to have "clean fun" with family members. Building multicultural awareness is a priority. It is fostered through projects assigned to individual adolescents and shared throughout the community. Permission to pursue particular activities of interest can also be requested. The procedures required to request special activities are seen as another way to help residents learn to follow rules, delay gratification, and plan ahead.

Adolescents go on field trips, usually with their clan, in order to practice social skills outside the program and learn about artistic and cultural events. Trips to see plays, concerts, and museums occur every 4 to 6 weeks. Several community resources are routinely accessed to provide opportunities for activities off-site, including public libraries, parks and recreation areas, community centers, bowling alleys and theaters, and horse stables. Outings such as these are privileges that must be earned. Problems within the clan, such as misbehavior, might cause the outing to be canceled. Clan activities mimic those of a healthy family, in which fun activities are planned when things are going well but are postponed if the clan

members are not functioning well in order to focus on the problems. The type and frequency of outings will depend on the desires, motivation, and needs of the clan as a unit.

N. Coordination With Outside Agencies

Coordination with outside agencies, primarily Juvenile Probation and the Department of Child and Family Services, begins during the intake and assessment process. In cases where the child is a ward or dependent of the court, the probation officer or DCFS caseworker is assigned as the "authorized representative" for the resident, and therefore that person must approve many aspects of treatment planning. These include approving the list of visitors allowed, passes outside the facility, and medical and dental procedures. In addition, authorized representatives are informed about any incidents in the Academy involving the resident, and are required by their agencies to inspect the residents' homes prior to permission for home passes and to visit the resident on a monthly basis or more frequently. Parents are informed that the probation officer or DCFS caseworker will be working with the Academy in this capacity as part of the intake and orientation process, although they too are kept informed about all aspects of their child's progress in the program.

During treatment, most contacts with outside agencies are handled by the primary counselors, who act as case managers for residents. Primary counselors provide updates on the progress of residents on a monthly basis or, in some cases, more frequently (about once a week). These informal contacts include telephone calls, voice-mail messages, or written notes to the authorized representative, which briefly summarize how the resident is progressing in treatment. In addition to routine updates, the Academy staff helps to prepare probation officers and DCFS caseworkers for court appearances by summarizing the resident's progress in treatment.

If a resident is not working hard on his or her recovery and progress in treatment appears to be impeded, probation officers can be called upon to help exert some pressure on the resident to more fully invest in the treatment process. Probation officers have leverage over the resident by being able to remind him or her of the legal consequences of continuing a delinquent lifestyle after discharge, and thus they can motivate residents to work harder. Probation officers can also be called upon to help work on special issues; for example, he or

she can help to work with problematic family members, by reminding them of the legal process and consequences of failure to adhere to the program and progress through treatment.

DCFS caseworkers can be approached for the same types of issues, but they have less leverage over the resident because there are no legal consequences built into the social service system. Nonetheless, the caseworker can lend a sympathetic ear to resident and family issues and can work with them from a different perspective to encourage them to invest fully in treatment.

As plans for re-entry are being made, authorized representatives are involved in the discharge planning process. Within the probation system, the probation officer asks for a recommendation as to whether continued probation is necessary after discharge. At Lake View Terrace, the answer to this question is almost always to recommend an additional year of probation, since residents are thought to benefit from the continued structure of probation and having formal repercussions for delinquent behavior or substance abuse. Within both systems, the authorized representatives help to make decisions about where the resident can safely live in the greater community.

O. Re-Entry Curriculum

As residents near completion of the program, they are given a series of seminars that compose a re-entry curriculum (see table below). This includes 16 sessions over 8 weeks that are specifically geared towards issues that arise as residents transition out of the Academy.

After completing the residential portion of the program, arrangements are made for residents to live outside of the program: at home, in a less restrictive setting, in a transitional living arrangement, or at one of the adult programs. They are encouraged to participate in the aftercare services at the Academy. These include continued case management, weekly group meetings, and an open invitation to visit the Academy or to stay overnight. These services continue for 12 months.

