WELCOME!

We are honored that you have entrusted us with the care of your child. We recognize that it is difficult to send a child away from home and entrust him/her into the care of others. We know that the decision to place your child in our care was not an impulsive one. It was made after careful consideration, and perhaps a great deal of anguish and pain.

Each member of the Institute is deeply committed to helping adolescents and their families reclaim a sense of wholeness in their lives. We purposefully chose fields in which we could actively make differences in the world. We reach out to you, and offer you our assurance that we will do everything in our power to help you and your family during this time of need. We maintain high expectations of ourselves, and recognize that each client is someone's child. As parents ourselves, we know that when our children are in pain, we hope and pray that those working with them realize that they represent the *world* to family, grandparents, and friends back home. There are few things in life as rewarding as seeing hope and direction once again in the eyes of the hopeless. We are grateful for the opportunity you have given us to work with you and your family.

The Senior Staff

PURPOSE OF THIS HANDBOOK

Placing your child under the care and guidance of others generates a host of questions and concerns. These questions range from simple housekeeping items to complex clinical matters. This handbook is intended to address these questions and provide additional information pertaining to the various aspects of the Institute. This handbook addresses the fundamental variables and procedures in the treatment of your child. It also includes salient issues for parents to be aware of in order to make this experience optimal.

Throughout some of the different sections of this handbook, we have attempted to list frequently asked questions regarding the subject matter and have attempted to respond to those questions in a fashion that we hope provides you with answers as to *what we do, why we do it, and what we encourage you to do.*

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Section 3 **Admission and Length of Stay**
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Section 4 **Treatment Philosophy and Services Offered**
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Section One

Overview

The Aspen Institute for Behavioral Assessment (The Institute) is a specialty psychiatric hospital, licensed to provide services to adolescents between the ages 13-18. Our mission is to provide psychiatric stabilization, comprehensive evaluation, brief intensive treatment and integrated prescriptive services for adolescents who meet the admission criteria. We achieve this, by implementing a wide range of multidisciplinary diagnostic and treatment interventions, individualized to the needs of each client. After identifying and distinguishing these needs, the Institute then provides prescriptive treatment recommendations in the area of social, psychological, emotional, familial and behavioral health. Further, we develop and initiate a comprehensive treatment plan of care prior to the child being placed in a sub-acute, residential treatment, therapeutic boarding school, or outpatient setting as clinically indicated.

The Senior Staff at *The Institute*

Jared U. Balmer, Ph.D., Executive Director. Dr. Balmer is a licensed Marriage and Family Therapist with over 30 years experience in the treatment of adolescents and their families. Dr. Balmer has founded a number of treatment facilities, including a specialty psychiatric hospital for children and adolescents. He has lectured widely across the U.S. on family and adolescent related issues and is the co-founder of The Institute Residential Treatment Center and the Oakley School. He is the recipient of the 2006 Leadership Award of the National Association of Therapeutic Schools and Programs.

Kristin Shadow, M.D., Medical Director. Dr. Shadow is a board certified pediatrician, a board certified adult psychiatrist, and a board certified child and adolescent psychiatrist. She received her Doctor of Medicine Degree from the University of Nevada School of Medicine in Reno, Nevada. Dr. Shadow completed her Triple Board Internship and Residency Program at the University of Utah. Over the last five years she was worked at the Primary Children's Center for Counseling.

Richard Davidson, M.D., Psychiatrist. Dr. Davidson is a board certified psychiatrist with 20 years experience working with patients in both the public and private sectors. He received his medical degree from George Washington University and completed his psychiatric residency at the University of Utah. Dr. Davidson was an air force flight surgeon who served during Desert Storm. Dr. Davison has worked as adjunct faculty with the University of California at Irvine and the University of Utah. He has served as the medical director of a number of organizations including psychiatric, impatient units for children and adolescents. His focus of practice is primarily with emotionally disturbed children for evolution and treatment of complicated and refractory conditions.

Kirk Simon, M.D. Psychiatrist. Dr. Simon is a board certified pediatrician, a board certified adult psychiatrist and a board certified child and adolescent psychiatrist. He received his Doctor of Medicine Degree from the Medical College of Wisconsin in Milwaukee, WI. Dr Simon completed his Triple Board Internship and Residency Program at the University of Utah. Dr. Simon has been on faculty or adjunct faculty at the University of Utah for the last 7 years. He has served as Medical Director of the Psychiatric consult liaison program at Primary Children's Medical Center and Primary's Residential Treatment Center for children 5-14 years old. He enjoys caring for children and families with complex medical and mental healthcare issues.

Mike Bulloch, L.C.S.W., Clinical Director. Mr. Bulloch is a licensed clinical social worker. He is a seasoned therapist whose career is marked by his specialty in the diagnosis and treatment of adolescents and their families. He has practiced in a variety of settings which include outpatient care, acute, care, residential care, and therapeutic boarding schools. Previous to joining the Institute, he served as Director of Clinical Development at Island View RTC and for six years as the Clinical Director of the Oakley School.

