Subject: Thinking for a Change (T4C) Program Description	**Policy Number:** 5021
Scope: All T4C Program staff	**Effective Date:** August 14, 2015 **Revised/Reviewed:** August 25, 2015; November 2, 2015; November 9, 2015; October 4, 2016

POLICY: Thinking for a Change (T4C) Program Description

Service Overview:
Thinking for a Change (T4C) is a cognitive–behavioral therapy (CBT) program that includes cognitive restructuring, social skills development, and the development of problem-solving skills. T4C combines cognitive restructuring theory and cognitive skills theory to help individuals take control of their lives by taking control of their thinking. The foundation of T4C is the utilization of CBT principles throughout the group sessions. There is an extensive body of research that shows cognitive–behavioral programming significantly reduces recidivism of offenders. The program is divided into 25 lessons (each lasting approximately 1 to 2 hours), with the capacity to extend the program indefinitely. The curriculum is implemented with small groups of 8 to 12 offenders. Each lesson teaches important social skills (such as active listening and asking appropriate questions) as well as more complex restructuring techniques (such as recognizing the types of thinking that get them into trouble and understanding the feelings of others). Most sessions include didactic instruction, role-play illustrations of concepts, a review of previous lessons, and homework assignments in which participants practice the skills learned in the group lesson. Thinking for A Change is identified as a *promising* program at crimesolutions.gov. Thinking for A Change is a closed group model.

Referrals:
This T4C program targets youth ages 11 to 17 years old who are at risk of being committed to DJJ custody due to consideration of felony commitment or STP admission, all youth who at risk of receiving secure confinement or secure detention, or other court involved youth. All youth meeting the aforementioned criteria must also score moderate to high (2 or higher) on the Pre-Disposition Risk Assessment (PDRA) assessment tool. This population is commonly at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system. All youth and families who enter the T4C Program shall be asked to sign an agreement or contract verifying their willingness to participate in the program and comply with all program requirements. {SERVICE PROVIDER} T4C program staff will be expected to engage all referred families, even if families demonstrate reluctance to participate.

Priority Criteria:

- PDRA Score of 2 or higher
- At-Risk of Commitment to DJJ
- Consideration of STP Admission
- Consideration or Risk of Secure Confinement or Detention

Exclusionary criteria:

- Youth who are actively suicidal, homicidal, or psychotic
- Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems. See Attachment A for additional information regarding referrals of youth with co-morbid psychiatric problems.
- Juvenile sex offenders (sex offending in the absence of other delinquent or antisocial behavior). See Attachment B for additional information regarding this referral criterion.
- Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism. See Attachment C for additional information regarding this referral criterion.

Geographic service delivery area:
T4C Services will be provided in {X County} by trained T4C staff.

Program Capacity:
Number of T4C Staff per Team: 2
Caseload slots average: 8-12 clients per group
Targeted average length of treatment: Target 120 days (4 months)
Treatment slots available per group: 12
Estimated annual program capacity (avg. total treatment slots available x 3): 36

Referral Process:
Referrals are accepted by {X} Juvenile Court and Department of Juvenile Justice (DJJ) staff on youth who meet qualifying inclusion criteria noted above. Referral forms are faxed to {SERVICE PROVIDER} along with supporting documentation. Referrals are logged in by {SERVICE PROVIDER}'s Referral Coordinator and entered into {SERVICE PROVIDER}'s electronic medical record system. Referrals are then forwarded to the Clinical Director of Evidenced Based Programs for eligibility review. Once eligibility is determined, if the referral is accepted, the Clinical Director of Evidenced Based Programs will assign the case to a T4C staff and notify the referral source of the name of the assigned staff. Is the referral is not accepted, the Clinical Director of Evidenced Based Programs will notify the referral source of the reason of denial and document the rationale for denial in the system.

Referral Procedures

The purpose of this section is to detail the referral process so that all T4C staff and key stakeholders and referral agents understand how the process should work. Such understanding will assist staff to better serve the referring agencies.