Re-Entry Curriculum		
Week	Session Number	Topic
1	1	Values and Goals
	2	Decision-Making and Problem-Solving
2	3	Sexuality, STDs, and HIV/AIDS
	4	Relationships/Personal Boundaries
3	5	Political Awareness/Letters/Government Structure
	6	Cultural Awareness/Stereotypes
4	7	Communication Skills—You and I Statements
	8	Life Skills: Part 1—Grocery Shopping With Pre-Planned Menu
5	9	Relapse Prevention
	10	Stress Management and Relaxation
6	11	Socialization: Part 1—Mock Meetings, Phone Calls, Resource Network, Dialogues for Social Outings
	12	Life Skills: Part 2—Sewing, Personal Grooming, Cooking
7	13	Spirituality—“Chicken Soup for the Soul”
	14	Socialization: Part 2—Trip to Skating Rink
8	15	Job Preparation (Guest Speaker)
	16	End of Course—Dinner Celebration

IV. DISCIPLINARY AND GRIEVANCE PROCEDURES

A. House Ban/House Retreat

The community within the Academy changes over time as new residents enter and old ones leave. There is a constant balance between negative forces and positive ones, and at times the negatives begin to outweigh the positives, creating an environment in which treatment is stifled. When staff members agree that this is occurring, they can call a "Retreat," which shuts down all outside social contacts with family members and friends for a period of 4 to 6 weeks. The program runs normally except for this ban on outside contacts. This forces the residents to focus on the community and to begin to work towards their recovery. Retreats tend to occur two or three times a year.

Case Vignette

Shortly before the holidays, drugs were found in the Academy after several residents returned from home passes. Clinical staff determined that this was the result of poor supervision during the passes—parents had allowed residents to deviate from plans for the passes and to return home and hang out with friends. Residents had obtained drugs from their friends or had recovered them from stashes in their homes. Staff members decided to call a short house retreat (just 2 weeks), to end before the holidays. They felt this would allow residents to focus on their recovery and give time for work with parents around pass issues. During the retreat, social events with family and friends were eliminated, and family involvement sessions focused on how to discover and remove stashes in the resident's home and the importance of sticking with plans for passes. Family therapy sessions also continued, focusing on these issues for individual residents as needed. The retreat was ended before the holidays so that passes and social events with family members could resume.

B. Disciplinary Procedures

As described in the "Privileges and Sanctions" section (in Section II), a core component of Phoenix Academy is the shaping of adolescents' behavior through privileges and sanctions. Staff members are encouraged in training to use rewards and privileges more than sanctions. When sanctions are used, they are carefully designed and are part of the treatment plan, such that they never involve degrading, embarrassing, or humiliating the resident. All residents have basic rights to be involved in the community; participate in

group therapy sessions and family therapy sessions; and have three meals a day, 8.5 hours of sleep, hot showers, clean clothing, and educational opportunities. Earned privileges can be taken away for disciplinary purposes. Residents may be restricted from school activities if their behavior is dangerous to others; school personnel are informed so that alternative educational arrangements can be made. Similarly, school personnel can suspend a student, following school guidelines, but must consult with the clinical staff before initiating a suspension. School personnel can also assign detention for poor classroom behavior (held weekly on Sundays to minimize interference with the rest of the treatment program).

Discipline is offered in the following progression, unless the behavior in question is dangerous or severe: (1) “pull-ups,” (2) processing incident slips, (3) discussion, (4) verbal reprimand, (5) intervention (learning experience for individuals, house retreats for the entire group), and (6) expulsion. Time-outs can also be used if necessary, in which the resident is restricted to sitting in a designated area (unlocked room, near staff) and is isolated from routine program activities. When time-outs are given, senior staff members must be notified, and they will assign a staff member to monitor the time-out. These are documented in the resident’s chart and in the communication log with the date and time, location, staff member monitoring it, and the reason for the time-out. Corporal punishment is never used.