Dave Ericksen, Ph.D.., Psychological/Assessment Services - Dr. Ericksen is a licensed clinical neuropsychologist with nearly thirty years of experience working with children, adolescents, and families. He completed a pre-doctoral internship at Primary Children's Hospital in Salt Lake City and in 1982 obtained his Ph.D. from the University of Utah. In 1985, Dr. Eriksen completed a post-doctoral residency in neuropsychology. He has worked and consulted with numerous inpatient and residential programs for adolescents and adults since 1980. .

Sue Crosland, R.N., Director of Nursing - Ms. Crosland received her Bachelors of Science Degree in Nursing from Westminster College in Salt Lake City, Utah. She has over 15 years of experience working with children and adolescents in a variety of settings form psychiatric hospitals to residential treatment facilities. For the past five years, she has worked as an RN in acute settings.

In addition to the above senior staff, The Institute is comprised of an integrated, multidisciplinary team which includes, nurses, primary therapists, teaching staff, chemical dependency counselor, psychologists, activity therapy staff, and milieu and support staff.

Section Two

Goal and Purpose of the Institute

Often, an adolescent's diagnostic picture and the matching interventions and services called for are easily or moderately transparent. However, some youth present a more complex picture and required a more in-depth, comprehensive assessment and diagnostic evaluation.

This critical information will not only answer questions about the nature of the problem, but it will provide caregivers and referring professionals with invaluable data to help place children in the most appropriate settings with services to meet their needs. The accumulation, and more importantly, the integration of this data are often encumbered, as parents and professionals are relegated to gather data in a piecemeal fashion from a variety of specialists over an extended period of time.

At the Aspen Institute, we conduct all of the assessments necessary to provide vital information, and we deliver specific recommendations on the best possible follow-up care for the child relative to his/her diagnostic picture—all under one roof.

The Aspen Institute's services include:

- Comprehensive behavioral, psychological, psychosocial, neuro-psychiatric, educational, chemical dependency, and related assessment services (i.e., speech, hearing, vocational, occupational/recreational, etc.).
- Crisis stabilization.
- Early intensive treatment regiments, such as individual, group, family, milieu, educational, recreational, and related forms of therapy.
- Integrated, comprehensive prescriptive evaluations/assessments, charting the course for a program of step-down services based on residential, outdoor, or community intervention.

Our new, custom-built facility is specifically designed to effectively render these services. It is licensed as a 26-bed acute and sub-acute treatment facility by the Utah Department of Health. The Institute is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

QUESTIONS AND ANSWERS

Q: ***What is the minimum length of stay at the Institute?***

A: Our primary goal is to arrive at a comprehensive, integrated assessment which charts a course that future service and interventions can and should be applied in the healing process of the total child.

In order to achieve this goal, the “total” child must be evaluated. Such evaluations and assessments are not limited to extensive batteries of formal tests, examinations and measurements, but must include “in vivo” observation of how the child reacts to different treatment modalities, classroom settings, peer interaction, possible medication regiments, recreational and diversionary activities, and structured and leisure activities.

To accumulate accurate data, the child must be acclimatized to a certain degree, free for initial stressors associated with placements and passed the “honeymoon” phase, where the child can “look good” for a week or two. For these reasons, the average length of stay is typically under two months, but not shorter than five to six weeks.

Below is a general outlined of services provided during a typical stay at the Institute.

Stages of Assessment/Treatment

Pre-Admission

- Referral is reviewed for admission criteria by the Clinical/Medical Director
- The onsite insurance specialist verified medical/psychiatric insurance benefits
- Referral source and parents are informed about third party payor options.

Week One

- Assessment for self-harm related issues. Does the Resident require safety precautions? Is the Resident knowing or unknowingly in possession of Contraband? Are skin checks required? etc.
- Complete Health/Physical examination including EKG, Height, Weight, Vitals, nutritional Screen, etc.)
- Complete Medical History.
- Orientation of Resident to the milieu via Resident Handbook and staff.
- Completion of Psycho-Social Assessment
- Preliminary Psychiatric Diagnosis conducted by Psychiatrist (necessary for third party payor).
- Utilization Review with managed care. (Certification with possible physician to physician review).
- Establish accurate baseline of overall level of emotional and social functioning.
- Contacting prior care givers-, referral sources, and parents for additional data (i.e. prior testing, clinical impressions, etc.
- Development of Initial Treatment Plan.
- Rapport Building i.e. establishing a relationship with the client. Defining/establishing roles and boundaries with the client.
- Establishing/reinforcing trust with Family *and* the referral source through Communication. Contacting prior providers for additional data.
- Weekly review/update with Referral Source.

Week Two, Three, and Four

- Core psychological testing. (Psychiatric, Psychological, Chemical Dependency, Family System, and Recreational/Leisure Assessment/Evaluation).
- Educational Testing/Evaluations
- Medication Evaluation. (Potential changes with medications i.e. titrating medications, introducing or discontinuing medications. Phone call informing parents, requesting consent for proposed changes).
- Determining need and extent of individualized care of the client.
- Development of Master Treatment Plan.
- Re-assessing resident dynamics within the daily milieu and formal therapy encounters.
- Re-assessing diagnostic impression. Additional psychiatric and/or psychological testing may be indicated to arrive at a differential diagnosis. (i.e. Neuro-Psychological Testing, Brain Mapping, Dietetic Evaluation, Speech and Language Assessment, Psycho-Sexual Risk Assessment, PDD spectrum evaluation, etc.).
- Weekly review/update with Referral Source. Preliminary Testing is shared with referral sources.

