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# Still Shackled in the Land of Liberty

## Denying Children the Right to be Safe From Abusive "Treatment"

***Wanda K. Mohr, PhD, APRN, FAAN***

The troubled-teen industry has come under federal scrutiny after over a decade of reported abuses and the reported deaths of at least 10 children. This article provides a brief overview of the development of the troubled-teen industry, addresses the thorny issue of parents' right to send their children to these facilities vis-a-vis the rights of their children, and argues that nurses and other health professionals have a collective obligation to speak out against them in the strongest possible terms. Suggestions for action by nurses are proposed that could protect vulnerable children against this continuous cycle of institutionalized child abuse masquerading as therapy. **Key words:** *children's rights*, *residential treatment*, *vulnerable populations*

FOR over a decade, parents seeking help for their children turn to programs in the United States known collectively as the "troubled-teen industry."[1] The troubled-teen industry arose in its various forms, slowly insinuating itself into an environment in which mental health services for children and their families are either not available or inadequate.[2,3]

The troubled-teen industry facilities go by a variety of names: among them are behavior modification schools, therapeutic treatment facilities, attitude adjustment schools, emotional growth schools, wilderness therapy programs, attachment therapy institutes, and boot camps. Many of these programs are located within the western areas of the United States where they are subject to very little oversight or regulation. Some operate overseas, mostly in developing countries, where they are subject to even less regulation.

***Author Affiliation:*** *University of Medicine and Dentistry, New Jersey School of Nursing, Stratford.*

***Corresponding Author:*** *Wanda K. Mohr, PhD, APRN, FAAN, University of Medicine and Dentistry, New Jersey School of Nursing, 40 East Laurel Rd, Stratford, NJ 08084 (mohrwk@umdnj.edu).*

In response to Internet advertisements full of testimonials, parents send their children to these facilities unaware that the staff are generally unqualified or underqualified to provide services, such as education and psychotherapy, and that their methods range from questionable to highly dangerous and abusive.[2] Apart from testimonials, these facilities cite no legitimate theoretical foundation that is consistent with what we know about child development, no research upon which to rest their claims, and because of loose regulations that vary from state to state,[2] children are not protected from harm. For many years incidents of abuse and death of children have been reported in news reports, with little effort on the part of state or federal authorities to bring them under legal scrutiny. The results of the harsh "discipline" endemic of this industry have been seen in reports of death and abuse that has surfaced sporadically, but on a regular basis, over the past decade.

For example, in 1990 two teens were reported to have died in wilderness camps following long hikes under harsh conditions in Arizona and Utah. One of the operators of these camps was back in business after receiving immunity from prosecution in return for

their testimony against one of the partners, and 4 years later a 16-year-old child died from peritonitis caused by a perforated ulcer that was ignored by their camp staffers.[1,2]

In 1998, a 16-year-old child died of empyema at a boot camp in Arizona after having been subjected to various acts of humiliation by staff members who insisted that he was "faking" his illness. During the late 1990s, children were reported to be subjected to abusive conditions and mind control tactics employed by staff members employed at facilities run by a consortium called Teen Help. These kinds of events continue. In 2000, two children died proximal to a restraint procedure in a "therapeutic wilderness program."[1,2,4] In 2006, a 14-year-old child died in a Florida boot camp after having been beaten and restrained by camp guards. More detailed information is available at the Coalition Against Institutionalized Child Abuse Web site.[5]

Huffine and Mohr[6] and Mohr[7] drew the attention of nurses to this problem many years ago, and Friedman et al[8] brought the troubled-teen industry to the attention of the mainstream psychiatric community. Recently, Thomas[9] wrote an editorial about abuse in wilderness camps. Despite their history of successful advocacy efforts on behalf of patients in the past, the nursing community has been quiet about this subject. This is troubling insofar as this is but the latest iteration in the history of abusive conditions and practices suffered by children. In the past, nurses decried the misuse of seclusion and restraints and the exploitation and maltreatment of children and teens by the for-profit psychiatric industry. They worked with advocacy groups (eg, National Alliance on Mental Illness and others) as well as the news media to bring about needed regulation and needed changes in both areas.[10–12]

This article provides a brief overview of the development of the troubled-teen industry and addresses the thorny issue of parents' rights to send their children to these facilities vis-a-vis the rights of their children. It argues that nurses and other mental health professionals have a collective obligation to speak out against the conditions in these facilities and the situational factors that have given rise to them. Finally, suggestions for action by nurses are proposed that have the potential to protect children against a continued cycle of abuse masquerading as therapy.*

## BACKGROUND

Ascertaining how the troubled-teen industry came about and proliferated is difficult. Little accurate descriptive or historical data are available, outside of the popular press. Most of these programs never come to the attention of authorities. But in response to reports of abuse and deaths an investigative report was[1] published about these facilities, and the United States General Accountability Office (USGAO) conducted an investigation resulting in congressional hearings in 2007.[13]

Web sites promoting boot camps and "behavior modification" schools often refer to "tough love" in their descriptions. "Tough love" is a variation of TOUGHLOVE, which is a registered trademark for TOUGHLOVE International started in the 1970s.[14] The program employed a zero tolerance approach to deviant behavior. Although York's philosophy has no resemblance to the "tough love" promoted by the troubled-teen industry, the industry has used it to promote their programs, while avoiding copyright infringement of the TOUGHLOVE logo.