Expulsion from the program is used as a last resort. The program director or deputy director will call a case conference, including the parent or guardian and clinical team. If an expulsion is recommended by the program director, it must then be approved by the vice president for clinical services.

C. Grievance Procedures

Residents and their parents or guardians have the right to seek resolution of any complaint about the program. Residents can file a complaint with the program director, who then initiates an investigation. This investigation report becomes part of the clinical record and is also sent to the vice president for clinical services. If the client is not satisfied, a meeting with the vice presidents for clinical and administrative services is scheduled. If still not satisfied, the client can file a complaint with the referring agency. Clients are also free to contact their placement officer or the Department of Social Services at any time and to request contact with their placement officer between regular (monthly) visits through their

primary counselor. They can also request a meeting with administrative staff members during regular business hours through their primary counselor. Each resident receives a copy of residents' basic rights and the grievance procedures upon admission into the program, and this information is also posted around the facility.

V. THERAPIST SELECTION, TRAINING, AND SUPERVISION

Phoenix Academy at Lake View Terrace employs about 180 clinical staff members. Clinical staff members include about 30 professionals, with degrees in psychology, medicine, social work, or education, as well as para-professionals with life or job experience that enables them to work effectively with this population. About 70 of these qualify as child care workers or counselors.

Those with professional degrees conduct the family and individual therapy, do psychological testing and psychiatric evaluations, and are available for crisis intervention. They have advanced degrees and training in therapeutic and evaluative techniques but do not necessarily have experience with adolescent substance abusers prior to joining Phoenix Academy. Some bring special expertise to the program and are able to offer groups to residents in their area of expertise (e.g., sexual abuse therapy groups).

The para-professional staff members tend to spend more time with the residents and act as their primary counselors. Many are in recovery themselves, and thus they act as important role models for residents. They tend to have a range of prior life and job experiences. Those with minimal experience generally begin at the Academy as a counselor and later advance to more senior roles, such as that of primary counselor. Others may begin at a slightly higher level, depending on their experience and education.

New staff members spend half of their first day getting an introduction from a senior staff member and spend the other half "shadowing" a staff member who has been approved as a trainer. After this, they are permitted to supervise residents, but they also continue with a series of training meetings during the next 6 months and then throughout their tenure at the program.

Community Care Licensing (CCL), the organization that oversees group homes in California, has certain requirements for staff training. During the first 90 days, new clinical staff members are required to complete 16 hours of training. At Phoenix Academy, training exceeds this requirement: clinical staff members complete 24 hours of clinical training, 4 hours of new employee orientation, and 8 hours of CPR training if they are not already certified when hired. The 24 hours of clinical training include four 2-hour classes of clinical orientation [(1) documentation, special incident reporting, child abuse reporting, and Title 22

group home laws; (2) the TC perspective; (3) resident meetings, standards in the community, and family involvement; and (4) encounter groups], a 4-hour session on operations within the facility (food service, medical procedures, and emergencies), a 4-hour course on boundaries and professionalism in the field, and an 8-hour course on emergency intervention plans for unmanageable residents.

During the next 3 months, the new staff members complete additional training. A 3-day intensive class on the TC model is included, which explores in depth all aspects of the TC philosophy and components of the program. A 2-day program on working with adolescents is also offered, to help staff members understand how to tailor the TC model to adolescents. A variety of special topics seminars are also provided: dual diagnosis, counter-transference, eating disorders, relapse prevention, cultural diversity, gangs, water safety training (for the pool), and behavior management. Finally, a series of 16 2-hour seminars are offered on specific aspects of the TC model (e.g., privileges and sanctions, group facilitation, progressive disciplining) to hone skills within the TC. Staff members are required to complete 40 hours of training within the facility each year, and CCL requires an additional 5 hours of training outside of the facility in the first year and 4 hours in the second year.