{X} County Primary T4C Referral Contact Person:
Name:
Telephone:
Email Address:

Eligible Referral Sources

Agency: {X} County Juvenile Court
Primary Contact Person:
Phone number:
Email Address:
Estimated annual number of referrals:

Referral Procedure:

1. **Notification of Openings:** The T4C Referral Contact person will notify all eligible referral source contact persons of availability for referrals.
2. **Inquiries:** Any person interested in making a referral may call the T4C Referral Contact to informally discuss whether a potential referral would be appropriate for T4C, and to determine the appropriate method for initiating and managing a formal referral.
3. **Determine appropriateness:** When either an inquiry or a formal referral is relayed to the T4C Referral Contact person, case information will be reviewed to determine that the youth meets the inclusion criteria, and there are no known reasons for exclusion. If the T4C Referral Contact person is not the Clinical Director of Evidenced Based Programs, the Contact person confirms with the Clinical Director of Evidenced Based Programs that the youth is appropriate for T4C prior to accepting the youth into treatment. For youth not eligible for T4C for any reason, the T4C Referral Contact person will offer assistance in finding other resources.

4. **Determine program availability:** The T4C Referral Contact will notify the referring agent if the program is immediately available, or will project the time of program availability (e.g., next group start date). If T4C is not available within the 60-day time frame, the T4C Referral Contact person will offer assistance in finding other resources for the youth and family referred.
5. **Funding availability:** At the time of initial referral discussions, either the referring agent or the T4C staff will determine if the youth and family in question is appropriate and qualified for the available T4C funding. If not, the T4C staff may assist the referral agent in either seeking the funding or locating another service.
6. **Family Engagement:** The referring agent will contact the family first to assure that the planned referral is acceptable to the youth's caretaker. If so, the referring agent will coordinate the first contact with the family. T4C staff will make first contact with the family to obtain initial consents, obtain baseline outcome data, discuss program policies, and answer any questions the youth and family may have prior to the first group session.
7. **Consent for Treatment:** Upon initial contact, T4C staff will explain the program and seek consent for treatment from the primary caretaker(s). If a family is reluctant to consent for treatment, T4C staff will collaborate with the referring agent to engage the caretaker(s). Only when all efforts by T4C staff to engage the caretaker(s) have been exhausted and the caregiver still refuses treatment, will the case not be opened for treatment.

Treatment Initiation: Upon completion of the consent for treatment, the youth and family will be assigned to a T4C group, and treatment can then be initiated with the next scheduled T4C group. The T4C Referral Contact person will notify the referring agent that treatment has been initiated. The T4C staff will enter the youth into the system along with pre-treatment outcome data within 3 days so that the quality assurance process is initiated.

Guidelines for the initiation of new referrals:
To give the referral process adequate advance notice, the Clinical Director of Evidenced Based Programs will look at the following indicators on a monthly basis to plan for new referrals:

- Cases where the majority of overarching goals are met and groups that are targeted to end within 30 days.

Geographic area served:
T4C is delivered in a community based setting, such as at the local Juvenile Court, DJJ office, or at a {SERVICE PROVIDER} facility.

Location of Program Office:
{SERVICE PROVIDER}
Address

Tel:
Fax:
Web:

Contact for referrals:
Tel:

Program Capacity:
Capacity for each T4C group is between 8-12 youth.

Staff training and education requirements and organizational structure:
The Clinical Director of Evidenced Based Programs shall have a Ph.D. or, as a minimum, a Master's Degree and should be experienced in providing individual, group, marital or family counseling or psychotherapy. They will have at least three years post-degree experience working with the delinquent youth and their families in community-based settings.

T4C group facilitators shall ideally be clinicians with a Master's Degree in counseling, social work, psychology or related fields. Occasional exceptions will be made for highly skilled clinicians with a Bachelors Degree and a minimum of 3-5 years appropriate therapeutic experience. The use of Bachelor-prepared staff must be approved on a case by case basis by the agency CEO.

Training:
{SERVICE PROVIDER} T4C program staff shall be trained by {TRAINER}. {TRAINER} will ensure delivery of a four-day National Institute of Corrections' approved Thinking for a Change Facilitator Training Program. This training will include both initial and ongoing in-service training and consultation. After completion of the T4C facilitator's training, eligible participants will be provided a certificate documenting their successful completion of a four-day Thinking for a Change Facilitator Training Program approved by the National Institute of Corrections. Participants will receive up to five (5) hours of post training T4C program consultation within twelve (12) months after delivery of initial training by {TRAINER}. Additionally, {TRAINER} will include the provision of individualized and programmatic technical guidance to the Thinking for a Change implementation team and facilitators, identifying programmatic gaps, and making recommendations for program and facilitator improvement. After the five initial hours, additional consultation is available for an additional hourly fee.