Week Five and Six

- Multi-Disciplinary Team contributes recommendations for the Integrated Multi-Disciplinary Report (MDR).
- Final Medication adjustments.
- Preliminary testing review with referral source and sent to potential programs.
- Formulation of Course of Treatment by the Multi-Disciplinary Team.
- Reviewing the MDR with Referral sources.
- Reviewing the MDR with Parents and Referral Sources.
- Closure with RT
- Surveys: Parent and Resident.

Section Three

Admission and Length of Stay

In most cases, adolescents admitted to the Institute had previous involvement in mental health services including outpatient therapy, residential treatment, therapeutic boarding schools, sub-acute treatment and/or psychiatric hospitalization. Typically, the reason why a child comes to the Institute is because the course of recovery to optimal health has been obscured or is not progressing optimally. Stabilization and/or a comprehensive assessment may shed further light on the nature of the presenting problem and subsequently chart the way for further intervention.

Since the primary purpose of the Institute is to provide diagnosis and assessment, not treatment, the average length of stay is relatively short and in most cases will be less than two months. However, even though the adolescent may be familiar with treatment routines, admission to the Institute may be perceived by the youth as a “step back.” Hence, The Institute will make every effort to communicate to the child that the admission is not a “punishment” for failed expectations, but an opportunity to find new and better ways on the way to improvement.

Notwithstanding, regardless of the Institute’s efforts in this regard, the adolescent may approach the admission reluctantly, and in some cases, with a great deal of opposition. Hence, the child will employ all of his/her “skills” to convince you to take him/her home.

Q: ***My child is very angry with me for placing him. I am not quite sure how I should react to his anger?***

A: Often, teenagers make it strongly known that "there is nothing wrong with me", and that if "you would only back off, everything would be just fine." His or her problem is not theirs. It is always someone else, typically yours -- so they claim.

As a result, shortly after your son or daughter enrolls at the Institute, he or she may attempt to arouse feelings of guilt and anxiety within you. Few residents do it unconsciously, many do it deliberately. We call this "GUILT-LOADING". The central aim of guilt-loading has one and one purpose only – for you to rescue your child and bring him home.

The full frontal attack of guilt loading is: "Why did you put me in here? I can't believe you did this to me. You obviously don't care about me. I don't deserve this! If you don't get me out of here, I’ll never talk to you again. If you take me out of here, I'll do anything you want me to do. If you don't take me out of this place, I'll kill myself! If you think that I will change, you are wasting your time and money. etc., etc., etc.

The second method of guilt-loading is somewhat more subtle. It is known among behavioral scientists as "triangulation". This simply means that one person is misinforming, lying or telling half-truths to a second person about a third person in order to get the third person "in trouble". Typical examples of triangulation attempts from your son or daughter may be: "My therapist told me that it is really all your fault that I ended up here. I talked to

my father last night and he does not think that I belong in a place like this. Like the previous method it is designed to weaken your resolve and make you feel guilty.

The third method is the "horror story" approach. Through misrepresentation or exaggeration, the child tries to make you feel guilty. Examples are: "They are not feeding me. They are feeding us too much, they are going to turn me into a pig. There is never hot water for the showers. Mother, you have to believe me. My roommate is an aggressive, psychotic pervert. I feel unsafe. Nobody on the entire staff has talked to me for days. I'm the only sane person in this place. Compared to other kids here, I have no problems", etc., etc.

Do not let "guilt-loading" overpower you. As long as your son or daughter thinks there is a chance to control you by these manipulative techniques, such self-defeating efforts will probably continue. If he/she succeeds in making you feel guilty, then you will need to work with your adolescent's therapist who can help you through this period. Remember that "getting hooked" by guilt-loading and not being able to overcome it, significantly hampers the short and ling term rehabilitation process of your son or daughter.

Q: ***How long is my child going to stay angry at me? For me to entertain the idea that she may never forgive me for placing her in a treatment center, is unthinkable.***

A: *After many years of experience, and working with thousands of adolescents, we can assure you that this "anger period" is typically short lived. For the most part, after about 3-4 weeks your child is over the anger stage for having been placed. Albeit, your child might still deal with anger for various reasons, however, such anger typically is not for placing him at the Institute. Your child may be angry about a sexual assault, for losing a parent, for being mistreated by his peers, etc., etc. However, for the most part, children at the Institute begin to realize that being here is an attempt to help them instead of punish them.*

One of the most helpful things that you can do in dissipating the child's anger is to sound like a "broken record". "Johnny, I love you but something had to be done. Other avenues did not render the desired result and we did what made the most sense. We need to find out what is really going on with you and how you, us and others can best help you in the future." His reply may sound something like this: "But mom, you don't understand, this place is crazy. If you just give me one more chance I can prove to you that things will be different". Your response is simply this: Johnny, I love you but something had be . . . . . – broken record.