The modern practice of "tough love" was first practiced in treatment facilities for heroin addicts in 1958 with a program called Synanon.[14] This program viewed drug

*For nurses interested in a fact sheet that they might share with their clients and other professionals on the troubled-teen industry and tips on helping parents to choose legitimate mental health programs, see the ASTART (Alliance for the Safe and Appropriate Use of Residential Treatment) fact sheet on the University of South Florida Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute Web site.

dependence as a character flaw and centered around verbally humiliating residents during intense encounter group sessions. Synanon fell on hard times when data showed that it had no more success in treating drug and alcohol dependence than government run programs.[14]

By the 1970s, new programs, some with government funding, began employing a combination of Synanon-type methods and combined them with so-called behavior modification techniques. The most infamous of these was Straight, Inc, which was designed specifically for "curing" teens believed to be using drugs.[15] Fuelled by Reagan-era antidrug hyperbole, the program opened numerous sites across the United States between 1981 and 1989. As knowledge of abusive practices surfaced, lawsuits and state investigations proliferated and, in 1993, after paying millions of dollars in damages, Straight, Inc, dissolved. Their methods, however, did not go away, and former Straight, Inc, employees opened up new "treatment" programs employing the same abusive tough love practices.[15]

A new genre of tough love programs began to emerge as the tough love drug/alcohol dependence programs fell on hard times. These programs combined the philosophy of boot camps with that of wilderness "therapy." Juvenile boot camps are correctional programs designed for delinquent youth who are generally restricted to nonviolence or to first-time offenders. They embody a military-style environment and characteristically emphasize discipline and physical conditioning.[16] Juvenile boot camps were developed as an alternative to longer terms of confinement in juvenile correctional facilities. The empirical literature on boot camps for youth is exceedingly sparse, and what does exist shows that participants in these facilities have high rates of recidivism and that they reoffend more quickly than those in control groups.[16,17]

The progenitor of the wilderness movement was Outward Bound, which was founded as a leadership course using the purported character building qualities of the wilderness as its foundation.[18] The idea was that physical challenges are encountered in the wilderness, and overcoming those challenges honed character and redeemed the soul. Wilderness therapy schools and programs distinguish themselves from wilderness experience programs by promoting wilderness therapy as an intervention and treatment for adolescents with behavioral problems.[18,19] The research literature on wilderness therapy is scant and most studies are conducted by industry organizations devoted to the promotion of "wilderness therapy."

Until the late 1980s, wilderness programs and boot camps were distinct entities, until the opening of the privately owned wilderness boot camp Challenger, which allegedly synergized the healing power of wilderness programs with the militaristic approach of boot camps through the catalyst of tough love.[1] These programs adopted the tactics and philosophies of Synanon and Straight, Inc, seeing children as needing to be broken down before they could be "healed." Challenger attracted a wealthy clientele who paid over $12 000 per month for "therapy" conducted by inexperienced staff, some of whom were teenagers themselves.[2] It closed after a Florida teen collapsed after a 4-day hike in the scorching heat of a Utah plateau. The owner was eventually banned from operating in Utah, but a previous employee opened a similar program called North Star Expeditions, in which a 16-year-old honor student, accused of being manipulative after he complained about stomach pains, died from a perforated ulcer.[1,5]

The latest iteration of "tough love" therapy is the attitude adjustment school. While there is scant literature that documents where or when these schools started or why they proliferated, there are some events that can be tied to their appearance. During the 1980s and 90s, troublesome teens and defiant children were admitted inappropriately to psychiatric hospitals, which became a growth industry.[20] Following the psychiatric hospital scandals of the 1980s and 90s and resulting federal, state, and civil lawsuits, the

for-profit psychiatric hospital industry was curtailed in its growth as a result of vigorous federal and civil prosecution,[21] the attention of psychiatric nurses, and media scrutiny.[9] Hospital closures coupled with managed care "efficiencies" meant that parents no longer had the option of placing their children in psychiatric facilities. Although we cannot be certain that the troubled-teen industry arose and proliferated as a consequence, the proximity of the two trends is compelling. The effects of several high-profile deaths of children in Colorado and other states may also have contributed to a fertile environment for the birth of "creative approaches" to the treatment of emotionally disturbed children, children who are gay, or otherwise become inconvenient or burdensome to their families.[22,23]

Attitude adjustment schools came under public scrutiny during the late 1990s with reports of forcible abductions of children from their beds by escort services to offshore "treatment" facilities in Jamaica, Samoa, and the Czech Republic surfaced. This led to a brief flurry of activity by the mainstream media and journalistic investigations into the troubled-teen industry. Although there are many such schools, the media investigations were almost exclusively focused on a large conglomerate of limited partnerships, centered in the western part of the United States, which exist to this day. For children who are sent to one of their facilities, life is closer to prison than school, with constant surveillance by staff and their peers, humiliation, forced work, solitary confinement, denial of nutrition, extended isolation and restraint, sleep deprivation, and other aversive "interventions." Lawsuits by former consumers and their parents describe conditions and actions by staff, which read like cases of child abuse.[1,2]