T4C Training Learning Objectives:
At the end of the training, participants will be able to:

- Describe theoretical foundations of cognitive behavioral approaches;
- Articulate the core principles and components of the Thinking for a Change program;
- Demonstrate a cognitive self-change lesson utilizing the Thinking for a Change program;

- Demonstrate a social skill lesson utilizing the Thinking for a Change program;
- Demonstrate a problem solving lesson utilizing the Thinking for a Change program;
- Plan for the implementation of the program within their agency; and
- Facilitate groups utilizing the Thinking for a Change program.

Service Plan Development

{SERVICE PROVIDER} shall:

1. Conduct a biopsychosocial assessment of each youth and identify the multiple determinants of the presented concerns (e.g., antisocial behaviors, disruptive, oppositional, impulsive, etc…) for each case. The assessment shall also make recommendations for any case-management, referrals (internal, external, or community based), or adjunct services that the youth may benefit from.
2. Identify and document the strengths and needs of the adolescent.
3. In collaboration with family members and referral sources, identify and document problems (example, peers, school, neighborhood, etc.) that explicitly need to be targeted for change.
4. Require T4C staff to write a service (treatment) plan for each family. This plan will incorporate the desired outcomes of the key participants/ stakeholders involved in the youth's treatment (e.g. parents, probation, social services, school personnel, etc.). The treatment plan will identify client strengths, help the client define specific goals, provide instruction in ways to prevent the recurrence of delinquent behavior and other conflict, and set up resources and skills to maintain ongoing progress.
5. Have the Clinical Director of Evidenced Based Programs review and approve all service plans.

Discharge:

- At the conclusion of the group cycle, submit a final progress report and discharge summary to referring agency.
- Discuss termination recommendations with the referring agency representative, in person. The staffing shall occur no later than seven days prior to anticipated closure of the case. A written discharge summary, using the required format, shall be submitted to the referring worker no later than seven days after the case closure. The client's family may be invited to attend the staffing. The termination report shall be approved, in writing, by the Clinical Director of Evidenced Based Programs.
- Conduct a discharge meeting with the youth/family to summarize the progress made during treatment, options to maintaining progress, and the youth and family's satisfaction with the T4C services provided. The referring caseworker/client manager should be invited to the discharge meeting.
- Post-treatment evaluation data collection will be done by {SERVICE PROVIDER} using the Georgia definition for recidivism adjudication for a new law violation three years post discharge for successful completers. This data will be collected quarterly.

Quality Assurance:

{SERVICE PROVIDER}

will:

1. Complete yearly evaluations of workers to assess knowledge of and compliance with, T4C philosophy and intervention strategies.
2. Participate in quality assurance evaluation activities as designated by the {TRAINER} and other external agencies. Activities include, but are not limited to group meetings, site visitations, audio-taped reviews of direct sessions, and peer review of policies and procedures. Facilitators will receive up to five (5) hours of post training T4C program consultation within twelve (12) months after delivery of initial training by the {TRAINER}. Additionally, the {TRAINER} will include the provision of individualized and programmatic technical guidance to the Thinking for a Change implementation team and facilitators, identifying programmatic gaps, and making recommendations for program and facilitator improvement. After the five initial hours, additional consultation is available for an additional hourly fee.
3. Monitor the adherence of program staff to the T4C model by having a quarterly peer review using the "Thinking for a Change Facilitator Observation Form." (See Attachment D: Forms.)

Records Maintenance and Reporting:

{SERVICE PROVIDER} will:

Maintain a case record for each case accepted. This record shall include, but is not limited to, the following:

1. Client referral sheet.
2. Consent Data
3. Initial Assessment Data
4. Treatment plan
5. Weekly Progress Evaluations
6. Attendance Sheets
7. Pre & Post Treatment Outcome Tools
8. Discharge Summary

Program Outcome Objectives

Specific Georgia Criminal Justice Coordinating Council Program Goals & Objectives Include:

1. Reduce felony commitments by 20% from the annual 2012 rates to Department of Juvenile Justice and for STP admissions.
2. Reduce the rate of annual Secure Confinement.
3. Reduce the rate of annual Secure Detention.