Q: ***To what extent should I discuss the expected discharge date with my child?***

A: *It is best to indicate to your child that the stay at the Institute is relatively short. Most importantly is that fact that all the pertinent diagnostic and assessment procedures must be completed prior to the discharge date. A premature discharge my compromise the very purpose for which the services of the Institute were employed in the first place.*

Section Four

Treatment Philosophy and Services Offered

The primary purpose of the Institute is to provide comprehensive assessment and diagnostic services. They are fundamentally divided into ***core*** and ***optional*** assessment procedures.

Core Assessments	Optional Assessments
- Psychiatric Evaluation - Psychosocial Assessment - Family System Assessment - Health and Physical Assessment - Nutritional Screen Assessment - Self-Harm Assessment - Psychological Evaluation - Chemical Dependency Evaluation - Medication Evaluation - Recreational/Leisure Evaluation - Educational Evaluation	- Expanded Psychological Testing (Bender-Gestalt, Rorschach, etc.) - Neuro-Psychological Testing - Brain Mapping - Nutritional/Dietetic Evaluation - Vocational Testing - Occupational Assessment - Neurological Evaluation - Assessment/Evaluation of Learning Disabilities (NLD, Dyslexia, etc.) - Speech and Language Assessments - Psycho-sexual Risk Assessment

Every adolescent admitted to the Institute will receive a core battery of assessments as indicated above. In most cases, these procedures will provide us with the data to arrive at a differential diagnosis. However, is some cases, additional assessment and tests are called for to zero in on a particular problem.

It is important for you to understand that certain core assessments and tests should not be administered during the first 10-14 days at the Institute. Administering a test too early may result in false data, as the child is not acclimated to the environment. Achieving a basic comfort level is paramount to getting accurate testing results. In addition, some children come to the Institute on a variety of psychotropic drugs. The effects of these drugs and their influence on test results will need to be evaluated. In some cases, we may need to titrate some drugs down in order to get more accurate testing data.

In addition to standardized testing and other diagnostic procedures, each resident will be involved in a variety of therapeutic endeavors. Fundamentally, such services fall into six categories. They are:

- Psychiatry
- Therapy
- Education
- Recreation
- Therapeutic milieu
- Nursing

Psychiatry

In addition to providing psychiatric evaluations on all residents, the psychiatrist will conduct medication evaluation as clinically indicated. Hence, the psychiatrist will visit with the respective resident on a regular basis to evaluate the need, and/or the effectiveness of psychotropic medication.

Q: ***Will I be contacted when my child is taken off or placed on psychotropic medication?***

A: *Yes. If we think that taking your child off medication or placing him on a new or different medication regiment is clinically indicated, the psychiatrist will contact you, discusses the issues with you and implement the regiment only after you have provided us with the approval to proceed.*

Q: ***How often will the psychiatrist visit with my child?***

A: *The relative frequency of the psychiatrist's visit with your child depends on a number of variables. First, all clients admitted to the Institute will receive a Psychiatric Evaluation conducted by the psychiatrist. This will typically take place during the first week of stay, unless clinically contraindicated. Second, the frequency of the psychiatric rounds is dependant on psychotropic medication issues. Numbers of medications, titrating, reduction or introduction of new medications, all influence the frequency of the psychiatric oversight.*

Therapy

The primary goal of the Institute is to obtain a comprehensive diagnostic and evaluative picture of the child, followed by prescriptive protocols – a charting of they way – if you will, for further, long term interventions. Hence, individual and group therapies are conducted on a regular basis with two aims. First, to initiate, or in some cases to re-initiate, the change process, and second, to evaluate the qualitative and quantitative extended therapy services that best fit the need of the child.

In order to arrive at a comprehensive diagnosis, one must understand the larger social setting in which the child interacts. Hence, Institute staff will consult with family members or provide family therapy as indicated.

A large number of adolescents with emotional or behavioral problems demonstrate an overlay of drug and/or alcohol abuse. Routine counseling is provided for those residents where the assessment shows that such interventions are part of the comprehensive treatment plan.

Q: ***My child tells me that she/he is not seeing the therapist enough, what can I do?***

A: *The primary therapist sees your child three times per week for approximately 40 minutes in individual therapy. In addition, the therapist sees your child in group therapy five times per week for approximately one hour each session.*

The therapists' offices are strategically located throughout the building, encouraging spontaneous integration with the resident population. The result is that the therapist has numerous opportunities to interact with you child. All such interaction has therapeutic value and is part and partial of the individual and/or group therapy processes. Hence, if you child is claming that she/he is "therapeutically deprived", it is like that the child is attempting to manipulate you in some way in getting your sympathy.

Education

Due to the short length of stay, providing a formal, accredited educational curriculum that offers credit is unrealistic. In addition of evaluation learning differences and learning styles, the aim of the educational component of the Institute is to add additional information to the diagnostic picture of the child. In a classroom setting where subject matters of a wide variety are addressed, the multidisciplinary staff will glean critical information about the cognitive and behavioral learning disposition of the child.

Q: ***While at the Institute, can my child continue to work on school assignments from the previous school placement?***

A: *Yes.* In the event that the end of the block/semester is occurring at the time of admission and the school district is willing to allow A.I. to proctor exams.

Milieu Therapy

How a child interacts with his peers adds invaluable diagnostic information in helping us to accumulate a comprehensive view of the child. For that purpose, the resident is part of a therapeutic community with rules, expectations and consequences. These ruses are based on safety and pro-social behavior. How a child negotiates through a multitude of dyadic relationships becomes paramount in accumulating prescriptive protocols for long term treatment.