Parents pay from $26 000 to $54 000 a year to these attitude adjustment schools to modify their children's behavior, treat their substance abuse, or "cure" their homosexuality.[1] Although behavior modification techniques are powerful psychotherapeutic techniques, the creator of Teen Help's behavior modification program is not a psychologist, but an engineer.[1,24] Interestingly, owners of these facilities say that they are not in the business of psychology and they deny that they deal with emotional disorders. The only requirement to work in these facilities is to have "good youth leadership."[1,2]

## HOW UNVALIDATED TREATMENT APPROACHES CAN OPERATE

Whatever name they take, or however they characterize themselves, two significant ways in which entities of the troubled-teen industry differ from mainstream treatments are that they offer no empirical support and no theoretical support for their effectiveness. Instead, they offer anecdote and testimonial as "evidence" on their Web sites. Many of them deny the efficacy of mainstream psychiatric or psychological approaches to troubled youth.[1,8] Descriptions of these programs do not appear in mainstream peer-reviewed journals. Instead, they advertise prolifically over the Internet. In the event of some disastrous outcome such as a death, injury, or other untoward event, they may come under brief, albeit intense, scrutiny as a result of scattered news media reports. Judging from the available media reports, as well as the material presented on various Web sites, these programs operate on a punitive model.

In attempts to ameliorate behavior problems and/or to "teach" children appropriate behaviors, staff members employ an array of aversive procedures. These staff members may or may not have had a criminal background check, and their credentials for working with high-risk children may be questionable. Their use of various types of punishments are characterized on Web sites euphemistically as "consequences" with the word "consequence" not only being substituted for "punishment" but also transmuted into a verb. Thus, children are "consequenced" (*sic*) for their inappropriate behavior. Those consequences may range from being forced to do push-ups for hours,

to being forced to hike many miles with no nourishment and under brutal conditions.[1,8]

In light of its growth and staying power, one of the most peculiar aspects of the troubled-teen industry is that what it sells—"tough love"—is a discredited method for dealing with troubled teens. In 2004, the National Institutes of Health released a "state of the science" consensus statement on dealing with juvenile delinquency and youth violence, concluding that programs seeking to prevent delinquency through fear and tough treatment "don't work and there is some evidence that they may make the problem worse. . . . Such evidence as there is indicates that. . . boot camps, and other 'get tough' programs can provide an opportunity for delinquent youth to amplify negative effects on each other."[25] Even the US Department of Justice claims boot camps and military-style wilderness programs as interventions for youth at risk are not efficacious, especially over the long-term.[26] Despite the consensus of legitimate authorities, the troubled-teen industry continues to rely (successfully) on punitive and coercive tactics.

In addition, the problem of the troubled-teen industry is greatly exacerbated by media coverage of unorthodox approaches to health problems and their solutions, which frequently involve a phenomenon termed "pseudosymmetry." That is, reporters dutifully seek to "balance" their coverage of these treatments by giving each point of view equal weight, even though 99% of professionals may question the therapies' effectiveness. Two such examples of the recent past are the centers that specialized in coercive attachment therapies and rebirthing "therapies," which have been discredited by professional organizations.[22] Such seemingly balanced reporting gives the public the impression that serious debate over efficacy exists, where, in fact, there is none.

Complicating this situation, individual professionals and professional groups may be unaware of questionable and unvalidated treatments or unwilling to make public statements decrying them. Thus, outright quackery may continue to be employed by some members of mental health professions until or even after direct harm to a patient attracts the attention of the police, the courts, and the media. One example of such "treatment" in mental health facilities is the point and level system, a widely used but professionally discredited milieu programming.[27] Other include "attachment therapy" and "rage reduction therapy."[22]

## THE APPEAL OF THE TROUBLED-TEEN INDUSTRY

What accounts for the explosion of these programs and why are parents flocking to them? Validation of a treatment is a long and tedious process that bores most people and that few laypersons understand.[28] Approval of randomized experimental trials may be difficult to get if there is any possibility of harm to children, to say nothing of the travails and ethics of designing sham or placebo groups against which treatment groups can be compared. If done correctly and in a developmentally appropriate way, such research is difficult, costly, and time consuming. Moreover, even after it has been conducted, our canons of science require replication of results. Thus, many years may go by before a treatment or a medication receives approval. Even then the results are not likely to be trumpeted in popular magazines, television talk shows, or Web sites. They appear in specialty research journals that are targeted to professional audiences, written in intimidating academic prose, and presented in a pretentious and academic way that sometimes puts off even its intended audience. While such trials take place, patients and their families continue to suffer. Favorable reports based upon personal anecdotes may thus tempt busy practitioners to use an unvalidated therapy or to refer to questionable programs, particularly when faced with desperate parents seeking help for their children.