4. At least 75% of the youth participants will complete the program successfully. The successful completion rate is calculated as the number successful divided in the total of successful and unsuccessful.
5. At least 60% of youth completing services will no re-offend as calculated using the following recidivism definition;
6. A new charge (within 3 years of the initial post –adjudication community placement) which results in a juvenile court delinquency adjudication OR adult criminal court conviction.
7. Demonstrate a cost-savings through the provision of research-informed, community-based services to youth in the juvenile justice system

Discharge/Program Completion Criteria

In order for a participant to successfully complete Thinking for a Change (T4C), the participant must have met the successful completion policy outlined below. The determination to discharge a youth from T4C is based upon evidence of intervention effectiveness as evaluated from multiple perspectives (e.g. youth, parent, school, probation officer) indicating that:

- 70% of the overarching learning objectives and goals for each session module have been met and sustained;
- the youth followed all program policies successfully;
- the youth has few significant behavioral problems;
- the youth is making reasonable educational/vocational efforts;
- the youth is involved with prosocial peers and is not involved with, or is minimally involved with problem peers; and
- the youth attended (or made up) at least 23 of the 25 group sessions.

Successful Completion Policy

In order for a participant to successfully complete Thinking for a Change (T4C), the participant must have participated in (or made up) 25 of the 25 group sessions and have successfully met at least 70% of the session objectives for each T4C session. Meeting the above requirements will result in a Certificate of Successful Completion being issued during the graduation ceremony. Any participant not meeting the criteria above for successful completion, but still enrolled in the program during the graduation ceremony, will be issued a Certificate of Attendance, which will indicate the participant attended XX out of 25 T4C group sessions and will not reference successful completion of the T4C program. A certificate of attendance will be reported to the Criminal Justice Coordinating Council (CJCC), grant funders, as "unsuccessful", where as a certificate of successful completion will be reported to CJCC as "successful." Homework is required to be completed in the T4C program; homework is an integral part of T4C and completion of homework demonstrates graduated practice and skill attainment. Any participant who fails to complete homework for the third (3rd) time in group will be required to arrange to stay after group, during the session make-up period (7:10pm – 7:40pm), and complete the required session homework. Any participant who fails to complete or makeup homework for the forth (4^{th}) time will be discharged unsuccessfully from the group.

Missing or Incomplete Homework Occurrence Policy

- 1st incident - Participant is reminded about the importance of completing homework.
- 2nd incident- Verbal warning & discussion occurs with participant about a corrective action plan.
- 3rd incident - Participant required to attend make-up session group (7:10pm – 7:40pm) within the next 7 days to complete missing homework.
- 4th incident- Participant required to attend make-up session group to complete missing homework. Participant is discharged unsuccessfully if missing homework is not made up within 7 days.

Attendance Policy

The attendance policy for the T4C program requires that any sessions missed must be made up within one week of the originally scheduled session. Most make up sessions will occur after groups each week. In the event that a youth has to stay after group to make up a session, DJJ/Juvenile Court transportation services will likely not be available; in such event, the parent or guardian will be responsible for picking up the participant from make-up group session at the designated time. Participants cannot have more than two (2) unexcused absences and no more than three (3) excused absences; an excused absence is any absence that is deemed excused by the JPO/Juvenile Court officer. Any participant who has missed more than two consecutive weeks (i.e., 4 consecutive sessions) of group shall be discharged as "unsuccessful" from the program. If the participant missed the four consecutive sessions due to circumstances outside their own volition, the participant may be re-enrolled in the program during the next group cycle.

Program Assessment / Outcome Data

Pre-treatment baseline assessment data will be obtained using the Youth Outcome Questionnaire (Y-OQ® 2.0) and the Youth Outcome Questionnaire (Y-OQ-SR® 2.0). The Y-OQ®-2.0 is a 64-item report completed by the parent/guardian. It is a measure of treatment progress for children and adolescents (ages 4-17) receiving mental health intervention. It is meant to track actual change in functioning. The Y-OQ® SR 2.0 is the self-report version of the Youth Outcome Questionnaire (Y-OQ® 2.0). It is designed to serve as an additional source of data in tracking treatment progress for adolescents ages 12-18 receiving mental health treatment. These same instruments will also be obtained post-treatment in an effort to produce outcome data. Both outcomes tools assess the following areas: Intrapersonal Distress Scale Score (ID), Somatic Scale Score (S), Interpersonal Scale Score (IR), Social Problems (SP), Behavioral Dysfunction (BD), and Critical Items (CI). Data on program outcome objectives will also be collected in collaboration with Carl Vinson Institute of Government, CJCC, and the Juvenile Court.