Q: ***My child tells me that there are too many rules and regulation at the Institute? How should I response?***

A: *The reason for rules and regulations that govern the daily routine at the Institute is threefold: Fist, we must insure the safety of all residents and staff. Second, to operate an orderly, predictable, and therapeutic environment, free of negative pop-culture images, is paramount in the diagnostic and treatment process. Third, how a child negotiates rules and boundaries adds critical information in the development of the prescriptive protocols following discharge. Hence, tell your child to cope the best he/she can under the circumstances.*

Recreation

Adolescents struggling with emotional problems are often not making good use of their free time. To assess their past history is this area and introducing them some regular activities not only becomes diagnostic and therapeutic in nature. Hence, the resident will participate in daily and/or weekly activities of leisure education, recreational therapy, cardiovascular activities and other diversionary activities. To administer the recreation program at the Institute, we employ a full time recreational therapist.

Nursing

Nursing services are provided on a 24 hour/day basis. Nurses participate in the administering of medication, medication education, primary care issues and the implementation of the therapeutic milieu.

Overview of the therapy services proved:

Psychotherapy	Individual Therapy Group Therapy Family Therapy/Consultation Chemical Dependency Group	3 x 40 minutes per week 5 x 50 minutes per week 1 x 50 minutes per week 2 x 50 minutes per week
Activity/Recreational Therapy	Leisure Education Recreational Therapy Diversionary Activities Cardiovascular Activities	1 x 1 hour per week 1 x 1 hour per day 1 x 1 hours per day 1 x 1 hour per day
Education	Structured Classroom Learning	5 x 4 hours per week
Nursing Services	Primary Care and Medication Administration	24 hours per day/7 days per week
Psychiatric Services	Psychiatric Rounds conducted by a board certified Psychiatrist	As clinically indicated
Milieu Therapy	Informal Milieu Groups including Activities for Daily Living	Daily

Multi-disciplinary Case Conference

On a weekly basis, the status and progress of each resident is reviewed by the multi-disciplinary team. The attending psychiatrist, nurse, primary therapist, recreational therapist, teacher, milieu manager, chief psychologist, and clinical director, meet together and review past data and chart the course for the next week.

All the diagnostic and treatment data accumulated by the multi-disciplinary team will be “distilled” into a comprehensive report that will not only address the diagnostic formulation, but equally important, describe qualitative and quantitative prescriptive protocols for further treatment and interventions.

Q: ***Next to the core assessment, what additional assessment will be administered, and are there additional costs involved in these tests?***

A: *As indicated above, the core assessments are rather comprehensive and will provide very adequate diagnostic information of a child. However, as the diagnostic picture evolves, and more questions arise regarding certain areas of physical, neurological, biological, emotional, cognitive and/or psycho-social functioning, additional tests and/or assessment procedures my be indicated. If this is the case, a member of the multi-disciplinary team will contact you and discuss the issue with you. Additional assessments are only administered with your permission.*

The cost associated for all optional test/assessments are billed on an individual basis and are not included in the daily rate charges.

Q: ***How much contact will I have with members of the multi-disciplinary team?***

A: *You will communicate on a regular basis with members of the multi-disciplinary team.*

Primary Therapist - You will be schedule for a weekly family therapy/consultation phone conference with the primary therapist of your child. The therapist and you will negotiate an optimal time for such a phone conference.

Psychiatrist – During the course of the stay at the Institute, you will communicate with the psychiatrist at least once, typically early on during the intensive assessment phase. Depending on medication related issues or other medical issues, the psychiatrist will communicate with you as needed.

Nurse – The nurse will contact you regarding any primary care issues. For example, if your child has sore throat and need medication, you will get a call from the nurse, or, if we find some abnormality during the initial medical exam, your will receive a call from the nurse, the nurse practitioner or the physician.

Section Five

PHYSICAL HEALTH

Physical Exam

Upon entry of your child into the Institute, he/she will receive a health and physical exam, including a EKG exam, by one of our physicians or our fully licensed nurse practitioner. The cost for this exam is included in the daily per diem charge. As a result of the exam, if your child requires additional and/or routine medical testing including laboratory blood testing, and/or medical treatment including psychopharmacological medications, you will be responsible for those costs. In such an event, an Institute's medical team member will contact you and enlist your feedback, direction and desires as to the course of action pursuant to medical treatment.

Dental

As part of the physical exam by the physician, a dental screening exam will be conducted. Should the resident require dental care, the nurse will contact you, tell you about his/her findings and recommendations and enlist your direction in the choosing of an appropriate course of action.

Emergency Care

In the event that your son or daughter requires emergency medical care, it will be handled immediately and you will be notified of the circumstances as soon as possible. The medical/nursing staff of the Institute will keep you informed regarding such care.

Emergency care is typically handled at the Davis Hospital (6 mi. from the Institute), equipped with a fully accredited emergency room service. The resident is transported by car or ambulance, according to the need.

Non-emergency medical care, such as cosmetic surgery, care of warts on the body and extremities, acne, etc. are done only with parental permission.