In addition, the mental health system in the United States has been described as being "in shambles."[3] It is characterized by therapies

and programs that range from excellent to dubious, which most laypersons are ill-equipped to evaluate. Families with troubled children suffer and endure the vagaries and failures of endless, imprecise mainstream therapies and programs of varying quality. The financial cost of mainstream mental health treatment can pose an enormous burden to many families. When they see less than dramatic outcomes, they may wonder about the investment that they have made.

Like terminal cancer sufferers, desperate parents searching for help will grasp at anything that promises to relieve the chaos that has become their lives. Hearing glowing testimonials suggesting effectiveness on Web sites that make it simple to sign up their children, it should come as no surprise that parents are attracted to these programs. In addition, some of these programs appeal to very important and ingrained ideologies pervading the US character, such as the appeal of the value of hard work and suffering in the face of an unforgiving mother nature. The enduring of a trial of suffering and subsequent higher levels of moral or spiritual development are very much part of the American Judeo-Christian ethic.[29]

## HOW THESE APPROACHES TO TROUBLED CHILDREN ARE INCONSISTENT WITH EXTANT THEORY

In the past decade, enormous advances have been made in our understanding of childhood psychopathology and maladaptation. Current understandings of child psychopathology incorporate neurobiological factors, parent-child relationships, attachment processes, long-term memory stores that develop with age and experience, microsocial and macrosocial influences, cultural factors, age and sex, and reactions from the social environment as variables and processes that interact and transform children over time. Most informed professionals now understand the roots of child maladaptation as the result of complex interactions over the course of development between the biology of brain maturation and the multidimensional nature of experience.[30] Current conceptual models of childhood psychopathology draw on and integrate a number of ecological and transactional perspectives to explain how risk and protective factors at multiple levels of the child's ecology and their prior development contribute to an understanding of the developmental consequences of exposure to environmental influences and the processes that underlie both maladaptive and resilient outcomes.

Approached in this way, it is clear that the enormous range of ever-changing variables influence each child in unique ways and, therefore, no one approach will be appropriate for each child or his or her family. Trends in legitimate service delivery have reflected this dynamic understanding of children in context and the focus for interventions has shifted from the child himself to the family in the context of their community and they have been targeted more precisely to their unique situations. Indeed, the US Surgeon General's only report on mental health[31] called upon mental health professionals to design culturally sensitive treatment that takes into account the complex interactions and interdependence of the child, family, and the greater community. This represents a fundamental departure from traditional service provision and the one-to-one relationship of client to therapist in weekly 50-minute sessions, and it affirms the importance of environment, as noted by nursing scholars.[32]

When children are removed from their homes and communities to remote wilderness environments or to offshore islands, they are also removed from the very sources that can exert the strongest influence on them. The same limitations that apply to restrictive mainstream residential treatment facilities also apply to the troubled-teen industry approaches, in that even if behavior changes occur, it is highly unlikely to generalize to children's environments when they complete the

program. While in a troubled-teen setting, different contingencies and operant variables are likely to be operating than those present in the environment outside that setting. Learning and operant theory posits that sustained modification of behavior is far more apt to occur if children and family are treated where they live and where they have a daily opportunity to engage in practicing more adaptive ways of relating.

## COERCION AND THE LAW: THE RIGHTS OF PARENTS

In the United States, parents possess several fundamental rights protecting their decisions to send their children to whatever treatment programs they choose. While there is no explicit parental right articulated in the US Constitution, under common law and Supreme Court jurisprudence parents have a fundamental right under the Due Process Clause of the Fourteenth Amendment to make decisions concerning the care, custody, and control of their children, and specifically to direct their child's discipline, education, and healthcare.[33,34]

Unlike other countries, US jurisprudence has failed to recognize the damaging effects of corporal punishment.[35] Thus, in the United States parents also have a right, and a duty under some religious persuasions, to discipline their children as they see fit. Corporal punishment is still permitted in every state, either under state statute or common law.[36] These rights are limited to punishment in the best interest of the child, but the distinction between discipline in the best interest of the child and actual criminal child abuse is blurry.

Parents also have both a right and a duty to provide psychiatric care for their child, and failure to do so can lead to criminal charges of child neglect. In *Parham v. J.R.*,[37] the United States Supreme Court ruled that parents may voluntarily commit his or her child to a mental health facility against the child's wishes, but that this power is not absolute. But, parents retain plenary authority to seek involuntary psychiatric care for their children subject to independent examination and medical judgment. Parents also may elect to place their children in the care of an entity that may function *in loco parentis*, which means that the entity (or individual) so designated is delegated the rights of parents with respect to the child.[37]