The How I Think Questionnaire will also be used to

Communicate outcomes to Stakeholders:

Sharing key case-level and program level outcomes with the appropriate stakeholders promotes active stakeholder engagement for program support and ongoing problem-

solving. When reporting to referral agencies, it is the burden of the T4C providers to translate outcomes from the clinical terminology used in case-specific evaluation to the terms being used for program goal setting and program evaluation. All case outcomes should be reported in ways that refer to the program goals listed earlier.

Outcome Reporting Requirements

Reporting case outcomes to the referral source: Each case closure will be staffed monthly with members of the Juvenile Court.

Sharing Program-level Reviews with Key Stakeholders: At least annually, the T4C program will be reviewed for purposes of identifying status of adherence, program-level goals, strengths, identified barriers to program success, and interventions for ongoing program improvement. A summary of the program review will be reported (preferably verbally) to all key stakeholders in the County.

Attachment A: T4C Referral Guidelines Regarding Youths with Co-Morbid Psychiatric Problems

While T4C is appropriate for youth presenting primarily with behavioral problems that may have mild to moderate co-morbid psychiatric problems, youth whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems, should be excluded from T4C groups.

Examples of youth characteristics that may indicate a referral is inappropriate for a T4C group include:

- Actively psychotic (unless temporary and due to drug use)
- Diagnosed with schizophrenia
- Actively suicidal or recent attempt
- Actively homicidal

In some cases, it is possible that a youth will be inappropriate for referral due to psychiatric problems that are not as obvious or clear as the above characteristics, such as youth accurately diagnosed with bipolar disorder or youth taking antipsychotic medications. Determination of whether these youth are appropriate for T4C groups requires a thorough evaluation of the relevant factors by the T4C staff. In particular, the team should assess the potential for disruption to the overall T4C group process, the degree to which psychiatric, biologically-based factors are the primary reasons for the youth's behavior problems, as opposed to "willful misconduct," the degree to which active management of the psychiatric condition and/or medications is needed, and the degree to which extensive safety interventions are likely to be needed. Staff should also do their best to ensure that the psychiatric diagnosis is well documented and based on a thorough assessment.

Example of an appropriate referral of a youth with co-morbid psychiatric problems: *TL is a 16-year-old female with a history of depression, past suicidal ideation and past suicide attempt, who was hospitalized for an overdose 2 years prior to the current referral. She was referred by the juvenile courts for shoplifting, truancy and runaway behavior. She is not currently suicidal and has had no suicide attempts since the hospitalization.*

Example of an inappropriate referral of a youth with co-morbid psychiatric problems: *JM is a 15-year-old male referred by the juvenile courts for domestic violence. He is currently trying to harm his mother and himself. He has ongoing suicidal ideation and has been diagnosed with bipolar affective disorder. He is intermittently homicidal toward family members. He has experienced these problems periodically for the past 2 years.*

Attachment B: T4C Referral Guidelines Regarding Sex Offending Behavior (a.k.a. Problem Sexual Behavior)

The decision to implement the T4C model with a given population should be formed by empirical data about the effectiveness of the model with the target population. Treatments for juvenile sex offenders are rapidly proliferating in the absence of data supporting their effectiveness. T4C programs may not accept referrals for primarily sex offending behaviors, given that the model is delivered in a group format. However, youth who have previously engaged in sexualized behavior can be accepted into an T4C program, as long as the sex offending behavior is not the primary reason for referral and the youth has successfully completed and been discharged from treatment for the sexual offending behavior(s). Below are two examples that serve to clarify appropriate versus inappropriate referrals into a T4C program.