The timing and ordering of training vary for each staff member, depending on when they begin work and which courses are being offered. As such, much of the early training occurs on the job through observation and discussion, and supervision is provided by more senior staff members. Since the staff operates as a whole with residents, there are ample opportunities to discuss the progress of individuals and to observe the program components in action.

VI. OUTSIDE INFLUENCES ON PHOENIX ACADEMY: FUNDING AND LICENSING STRUCTURE

The practices and structure of the Academy are shaped by outside influences, such as funding streams and licensing requirements, in addition to the TC philosophy and the Academy model. This section describes those influences at Lake View Terrace and the way in which they have shaped the practices described above.

California has not made a full commitment to adolescent substance abuse treatment, so funding is insufficient. In addition, efforts to convert both mental health and substance abuse methods into a managed care structure are under way. In 1993, California diverted State alcohol and substance abuse funds to support Medi-Cal services, which do not include residential treatment. Thus, funding for long-term residential treatment has eroded over the past few years.

Because of the lack of funding for residential treatment programs within substance abuse treatment sources, Phoenix Academy is licensed as a group home, rather than as a drug treatment program, and is therefore primarily funded by Aid to Families With Dependent Children (AFDC)/Foster Care dollars, governed by out-of-home placement orders. However, the AFDC/Foster Care funds were never designed to meet the full cost of services. The AFDC/Foster Care rate classification system remained stagnant for about 10 years, with a minor cost adjustment recently. In addition, licensing requirements have shifted over time to more intensive supervision of children versus treatment, and the treatment of choice has become the mental health model, involving mental health and social work professionals. Although the Academy was originally planned to have a capacity of 300 beds, the City Licensing Authority limits capacity to 150 beds, phased in over 2 years, limiting the Academy's size.

Recently, at the request of the Probation Department, Lake View Terrace has developed an intensive assessment unit to evaluate the needs of youths who have been failing in their placements. This program ("Genesis") has a 30-bed capacity and is funded through AFDC/Foster Care dollars, at a higher rate of reimbursement (a Level 12 facility, at $4,760 per month). After assessment and stabilization, youths are sent into appropriate services at

the Academy or elsewhere. This new program reduced the capacity of the Academy from 150 beds to its current census of 120 beds by converting 30 beds to this new entity.

Over the years since its founding, referral sources for the Academy have shifted from voluntary to probation-mandated treatment. Lake View Terrace is funded to serve Probation and Children's Services through AFDC/Foster Care funds (the Academy is rated as a Level 5 Group Home) and can serve up to its capacity of 110 beds with this funding at a rate of $2,510 per month. In addition, it holds a fee-for-service contract for eight beds through the Los Angeles County Alcohol and Drug Program Administration for non-probation children. It also accepts private fees on a sliding scale, based on the family's ability to pay. In addition to funding for beds, Lake View Terrace receives money from the School Breakfast and Lunch Program, a clothing allowance for residents through Probation and Children's Services/AFDC funds, and food stamps for youths. Donated goods and contributions are also used to augment programs in the Academy. Since AFDC/Foster Care funds do not currently cover costs, additional money is raised through donations and contributions, and the Phoenix House national organization offsets any remaining funding gap.

VII. REFERENCES

De Leon, G., ed. *Community as Method: Therapeutic Communities for Special Populations and Special Settings*. Westport, CT: Praeger Publishers, 1997.

APPENDIX: CLINICAL RESEARCH SUPPORTING PHOENIX ACADEMY

The following reprint is from Research Monograph 182, published by the National Institute on Drug Abuse, describing RAND's evaluation of youth outcomes at Phoenix Academy versus several comparison sites.