## COERCION AND THE LAW: THE RIGHTS OF CHILDREN

The rights of children in the United States fall somewhere between those of protected citizen and property. Children's rights jurisprudence in the United States is inconsistent and conflicted. Legal scholar Barbara Woodhouse[38] has suggested that one reason for this is that the laws have been forged out of crisis intervention. The US Constitution requires that a case or controversy implying some sort of conflict be present as a condition to court action. Advisory opinions are not part of the US legal tradition as they are in other countries. While the body of scholarship on children's competence to assent to treatment is sparse, the idea and the importance of considering children as sentient beings who possess personal autonomy are not new. It has been championed by Rodham[39] who argued that children should be presumed legally competent until proven otherwise, and that their opinions and preferences elicited when questions of decision making arise. Moreover, by asserting children's right to life as a distinct personality and a right to possess a legally recognized entity, the United Nations Convention on the Rights of the Child [Convention][40] was the first document to state explicitly that children have a say in processes affecting their lives. Article 12 of the Convention provides that children who are capable of forming views must be assured the right to express them on all matters affecting them, and these views must be given due weight. Under Article 3, the Convention provides that

a child "considered by internal law as having sufficient understanding" is to be granted, and is entitled, to request the right to receive all relevant information, to be consulted and to express his or her views, and to be informed of the possible consequences of compliance with these views and the possible consequences of any decision.[40] However, the Convention holds no authority in the United States.

Although parental authority still overrides children's assent or dissent, whether a child or an adolescent gives active assent or dissent may play a powerful role in the type, frequency, and execution *and success* of treatment. The concept of "success" and engagement in therapeutics is not one that is given consideration in discussions of parental rights to force "treatment" upon their children.

A number of civil and criminal lawsuits have been filed against the troubled-teen industry on behalf of children and by children who were formerly held in their facilities. If there is a sufficient link between an action taken by a behavior modification facility and state action, children may assert a civil rights claim. In *Milonas v. Williams*,[41] 2 former residents of a facility brought a class action suit challenging their treatment and confinement, and asserting that the administrators ("acting under the color of state law"[41(p934)]) had caused them to be subjected to cruel and unusual punishment, inhumane and nontherapeutic treatment, and denial of due process of law (acting under the color of the law means having the legal appearance of being able to discharge certain actions). The school's administrators were found to be acting under the color of state law because various states, either through their juvenile courts or their school districts, had placed the plaintiffs, or at least many members of the class, in the institution, and because there was insignificant funding and regulation by the state. The court thus held that the complainants' constitutional and statutory rights had been violated. The US Court of Appeals for the 10th Circuit agreed with the district court finding that a child involuntarily confined by the state to an institution retains liberty interests that are protected by the Due Process Clause of the Fourteenth Amendment including the right to reasonably safe conditions of confinement, the right to be free from unreasonable bodily restraints, the right to be free from censorship of correspondence, and the right to privacy of his or her own thoughts.[41(p942)]

But, these decisions are not the norm, and children continue to be placed without their consent in abusive situations with little protection except the threat of future civil litigation. The doctrine of informed consent implies a right of informed refusal. In the United States, competent adults have that right, not only under common law, but as part of their constitutional right to privacy. That right has generally not been extended to minors.[42]

## REGULATION OF THE TROUBLED-TEEN INDUSTRY

At this writing, there is no federal regulation of the troubled-teen industry, nor is there any requirement that psychotherapies, even for children, be proven safe and effective before marketing. A few states have adopted regulations, but many facilities avoid state licensure and monitoring by claiming exemption to state licensure requirements.[1] Regulation from oversight is easily circumvented by designating a residential treatment program as a boarding school, even if it has no educational services per se. Only a handful of states have attempted to close this loophole. Montana, which has a large number of these facilities, failed to pass a bill that would have prevented behavior modification schools from avoiding licensing requirements by merely changing how they describe themselves.[43] However, there is legislation (HR 1738 "End institutionalized abuse against children") introduced in 2008 by Representative George Miller (D) of California that, if passed, would ensure that all youth residential facilities and programs would be licensed and regulated.

**USGAO REPORT**

In response to a number of complaints of serious abuse in these facilities, the Committee on Education and Labor of the US House of Representatives conducted an investigative hearing on October 9, 2007, on "Cases of Child Neglect and Abuse and Private Residential Facilities." The hearing was accompanied by the release of a report by the USGAO, entitled "Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth,"[2] which was conducted at the direction of the US Congress. Although the investigation was hampered by the fact that there is no central government repository that collects such data, the forensic unit of the USGAO conducted numerous interviews and examined nearly 2 decades of documents that included state investigations, autopsy reports, police reports, parents' complaints, and depositions from closed or settled civil lawsuits. Spanning the years from 1990 to 2007, the unit found thousands of allegations of abuse, some of which involved deaths in these facilities. Facilities investigated included those located in the United States, as well as those located overseas. The USGAO found that during a single year (2005), 33 states reported 1619 staff member involvement in incidence of abuse.

They also found ineffective management that resulted in hiring untrained and uneducated staff, lack of adequate nourishment, and negligent and/or reckless operating practices. They concluded that these factors contributed significantly to the deaths in these facilities.