Example of an appropriate referral of youth with sex offending behaviors: *A 16-year-old male has a history of criminal charges for shoplifting and breaking and entering. He is chronically truant from school, and there is a strong suspicion that he abuses marijuana and alcohol. There are also two reported incidents of inappropriate sexual behavior by this youth, including touching the breasts of a classmate and attempting to force sexual relations with the younger sister of a neighborhood peer. These two incidents occurred in close proximity to one another and there have* been no further allegations for the past year.

Example of an inappropriate referral of a youth with sex offending behaviors: *A 15-year-old male has just been charged with a third sexual offense, molesting a 4-year-old neighbor. This youth has a history of two similar offenses with other children in the past year. The youth has no other reported behavior problems. He attends school regularly, functions at grade level, and has only been involved with the courts for allegations of sexual misconduct. The referral indicates there are reports of verbal conflict between parents and the youth and within the marital dyad.*

Attachment C: T4C Referral Guidelines Regarding Youth with Moderate to Severe Difficulties with Social Communication, Social Interaction, and Repetitive Behaviors

Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, should be excluded from T4C due to the fact that they may respond poorly or in adverse ways to some of the interventions employed by T4C. These difficulties may be diagnosed as Autism Spectrum Disorder (ASD) at Levels 2 or 3, or as Childhood Autism (CA.). Importantly, the expertise to treat this problem, which is biological in nature and differs substantially from "willful misconduct," does not exist within the resources currently available to T4C staff. Youth who present with mildly delayed communication and social interaction difficulties,(e.g. diagnosed with ASD with social communication and repetitive behaviors at Level 1, or diagnosed with Childhood Autism based on mild difficulties,) may qualify for referral assuming that the focus of treatment concerns youth conduct disorder symptoms. Such youth should be considered on a case-by-case basis.

The decision to implement the T4C treatment model with a given population should be informed by empirical data about the effectiveness of T4C with the target population. Currently, the T4C treatment model has not been empirically evaluated for youth diagnosed with Autism Spectrum Disorder or Childhood Autism. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) defines ASD as follows:

"The essential features of Autism Spectrum Disorder are persistent impairment in reciprocal social communication and social interaction, and restricted, repetitive patterns of behavior, interests or activities. These symptoms are present from early childhood and limit or impair everyday functioning."

The DSM-V includes severity levels for ASD, as follows:

- Level 3, "requiring very substantial support" and including "severe deficits… severe impairments in functioning… behaviors markedly interfere with functioning in all spheres."
- Level 2, "requiring substantial support" and including "marked deficits…behaviors interfere with functioning in a variety of contexts."
- Level 1, "requiring support" and including "without supports in place, deficits…cause noticeable impairments… significant interference with functioning in one or more contexts."

The ICD-10 defines Childhood Autism as follows:
"A pervasive developmental disorder defined by the presence of abnormal and/or impaired development that is manifest before the age of 3 years, and by the characteristic type of abnormal functioning in all three areas of social interaction, communication, and restricted, repetitive behavior."

Example of an appropriate referral: *MA is a 16 year-old-male who has been diagnosed with Autism Spectrum Disorder (Social Communication and Repetitive Behaviors both Level 1). MA was recently referred to T4C because of charges of burglary and shoplifting. He has also been observed smoking marijuana. Due to significant difficulty relating to youth his age, MA has been hanging out with a group of 13- year-old males who seem to be the instigators of the recent burglary and shoplifting and of the marijuana use. MA told his mother that he went along with the shoplifting plans because he wants to have friends. His mother states that following ongoing interventions he has recently shown some success in being able to interact with other youth but is more comfortable with younger children. MA has been unsupervised after school and some evenings because his mother works late.*

Example of an inappropriate referral: *AM is a 13-year-old male who has been diagnosed with Autism Spectrum Disorder (Social Communication and Repetitive Behaviors both Level 1). He has shown significant difficulty in relating to other youth at school. His teacher reports that he does not seem to understand how to play with others, avoids contact with classmates, and becomes disruptive or aggressive when in unavoidable proximity to other youth or when having to wait. His classmates view AM as odd, and he is frequently teased and bullied. As a result, he has been refusing to attend school. His mother has been trying to force AM to attend school, which has increased his anxiety and resulted in AM using physical aggression to resist his mother's efforts. Consequences for this behavior have not been effective and seem to increase his aggression. During a recent morning when his mother tried to get AM to go to school, he became extremely aggressive and assaulted his mother. He was subsequently arrested for domestic violence.*