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PHOENIX ACADEMY TREATMENT OUTCOMES: PRELIMINARY FINDINGS FROM THE ADOLESCENT OUTCOMES STUDY

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There is a small but growing literature on the effectiveness of adolescent drug treatment interventions. Unfortunately, few rigorous studies evaluate the effectiveness of the treatments most commonly available to youths,

their families and referring agencies. Instead, the adolescent treatment literature divides neatly between rigorous evaluations of novel theory-driven approaches that are not currently available in community settings, and evaluations of existing programs that use research designs too weak to support strong conclusions about program effectiveness. Typically, studies report treatment outcomes of youths who enter, for instance, inpatient versus outpatient community programs, without accounting for known differences in problem severity and other pretreatment characteristics of youths who enter these treatment modalities. Although statistical approaches are available to adjust comparison groups to account for known differences in background and drug use, we are aware of no published analyses of the major community treatment studies that use these approaches to generate more valid comparisons of treatment outcomes. This may be because the differences between treated cohorts are too extreme to be legitimately remedied through statistical adjustments.

In this report, we describe the treatment outcomes of 449 juvenile probationers referred by Los Angeles Probation to Phoenix Academy of Lake View Terrace, or to one of six group homes of comparable size and planned treatment duration, but which offer no specialized or intensive drug treatment services. Additional information about the group homes and study design are published elsewhere (Morral *et al.* in press). Sequential referrals to these seven placements were recruited for study participation between February 1999 and April 2000, if they were between the ages of 13 and 17, if they assented to participate and to having their parents notified of participation. These procedures resulted in a sample of 175 youths admitted to Phoenix Academy (the PA condition), and 274 comparison youths who entered other placements (COMP condition). Youths were interviewed using the Global Appraisal of Individual Needs (Dennis, 1998) while in detention prior to placement, and again 3, 6 and 12 months later. Over 90% of the baseline sample was successfully interviewed at each follow up.

In aggregate, participants were 87% male, 55% Latino, 16% white and had a mean age of 15.5 at the initial interview. A large percentage acknowledged symptoms qualifying them for either substance dependence disorders (53%), or substance abuse disorders (26%). Collectively they acknowledged committing 11,272 crimes in the 90 days preceding the initial interview. Nevertheless, substantial group differences distinguished PA and COMP participants. Indeed, among the 55 baseline variables we selected, a priori, as the most important indicators of group comparability (the "key variables"), significant differences were observed on 26.

To improve the comparability of the COMP and PA conditions, Propensity Score Analysis was used to weight COMP cases (Rosenbaum & Rubin, 1985). In the first stage of this case-mix adjustment approach, 24 of our 55 key variables were entered as independent variables in regression with treatment condition as the dependent variable. We used a boosted logistic regression algorithm (Friedman, *et al.* 2000; Ridgeway, 1999) to estimate the non-linear relationship, including up to three-way interactions, between the key variables and the treatment condition. The predicted values from this model correspond to the model estimates of the probability the case belongs to the PA condition. Case weights for the COMP condition were constructed as the odds associated with each of these probabilities. After applying weights to the COMP condition, only 4 significant mean differences remained between conditions on any of our 55 key variables: 1) PA youths had higher scores on a scale assessing the degree to which they attribute their problems to drugs (Problem Orientation Index: PA=1.38, COMP=.98); 2) a higher proportion of COMP youths denied ever using any drug or alcohol (PA=.00; COMP=.01); 3) a higher proportion of the PA sample reported a treatment need for drugs other than marijuana or alcohol (PA=.32, COMP=.20); and 4) COMP youths reported more recent engagement in illicit activities other than drug use.

Treatment outcomes were assessed with a between-groups repeated measures analysis for which COMP case weights were applied. At each interview, youths were asked how many of the past 90 days they spent in a controlled environment. Preliminary analysis confirmed that each group had equivalent mean times in controlled environment at each survey wave. Therefore, responses to this item were incorporated as a time-varying covariate in the hierarchical linear model of our repeated measures analyses, since outcomes like drug use must be adjusted for time "at risk." Drug use, crime and psychological functioning outcomes were assessed.