This USGAO report is depressingly similar to that ordered by Congress and conducted on the use and misuse of restraints in behavioral health facilities in 1998 and the for-profit psychiatric industry abuses in 1992.[13,20] Both of those reports resulted in Congressional hearings and significant reforms in the regulations governing restraint use and tightening of reimbursement to for-profit mental health hospitals. Nothing of regulatory substance has been passed on the troubled-teen industry as of this writing.

**PROFESSIONAL OBLIGATIONS OF NURSES WITH RESPECT TO THE TROUBLED-TEEN INDUSTRY**

Polls consistently show that nurses are among the most highly regarded and trusted professions by the public.[44] However, trust is easily lost in the absence of a strong voice on behalf of that public and trust must be earned on an ongoing basis. Abuse has been perpetuated on unsuspecting patients and their families in the name of treatment in the past.[21] These received attention by the professions only after they were brought to light by the media, politicians, or advocates. Professionals, as experts possessing special knowledge, have a special obligation to use their knowledge and power on behalf of the public. When that public is a vulnerable class, such as the mentally ill or children, that obligation becomes even more important and urgent. Nurses are aware that there is a difference between abuse and treatment and the situation in the troubled-teen industry should spark collective outrage by the profession.

To be sure, a solitary nurse speaking up may be the recipient of negative consequences by those in power, but this fact does not release professionals from their moral and ethical obligations under their professional codes. There is power in numbers and groups of professionals do have the power to speak up, educate themselves and the public, and work on behalf of vulnerable populations who have little voice to speak for themselves.

**RECOMMENDATIONS: TEACHING THE PUBLIC AND LOBBYING FOR EFFECTIVE REGULATION**

Nurses have an admirable history of advocating successfully for patients and patient care and helping to bring justice to whom it has been compromised. Two notable examples include the seclusion and restraint policy

reforms enacted in nursing homes and psychiatric facilities and in helping to expose the dissociative identity disorders industry.[11,12,45] The following are some ways that nurses can become more active in preventing the abuses that seem to fester and periodically erupt on the landscape of mental health provision to children and their families. As part of their teaching role, nurses must make patients aware of abusive and nontherapeutic practices. They must take a lead in encouraging children and parents who fall victim to abusive practices at troubled-teen institutions to report abuse and pursue civil litigation. Their professional organizations must develop position papers on residential treatment for youth.

Nurses can make this issue more visible by reading and writing about it. As mentioned, there is precious little in the actual scholarly literature designed to educate nurses on this problem. Schools are frequent recruiting grounds for young patients; hence, school nurses, as well as mental health nurses, can be targets for education about these institutions. Venues for disbursing information about the troubled-teen industry can include but also go beyond the scholarly literature. Newsletters and the popular press can provide platforms for nurses to write articles about this problem, and that can serve as a source of educating lay audiences about the harmful effects of coercive and authoritarian tactics on the mental health of young minds. Many of these sources of distribution are easily accessible and they often seek speakers for their meetings. Examples include local Rotary Clubs and speakers' bureaus of state chapters of National Alliance on Mental Illness. Nurses can take these opportunities to promote and educate the public about the paucity and inadequacy of the mental health system that has helped to give rise to abuses. At the same time they can educate them about legitimate interventions, such as the systems of care approach, sanctuary models of care, and trauma informed methods, that keep children in their communities and are based on strength and nurturance, not coercion.

To strengthen the rights of children, nurses might lobby collectively at the federal level on behalf of the ratification of the United Nations Convention on the Rights of the Child. Most nurses would be surprised to learn that the entire world has ratified the Convention, except the US and Somalia. The Convention is widely recognized as laying out the most comprehensive framework of children's rights ever formulated, and many scholars advocate US ratification.[46,47]

The Convention has 4 primary areas of concern to protect children's rights: the survival, development, protection, and participation rights. Survival rights mandate adequate living standards, including access to health services. Development rights include children's rights to education, access to information, to recreation and cultural activities, and to freedom of thought, conscience, and religion. Protection rights in the Convention guard children against economic and sexual exploitation, cruelty, arbitrary separation from their families, and abuses in the criminal justice system. The best interests of children are central to the Convention, which provides basic respect for a child's opinion on critical issues regarding the child. Each of these rights is implemented through appropriate legislative, administrative, and other measures.

However, because education, health, and family issues are predominantly within the province of states, rather than the federal government, lobbying should start by state nurses associations at the state levels. Nurses can demand that state legislatures enact appropriate regulatory legislation to protect teens from potentially abusive programs. These actions need not "reinvent the wheel." Nurses can join with other interested professions on behalf of such efforts. For example, in 2007, the American Bar Association (ABA) Commission on Youth at Risk issued a draft recommendation urging state legislatures to enact laws that require the licensing, regulating, and monitoring of privately owned residential facilities that offer treatment to at-risk children under age 18 for emotional, behavioral, educational,

substance abuse, and social problems.[48] The ABA concluded that this legislation should confirm the following:

1. Require licensure of, or otherwise regulate, private residential treatment facilities by defining clearly which programs must comply with the statute and impose minimum legal requirements to operate and maintain them, including standards regarding staff qualifications and residents' physical and emotional safety, educational, mental health, and other treatment needs.
2. Require government monitoring and enforcement of the operational standards outlined in the statute.
3. Promote the preferred use of appropriate in-home and community-based prevention and intervention programs for at-risk children and youth by requiring enhanced governmental support that provides families with better access to these programs.