Routine Medical Care

A physician is available on campus Monday - Friday, typically most every day. Sick call rounds are conducted on a daily basis by the physician, a nurse practitioner or a nurse. If a condition continues, off-campus medical care is obtained. For other than emergency medical care, you will first be contacted for discussion and permission to proceed.

Unless otherwise specified by parents or the insurance company, off-campus doctors/specialist, will bill the parents or their insurance company directly. **If your child is being treated for a non-psychiatric medical condition such as an infection, asthma, skin problems, etc., the Institute will bill you for the cost of the medication required to treat those conditions. Through a contractual pharmacy, you will get billed for the cost of psychotropic medication.** The Institute will not charge you for the costs associated with medication management, i.e. our physician and nursing fees.

Section Six

HOUSEKEEPING ITEMS

CONTACT PERSON

Your contact person at the Institute is the ***Primary Therapist*** of your child. All inquiries about your child's therapeutic progress should be directed to him/her. The Primary Therapist gathers information from a variety of sources to avoid over involvement of other staff and decreases possible “mixed” messages. The Primary Therapist typically has a 40 hour work week and is available during regular business hours. If you call and the Therapist is not available, please leave a voice message or leave a message with the receptionist. The Therapist will get back with you at his/her earliest convenience. If it is an emergency situation, please indicate this to the receptionist who will get an appropriate staff member to speak with you.

There are matters that the primary therapist typically does not get involved in such as physical health related issues. If you child requires dental work, physical therapy, new corrective eyeglasses, a consultation with an outside physician, etc., you may want to call the nurse at the Institute who will assist you in resolving the issues.

VISITATION POLICY

Due to the fact that the Institute receives residents nationwide, it is not practical to have set visiting hours for all but local visitors as parents/guardians are limited in terms of times and frequency for visiting residents. Non-local visiting parents, family members and guardians are accommodated whenever such visits occur. Visits should **always** be prearranged through the Primary Therapist. Visits should occur at times that would not interfere with any aspect of programming or occur prior to breakfast or after 8:30 p.m.

Guidelines for Visits are:

- Visitors under the age of 18 must be accompanied by an adult.
- Visitors should not bring food items to the resident. This decreases feelings of jealousy that others may feel who do not have the chance for visits/gifts. Food items from outside the facility also present a potential health hazard. Some youth with eating disorders may also experience undue pressure in such situations.
- The receptionist will ask the visitor for the "resident ID number" which must be given before the receptionist can validate that the resident is at the facility and before the visitor can be given access to the resident. The receptionist will check the visitation log to make sure the visitor is on the approved list.

MAIL

Many adolescents in treatment have strong negative peer groups in their home communities. Communication with such negative peers often significantly hampers the assessment and rehabilitation process. For this reason all outgoing mail from each resident is mailed to his parents/guardians. It is up to the parents to forward the mail.

The reason for such mail routing is the avoidance of receiving mail that may be detrimental to the therapeutic progress of the teenager. Manipulative teenagers can be very crafty in getting their "druggy" friends to smuggle in contraband via the mail or communicate other negative messages that may "hurt" the progress of the child.

All mail to the resident is opened by the resident in the presence of a staff member to assure that no contraband is passed on to the facility. The staff member who observes the opening of mail may not read the content of the mail unless invited by the resident.

Incoming mail must be from a person on the approved communication form that the parents fill out at admission. The mail will go directly the resident. If the incoming mail happens to be from someone <u>not</u> on the approved communication form, the mail will first go directly to the therapist. If the therapist deems the mail as inappropriate in anyway, that mail will be forwarded to the parents at which time the parents may decide what to do with it.

TELEPHONE POLICY

Following a one week observation period, phone calls between a resident and parent may occur if deemed clinically appropriate. These calls will occur within the presence of the therapist If first deemed clinically appropriate by the multidisciplinary team. The quality and topics of communication contributes valuable information to the overall clinical profile of the resident and family

Phone Calls

The first two week's of a resident's stay represents one of the most important stages in the assessment/ treatment process. It is during this time that valuable diagnostic information is gathered for the formulation of the clinical profile, treatment strategies, and the overall treatment plan. This information includes but is not limited to clinical assessments, interviews with parent and child and initial therapy sessions. It is also a time for new residents to orient themselves to their environment and to focus on the precipitants that required admission.

In this initial two weeks there will be a limited amount of interaction between parent and child to allow this process to occur. In the first two weeks of their stay there will be no phone calls from the resident to their parent/guardian. At the beginning of week three a phone call may occur between the resident and family if deemed clinically appropriate by the multidisciplinary team. This call will typically occur at the end of an Individual therapy session and will be coordinated by the therapist. Additional contacts may occur during this time period in the form of family therapy/consultation sessions.

It must be emphasized to staff and families alike that due to the level of acuity and diversity of the client population that the Institute serves, phone contact between each resident and family is highly individualized. Because of the relative short length of stay, treatment can not be compromised. If phone contact results in significant upheaval, distraction or regression on the part of the resident or family, direct communication will be discontinued.

Phone Contact Summary

1st Week of Stay:	No Phone Calls
2nd Week of Stay:	No Phone Calls
3rd Week of Stay	One 10-15 minute call (must be first approved by the multidisciplinary team) and supervised by the therapist.
4th week of Stay (and thereafter)	One 10-15 minute call (must be first approved by the Multidisciplinary team) and supervised by the therapist.

