Best Practice for Therapeutic Environments
A Guide for Clinicians and Administrators

Introduction

The therapeutic environment is an essential consideration when evaluating best practice for clinicians that are working with people who have health and/or mental health needs. The therapeutic environment is a factor well before a person is seen for services. In fact, as soon as a person comes into the parking lot, lobby, or other space, the environment has an impact on how the person will perceive the experience.

According to the American Psychological Association’s Dictionary of Psychology, a therapeutic atmosphere is, “an environment of acceptance, empathic understanding, and unconditional positive regard in which persons feel free to verbalize and consider their thoughts, behaviors, and emotions and make constructive changes in their attitudes and reactions.” When a person comes into a therapeutic environment, they should have a pleasant, beneficial experience. Throughout this document you can expect to encounter:

- Historical context pertaining to therapeutic environments
- What constitutes a therapeutic environment
- Contexts that may be therapeutic
- Recommendations for best practice in regards to therapeutic environments,
- Special considerations to be made when establishing or evaluating therapeutic environments
- List of resources used in researching effective therapeutic environments

Background and Rationale

What is a therapeutic environment?

The therapeutic environment is a constructed idea created before, during, and after experiences where services are rendered relative to health and/or mental health care. By creating a therapeutic environment, a person will be more at ease when coming in for services and will be likely to be more comfortable talking about sensitive topics, such as trauma. If an effective therapeutic environment is established, a person will be more likely to be less resistant because there is a subconscious sense of safety. Creating a therapeutic environment takes a conscious and intentional effort by the clinician and by those responsible for administration of programs. By creating a therapeutic environment, a clinician can support progress toward treatment goals, personal growth, and positive change for people seeking services.
There are various aspects that need to be considered when creating a therapeutic environment such as:

- Physical, environmental, and emotional safety
- Interpersonal and intrapersonal boundaries
- Physical space
- Engagement and communication

Safety is one of the most important considerations to be made when establishing a therapeutic environment. Perhaps a simple measure for considering safety is to ask yourself if you feel safe in environments where you are working. If not, what could happen to make those environments more safe? The office where intervention is happening must also be comfortable. If a person is uncomfortable, he or she may struggle to engage in therapy sessions. Engagement and communication are other aspects of the therapeutic environment that are vital. A clinician must have an awareness of how engagement and assessment skills are used that foster a sense of genuine concern and authenticity.

**How did we get to where we are?**

Much has gone into what we perceive as an effective therapeutic environment. For most people today, having a private, comfortable space is an important standard in creating a therapeutic environment. Of course, we know that there is much to consider and there are many different approaches to what such a space might look like. Whether consciously or not, many of the spaces used for therapeutic purposes today are grounded in over 100 years of clinical practice, mainly in psychology. (For more information, see Appendix A)

Today, we still find ourselves moving between what an ideal approach may be. Intensive in-home and other home-based interventions are built upon the notion that the most therapeutic response occurs in the home environment, usually between a child and his or her caretakers. Thus, the services are delivered in the home environment, which is obviously not controlled by the therapist. Conversely, more traditional family and individual therapy often occurs in an office space where the therapist completely controls the environment. Which is best? Of course, there is no solid answer to the question other than “both.”

**Bringing the environment to consciousness**

Generally, it is important to consider two major factors in constructing a therapeutic environment:

1) the physical space
2) the interactive space

These guidelines will be a resource for examining both of these areas as clinicians and administrators work toward creating optimal experiences for the people they serve. Intentionally attending to the therapeutic environment takes energy, focus, planning, and evaluation in addition to fiscal resources. It is important that administrators and managers be onboard with efforts to enhance therapeutic environments. The therapeutic environment needs to be consciously and continuously considered and analyzed to make sure that it enhances the experience of the people served.

**Context of the Therapeutic Environment**

There are many different contexts in which therapeutic environments exists. Although many exist in a more traditional context today, models are moving towards integrated health care services. The populations most served in mental health services are individuals with:

- Severe and persistent mental illness
- Developmental disabilities
- Substance use disorder

Each of these populations are served in a variety of locations and a variety of services are provided. Services that are provided usually should be specific to the populations that are served. Each population can benefit from the consideration of the therapeutic environment. Each of these populations receive a variety of care from outpatient programs, day programs, and residential programs. (For more information, see Appendix B)

**Recommendations For Optimal Therapeutic Environments**

Several studies by environmental psychologists have been conducted to determine what kind of environment is most pleasing and appropriate to people served. Many of these studies have used surveys to determine whether or not people have felt comfortable in the settings in which they have received counseling. There are many different components that go into consideration when discussing best practice for therapeutic environments. Below, there will be a discussion on the recommendations for the physical/built location, milieu, therapeutic relationships, interventions, and follow-up. Therapy can be conducted in private practice offices, clinics, counseling centers, and community spaces, as well as in facilities, and in homes and other community-based locations.

**Below are recommendations that address counseling centers, or offices in which there are several clinicians sharing a space where therapeutic intervention is conducted.**
Physical or Built Environment

Studies show that individuals start forming opinions and judgements about their experiences even before entering a building. Establishing a sense of security and safety before entering a counseling session is imperative for therapy sessions to be effective. There has not been a lot of research conducted on the location or parking; however, there has been a lot of research conducted on the physical space of therapeutic environments.