The analysis results showed a consistent pattern across many outcomes. For drug use, crime and psychological outcomes, PA and COMP participants had similar problems at baseline, and comparably sharp reductions in problems three months later. From that time on, however, PA problems remained stable or continued to decline, whereas COMP problems generally increased. In many cases these trends reflected statistically significant time by treatment condition interactions. Significant group by time interactions were found for the Substance Frequency

Index ($F[3, 1192]=3.5$, $p<.05$), a measure of the frequency and intensity of recent drug use, the Substance Problem Index ($F[3, 1192]=4.7$, $p<.01$), a count of the number of dependence and abuse symptoms experienced in the past month, and the Anxiety Symptoms Index ($F[3, 1192]=3.5$, $p<.05$), a measure of recent anxiety symptoms. The same patterns of outcomes with nearly significant group by time interactions were found for property crimes ($F[3, 1192]=2.16$, $p<.10$), and somatic symptoms ($F[3, 1192]=2.2$, $p<.10$).

These results suggest that therapeutic community treatment for adolescent substance abusers is associated with greater reductions in subsequent drug use, drug use problems, and some psychological distress than are found among comparable youths who receive residential interventions of similar duration and intensity, but without intensive substance abuse treatment services. Because this study used a quasi-experimental design, rather than random assignment to treatment condition, we cannot unequivocally attribute the observed differences in treatment outcomes to the treatment programs themselves. Unmeasured group differences might explain differences in outcomes better than treatment effects. Nevertheless, because this study employed a seemingly successful case-mix adjustment strategy, it offers a more rigorous examination of treatment effects than has been the norm in evaluations of community-based treatments for adolescents.

ACKNOWLEDGEMENTS: This research was supported by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (grant # TI11433).

***REFERENCES**

Dennis, M. L. (1998). Global Appraisal of Individual Needs (GAIN) Manual: Administration, Scoring and Interpretation. Bloomington, IL: Lighthouse Publications.

Friedman, J. H., Hastie, T., & Tibshirani, R. (2000). Additive logistic regression: A statistical view of boosting (with discussion). Annals of Statistics 28(2), 337-374.

Morral, A.R., Jaycox, L.H., *et al*. (in press). An Evaluation of Substance Abuse Treatment Services Provided to Juvenile Probationers at Phoenix Academy of Lake View Terrace. In S.J. Stevens and A.R. Morral (Eds.), Adolescent Substance Abuse Treatment in America: Exemplary Models from a National Evaluation Study . New York: Haworth Press.

Ridgeway, G. (1999). The state of boosting. Computing Science and Statistics 31: 172-181.

Rosenbaum, P. R. and Rubin D. B. (1985). Constructing a Control Group Using Multivariate Matched Sampling Methods that Incorporate the Propensity Score. The American Statistician, 39: 33-38.

*Note: Only those references that are cited in the Morral *et al*. work on pp. 111–113 have been listed here. In the NIDA monograph, these references are included as part of the list on pp. 114 and 115.

However, in a clinical setting and with repeated BP measurements, the prevalence of confirmed HTN is lower in part because of inherent BP variability as well as an adjustment to the experience of having BP measured (also known as the accommodation effect). Therefore, the actual prevalence of clinical HTN in children and adolescents is â^¼3.5%.7,8 The prevalence of persistently elevated BP (formerly termed â€œprehypertension,â€ including BP values from the 90th to 94th percentiles or between 120/80 and 130/80 mm Hg in adolescents) is also â^¼2.2% to 3.5%, with higher rates among children. â€¢ Therapeutic community or therapeutic community proper refers to the specific type of therapeutic milieu set up by Maxwell Jones and followers, e.g. Henderson, â€˜a small face-to-face residential community using social analysis as its main toolâ€™. â€¢ Therapeutic milieu is a social setting designed to produce a beneficial effect on those being helped in it, e.g. a sheltered workshop, hospital ward, hostel.Â Current treatment programs are now based upon specific treatment models that are not limited to behavior management, but also include reality therapy, psychodynamic approaches, and social/cognitive frames of reference.Â However, such clinical studies will be complex and more difficult to design and carry out.