FOOD AND CARE PACKAGES

We strongly discourage parents/guardians from bringing food to their child at the Institute. Parents are invited and encouraged to send packages to their sons and daughters. Items such as toiletries, clothing and books are acceptable. Residents are not permitted to subscribe to magazines and have them sent to Institute. Please do not send food items, candy or gum. However, due to limited storage space available in the bedroom area, we are not able to accommodate large care packages. It has been our experience that large care packages can lead to bartering among residents. This should be avoided.

PERSONAL ALLOWANCE MONEY

Due to the nature of the relative short stay and the relative restrictiveness in participating in off campus activities, there is not time and place for your child to spend money. Hence, please do not provide your child with personal spending money.

INTENTIONAL DAMAGE TO PROPERTY

If your child has been found responsible for the intentional damage to facility property, the repair of replacement cost will be billed to your account.

RUNAWAYS

The Institute is licensed as a specialty psychiatric facility and therefore has looked doors. This, however, is no absolute guarantee that a child will not run away. A resident may run away on the way to the gym or other on-campus activities and by all clinical indicators does not present a run risk. Please note, that since the beginning of operations, the Institute never had a run-away child.

Q: ***What does the Institute in case of a runaway?***

A: *As soon as we become aware of a runaway, the staff will initiate a search. Such a search is aided by radio, allowing staff to talk to each other with someone manning the "home station."*

Unless we find the child within 15-20 minutes, we involve the local law enforcement agencies (sheriff or police department) in the search. Description of the child, with accompanying photo is given to the respective agency.

Q: ***What should I do in case my child has run away?***

A: *In the unlike event of a runaway we will contact you and inform you what is being done to retrieve the child. In all run away situations, stay calm. In about 95% of all runaway cases, the child, sooner or later, will call you.*

Section Seven

CONFIDENTIALITY

Upon admission, parents/guardians as well as residents are asked to sign forms which guarantee that information regarding treatment issues and identifying information related to the clients and families of all program participants is kept confidential. It is crucial that identifying information such as names, addresses, work positions or other sorts of data which would allow one to identify a program participant be treated as confidential to ensure privacy. Your child may at times state that a fellow resident was involved in a situation that affects your son or daughter. It is not appropriate to ask for their name. You may certainly disclose personal information regarding yourself to whomever you wish, but it is not appropriate to share such information about others unless accompanied by specific written and witnessed authorized Releases of Information. Forms regarding such a release are available from Admissions and Administrative staff.

Section Eight

CLOTHING REQUIREMENTS AND PERSONAL ITEMS LIST

Adolescents, particularly those with emotional and/or behavioral difficulties, often utilize clothing, artifacts, and make-up as a way to express their oppositionality by subculturalizing into maladaptive lifestyles. In many instances, what is manifested on the "outside" is a reflection of what may be going on "inside". For this reason, The Institute adheres to a dress code that avoids the "very appearance" of negative sub-grouping including, drug, gang, hip-hop and other related "street-like" lifestyles. Inappropriate clothing will be sent back home following the initial inventory of a new resident's personal belongings.

Parents and guardians can significantly aid in the treatment process by pre-sorting objectionable and inappropriate items. Staff will also inventory and inspect personal belongings and clothing at the time of admission. Clothing should meet Code of Conduct guidelines (see appendix B). Please aid The Institute further by staying within suggested numbers of clothing items so as to avoid complete ward robes for each season of the year thus resulting in jammed storage areas and general clutter in the facility.
When providing additional clothing for your child, please be prepared to receive a shipment of other/older clothing to help keep down cluster and avoid preoccupation with styles as they may interfere with clinical issues.

PERSONAL BELONGINGS

In addition to standard clothing items, your son or daughter is encouraged to bring some items to the facility and discouraged from bringing others.

Encouraged Items:	Personal pillows, family photographs and mementos, posters (must be appropriate) stuffed animals, radio with earphones.
Inappropriate Items:	Camera, bedding items (with exception of pillow), expensive watch, jewelry, cassettes/CD's/MP3/iPod.

The Institute is not responsible for the loss or damage of any of such items.

PACKING LIST

Girls			Boys		
√	**Suggested Number**	**Item**	√	**Suggested Number**	**Item**
	2 Pairs	Pants or Casual Jeans **(no spandex tights or stretch pants allowed)**		2 Pairs	Pants or Casual Jeans **(no tight or stretch pants allowed)**
	5-7 pair/each	Underwear, Panties Bras,		5-7 pair/each	Underwear, Panties,
	2 pair	Pajamas		2 pair	Pajamas
	5 pair	socks		5 pair	socks
	1	Coat & Jacket **(for cold weather)**		1	Coat & Jacket **(for cold weather**)
	1	Hat and Gloves **(for winter time)**		1	Hat and Gloves **(for winter time)**
	5 each	Shirts		5 each	Shirts
	2 each	Sweatshirts, Sweatpants **(w/elastic waist)**		2 each	Sweatshirts, Sweatpants **(w/elastic waist)**
	2 pair	Athletic Shorts		2 pair	Athletic Shorts
	1 pair	Daily Shoes **(slippers or indoors shoes)**		1 pair	Daily Shoes **(slippers or indoors shoes)**
	1 pair	Athletic Shoes		1 pair	Athletic Shoes
	1	Electric Razor **(no blades)**		1	Electric Razor **(no blades)**
	2	Towels		2	Towels
	1	Pillow & pillow Slip		1	Pillow & pillow Slip
	1	Shampoo, deodorant, Tooth brush, Tooth past, etc.		1	Shampoo, deodorant, Tooth brush, Tooth past, etc.
	1	Travel Hygiene Bag.		1	Travel Hygiene Bag.
	1	AM/FM walkman **NO I-PODS**		1	AM/FM walkman **NO I-PODS**