Most psychiatric nurses would see the ABA's recommendations as simply laying out a blueprint for quality psychiatric care and would probably not take issue with any of these 3 recommendations.

Finally, at the risk of seeming self-serving, through their organizations they must collectively lobby for a mandatory nursing presence in institutions that house some of our most seriously traumatized and psychiatrically disturbed individuals. Even legitimate residential treatment facilities do not and are not required to have a strong nursing presence. Powerful psychotropic medications are provided by technicians who do not have the education to evaluate the effects of these substances on developing brains. The USGAO reported that parents were often unaware that their children would be put under the care of unskilled and uneducated individuals and presumed that professionals staffed these programs. This situation calls for immediate reform.

**CONCLUSION**

Each day, children continue to suffer human rights violations in unregulated troubled-teen facilities all over the world. Fortunately, there are ways to begin preventing the industry from profiting from their harmful methods. While children in the United States have the right not to be abused, there are currently few viable legal avenues to challenge parental authority to send their children to these programs. But, this can change, as US law based on a case model is not static. It is crucial that professional nurses become aware of these issues, which impact not only our vulnerable citizens but also ourselves. We must move ahead in collaboration with other professionals to prevent patient abuse and rectify injustice where it emerges.

History documents that those who give voice to strong intensities or convictions are at risk of being labeled inflammatory, emotional, or provocative. They can be marginalized by their fellow professionals as being "too" radical. So many of us have learned to speak (and perhaps even to think) in ways devoid of passion, learning to "go along to get along" and other such exercises in moral obviation. However, the stories of children being starved, made to march for hours in the desert, secluded for days in prison cell-like rooms, and subjected to sleep deprivation and other mind control techniques[1,49] must spark a sense of outrage and passion in us to take up the cause on behalf of those who need our help most. History shows that the fruits of silence contribute to hate crimes, racism, sexism, homophobia, genocide, and make for a brutish society. We must take up high-profile causes such as those described in this article and make ourselves visible and a significant presence as advocates on behalf of this very vulnerable population that suffers from the powerlessness of childhood, as well as the powerlessness and stigma of being different or having a mental illness. For the sake of children suffering in troubled-teen facilities, and for those of us who care about them, this cannot begin too soon.

## REFERENCES

1. Szalavitz M. *Help at Any Cost: How the Troubled-Teen Industry Cons Parents and Hurts Kids*. New York: Penguin Group; 2006.
2. United States General Accounting Office. *Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth*. Washington, DC: United States General Accounting Office; 2007. GAO-08-147 T.
3. New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. Rockville, MD: New Freedom Commission on Mental Health; 2003. DHHS Pub. No. SMA-03-3832.
4. Sleeth P. A 15-year-old Scappoose boy dies while being restrained at a high desert wilderness school. *The Oregonian*. Thursday, September 21, 2000:C02.
5. Coalition Against Institutionalized Child Abuse. http://www.caica.org/. Accessed April 8, 2009.
6. Huffine C, Mohr WK. Youth at risk—in facilities that are supposed to help. *J Child Adolesc Psychiatr Nurs*. 2001;14:200.
7. Mohr WK. More children are dying in so-called treatment. *Newsl Int Soc Psychiatr Mental Health Nurs*. 2001;4:4–5.
8. Friedman RM, Pinto A, Behar L, et al. Unlicensed residential programs: the next challenge in protecting youth. *Am J Orthopsychiatry*. 2006:76(3);295–303.
9. Thomas SP. Wilderness therapy under scrutiny. *Issues Ment Health Nurs*. 2008;29:435–436.
10. Malmgren H. (Producer). *Unsafe Haven*. *Sixty Minutes II*. New York; 1999.
11. Strumpf NE, Evans LK, Schwartz D. Restraint-free care: from dream to reality. *Geriatr Nurs*. 1990;11:122–124.
12. Mohr WK, Mahon MM, Noone MJ. A restraint on restraints: the need to reconsider restrictive interventions. *Arch Psychiatr Nurs*. 1998;12:95–107.
13. United States General Accounting Office. *Mental Health: Improper Restraint or Seclusion Places People at Risk*. Washington, DC: United States General Accounting Office; 1999. GAO/HEHS No. 99-176.
14. Jamzem RA. *Rise and Fall of Synanon: A California Utopia*. Baltimore, MD: Johns Hopkins Press; 2001.
15. Scott D, Goldberg HL. The phenomenon of self-perpetuation in Synanon-type drug programs. *Psychiatr Serv*. 1973;24:231–233.
16. Peters M, Thomas D, Zamberlan C. *Boot Camps for Juvenile Offenders Program Summary*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice; 1997.
17. MacKenzie D, Souryal C. *Multi-site Evaluation of Shock Incarceration*. Washington, DC: National Institute of Justice, US Department of Justice; 1994.
18. Castellano TC, Soderstrom IR. Therapeutic wilderness programs and juvenile recidivism: a program evaluation. *J Offender Rehab*. 1992;17(3/4):19–46.
19. Davis-Berman J, Berman DS. *Wilderness Therapy: Foundations, Theory and Research*. Dubuque, IA: Kendall Hunt; 1994.
20. United States Government Printing Office. *Profits of Misery: How Inpatient Psychiatric Treatment Bilks the System and Betrays Our Trust*. Washington, DC: United States Government Printing Office; 1992.
21. Mohr WK. The private psychiatric hospital scandal: a critical social approach. *Arch Psychiatr Nurs*. 1994;8:4–8.
22. Kennedy SS, Mercer J, Mohr WK, Huffine C. Snake oil, ethics and the first amendment. What's a profession to do? *Am J Orthopsychiatry*. 2002;72:5–15.
23. National Association for Research and Therapy for Homosexuality. http://www.narth.com. Accessed April 8, 2009.
24. Kilzer L. Abuse allegations fly government investigations, lawsuits claim that youths were mistreated; Teen Help denies charges. *Denver Rocky Mountain News*. July 20, 1999:1N.
25. Johnson RL, Bangdiwala SI, Cataldo MF, et al. Preventing Violence and Related Health-Risking Social Behaviors in Adolescents: an NIH State-of-the-Science Conference, NIH State of the Science Conference Statement. http://consensus.nih.gov/2004/2004YouthViolencePreventionSOS023html. Published October, 2004. Accessed April 8, 2009.
26. NIJ boot camps. http://www.ojp.usdoj.gov/nij/pubs-sum/197018.htm. Accessed April 8, 2009.
27. VanderVen K. Point and level systems: another way to fail children and youth. *Child Youth Care Forum*. 1995;24:345–367.
28. Dawes RM. *House of Cards: Psychology and Psychotherapy Built on Myth*. New York: Free Press; 1994.
29. Orenlichter D. Spanking and other corporal punishment of children by parents: overvaluing pain, undervaluing children. *Houston Law Rev*. 1998;148–185.
30. Perry BD, Pollard R. Homeostasis, stress, trauma, and adaptation. A neurodevelopmental view of childhood trauma. *Child Adolesc Psychiatr Clin N Am*. 1998;7:33–51.
31. US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999.
32. Chopoorian T. Reconceptualizing the environment. In: Moccia P, ed. *New Approaches to Theory*