Appendix A

CODES OF CONDUCT

Hygiene/Dress/Grooming Code

It is important that the facility is clean and free from any agents that may jeopardize the health and well being of residents and staff. In addition, emotional health and personal hygiene, grooming, and dress are often interrelated. Poor hygiene or negative appearance often contributes to or indicates and reinforces one's emotional pain and hopelessness.

Hygiene Code

1. Shower once each day (morning or night) and after physical recreation activities.
2. Brush teeth after every meal.
3. Wash hands before each meal.
4. Follow the individual treatment plan with respect to hygiene related issues.
5. Keep bedroom and bathroom clean at all times.
6. Change and wash personal linen at least weekly.
7. All dirty/used clothing must be washed at least weekly.
8. Clean-up after self when using general areas of the facility.
9. Residents must alternate use of socks/nylons to promote good foot hygiene.

Dress Code

1. All clothing must be prominently labeled with the initials of the resident.
2. Only clean clothing may be worn. (Clothing with holes, tears, patches, heavy fraying at the bottom or that is badly worn is inappropriate).
3. Clothing may not be gang related nor project a negative image (Clothing with alcohol, cigarette, musical groups, sexually suggestive content, combat clothes, Rave attire, sagging, hip-hop and/or oversized pants are all inappropriate).
4. No solid color outfits of gang nature or gang related attire including socks, shoe laces, bandannas, etc. is permitted.
5. No belts.
6. Pants can be only 1 size larger than waist to prevent "sagging" and cannot be "baggy" in the legs. Shorts can not be longer than the top of the knee and not shorter than mid-thigh. Skirts and dresses must be at knee-top length.
7. Shirts may be worn out unless specifically tailored to be tucked into pants. These include shirts with tails, uneven bottoms, etc. Shirts that hang down longer than the back pockets are also required to be tucked into pants.
8. No earrings. No body piercing (nose, tongue, belly rings, etc. for males or females); one (1) finger ring per hand for all residents; and only (1) bracelet per wrist. Choker type jewelry is not allowed.
9. Male and female residents must wear appropriate underclothing (bras for females). Underclothing should not be visible at anytime.
10. No sexually provocative clothing (i.e. short-shorts, halter tops, excessively tight, muscle shirts, low-cut tops, baby doll clothing, rolled-up sleeves, etc.). Shirts need to be of

appropriate length to prevent midriff or underclothing from showing especially when arms are raised. Tank tops may only be worn as underclothing.

11. No borrowing from fellow residents, nor “giving” of personal belongings to other residents.
12. “Punk-like” jewelry is inappropriate (chain chokers, spiked leather wrist bands, etc.). Each resident is limited to two (2) necklaces.
13. Tattoos will be covered with long sleeve, long pants and/or bandage.
14. Moccasin style shoes while on unit. Off campus shoes are stored in shoe lockers.
15. No steel toed footwear, platform shoes (soles/heels over 2 inches in height), or combat/army type boots while on off campus activities.
16. All residents must be properly covered at all times when in bedrooms, common bathroom areas, or other places within the facility with the exception of time when showering or while using the toilet facilities.
17. Proper sleep attire should consist of pajamas or a t-shirt and shorts/pajama bottoms. When residents are out of bed they should be properly covered at all times as sleep attire is not proper when in the hallway or when walking around in the room. All clothing must be prominently labeled with the initials of the resident.

Grooming Standards

1. Avoid the use of excessive make-up and remove make-up daily before bed.
2. Sharing make-up will result in loss of all make-up for a minimum of seven days.
3. Personal grooming such as hair combing, make-up, nail cutting, etc, is performed in the privacy of the resident’s bedroom and/or bathroom.

Haircut/Hairstyle Policy

Hair will not obscure eye contact.
All male students are expected to be clean shaven.

General Codes of Conduct

Code for Fostering a Safe Environment

It is paramount to the treatment environment that all residents enjoy a sense of safety and not have to deal with any form of violation of property and/or person. Therefore, all residents need to feel safe from physical, sexual, emotional, and property violations. For this reason all residents are expected to abide by the following Code of Conduct, and will **not** engage in the following:

1. Any form of violence (i.e. pushing, shoving, hitting, kicking, biting etc.).
2. Threatening or hurting oneself by self-mutilation, suicidal threat.
3. Any real or implied threat of violence.
4. Any form of inappropriate boundaries, including petting, touching, kissing, note writing, exhibitionism, or sexually offensive comments, etc.

ASPEN INSTITUTE
for Behavioral Assessment

Parent Handbook