*Development*. New York: National League for Nursing; 1986:39–54.

33. *Robertson v Red Rock Canyon Sch*., LLC, 2006 WL 3041469, 3-4 (D.Utah 2006).
34. *Nelson v Heyne*, 491 F2d 352, 354, 360 (7th Cir. 1974).
35. Straus MA. *Beating the Devil Out of Them: Corporal Punishment in American Families*. San Francisco, CA: Jossey-Bass; 1994.
36. *State v Fisher*, 972 P.2d 90 (Utah App. 1998).
37. *Parham v J.R.*, 442 US 584 (1979) No. 75-1690.
38. Woodhouse B. Hatching the egg: a child centered perspective on parents' rights. *Cardozo Law Rev*. 1993;14:1747–1775.
39. Rodham H. Children under the law. *Harv Educ Rev*. 1973;43:487–514.
40. United Nations High Commissioner for Human Rights. *Declaration on the Rights of the Child*. Proclaimed by General Assembly resolution 1386 (XIV) 20 November 1989. New York, NY: United Nations; 1989.
41. *Milonas v. Williams*, 691 F.2d 931, 940 (10th Cir. 1982).
42. Lonowski SC. Recognizing the right of terminally-ill mature minors to refuse life-sustaining medical treatment: the need for legislative guidelines to give full effect to minors' expanded rights. *Univ Louisville J Fam Law*. 1996;34:421–445.
43. Coalition against Institutionalized Child Abuse. 2005 Montana legislature http://www.caica.org/MT%20house%20bill%20628.htm. Accessed April 8, 2009.
44. Jones JM. Nurses remain atop honesty and ethics list. http://www.gallup.com/poll/20254/Nurses-Remain-Atop-Honesty-Ethics-List.aspx. Accessed December 5, 2005.
45. McDonald S, Ahern K. The professional consequences of whistleblowing by nurses. *J Prof Nurs*. 2000;38:303–309.
46. Woodhouse B. Speaking truth to power: challenging the power of parents to control their own. *Cornell J Law Public Policy*. 2002;481:493.
47. Mohr WK, Kennedy SS. The conundrum of children's rights in the U.S. health care system. *Nurs Ethics*. 2001;8:196–210.
48. Smith D. ABA Commission on Youth At Risk, Report to the House of Delegates 3. http://www.abanet.org/leadership/2007/midyear/docs/SUMMARYOFRECOMMENDATIONS/hundredfourteen.doc. Accessed February 2007.
49. Besen W. *Anything But Straight*: *Unmasking the Scandals and Lies Behind the Ex-Gay Myth*. New York: Harrington Park Press; 2003.