Location

Some articles discuss the ideal location of an office building. Some articles suggested that the office where therapy will be conducted should be located away from a main road, not close to a busy freeway or intersection.

- The busyness and stress from an intersection or freeway could negatively impact therapeutic work.
- The person is likely to feel more stressed coming from a crowded and stressful road situation.

Parking

Another consideration to be made is the size of parking lots. Studies have shown that parking lots should not be too vast in size, but still have enough parking spaces to accommodate the number of people served.

- Not having enough parking spots could give people the impression that they are not welcome or wanted.
- If possible, a parking lot with enough spaces for staff and visitors would be ideal.
- Also, clinicians and administrators should ensure that there is parking access for vehicles used by those with disabilities.

Milieu

The therapeutic environment begins when an individual enters the building or location where services will be delivered. There has been some research conducted on creating safety and security for persons as well as privacy, with limited research conducted on the reception area as well as entrances and exits, specifically. It is important to consider the entrance to the building, reception experience, and the waiting area. Creating a warm and inviting environment throughout the building is essential to establish a pleasant and safe experience.
**Entrances, Exits, and Reception**

The building should be clearly identified from the street so that people can easily locate the building in which they are going. Entrances to therapy buildings and offices should be clear and free of obstructions so the person knows where to enter the waiting area from the outside of the building.

- Entrances should also be accessible to those who live with disabilities, or there should be an accessible entrance and exit that is clearly identified.
  - For example, a ramp for entrance and exit as well as wide doorways, and access to restrooms.
- A consideration to be made about exits is the interaction with other people in the waiting area.
  - If possible, an exit that does not go through the waiting area would be ideal.
- The receptionist, if applicable, should have a pleasant demeanor, be warm and inviting to people that are entering the waiting area, and be patient with people as they are checking in. Often, reception areas are very open to the waiting area and this may impact confidentiality and a sense of privacy and safety. If the receptionist is collecting any sensitive data, he or she should be able to use a private space.

**Privacy in the Waiting Area**

The waiting area can be thought of a place between the emotional chaos of everyday life and the sanctuary of counseling sessions.

- It is important that the noise level of the waiting area be minimal because people are beginning to collect their thoughts and feelings before entering therapy sessions.
- Phone use by people is discouraged in the waiting area because other people may not appreciate hearing conversations.
- The waiting area should be pleasant with comfortable furniture that is clean and in good repair.
- The space should be maintained - painted and clean.
- There should be appropriate decoration and plants if safety is ensured.
- Books, magazines, or other reading materials should be available if appropriate.
- Toys for children should be available if appropriate.
- There should be access to restrooms and a private space for intake if it is done by reception.
Physical Space

Concerning physical space, there is a lot that can be done to help people feel more at ease in the therapeutic environment. Once in the service area, there should be a pleasant and well maintained environment in the hallways and other public spaces.

- Hallways should be wide enough to accommodate multiple people and people who need assistive devices.

A consensus of most studies conclude that service delivery areas must be addressed to create an optimal space: *office design, seating, lighting, color, and noise level/privacy*. Other important considerations are *smell, texture, and temperature*.

Office Design

- A room that has a warm and intimate setting is more likely to produce self-disclosure on the person’s behalf. A room too small may have a negative impact on the communication between the person and the counselor, however, a more generous sized room may help support a healthy working alliance.
- If the office is too big, the person could feel insecure.
- Clinicians must also take into consideration the symbolic meaning that may be portrayed by their office decorations. Certain decorations may influence a person’s beliefs of the clinician, creating possible negative or positive transference.
- Plants are often a good decoration to consider because they bring nature into the therapy room.
- Natural setting pictures have also been shown to have a calming effect on people.

Seating

- Studies have shown that people prefer to be at an intermediate distance between themselves and others, ranging from 48 to 60 inches.
- Other studies have shown that when people have some control over movable furniture, such as pillows or moveable chairs, they experience higher levels of autonomy, equality, and a higher degree of comfort.
- Having a choice of seating and seating arrangements has also been shown to create and instill a sense of personal autonomy.
- Consider furniture that will endure lots of use and be conducive to the populations served.
- Small chairs for children. Larger chairs or sofas for adults.
- Space to accommodate assistive devices.
Lighting

- If possible, natural lighting has the most positive effect for people. The availability of natural lighting has been shown to reduce negative symptoms and support self-disclosure.
- If natural lighting is not possible, dim or soft lighting is more pleasant and calming than fluorescent lighting.
- Using lamps or indirect lighting creates a more pleasant atmosphere.

Studies on color for office spaces have been inconsistent due to individual preferences to color responses. There are many variations on preferred color based on age and gender.

- Neutral, light, and soft colors are often a practical choice for clinicians when creating a therapy space.
- Having soft colors in the office promote a sense of calmness for the person and clinician.

Noise Level/ Privacy

- Soundproof rooms are essential for a person to fully engage in therapy and participate in self-disclosure.
- White noise machines may also help a person feel more comfortable with self-disclosure because they know what they are saying is in session is confidential.
- All efforts should be made to minimize office and extraneous noise so as the work is not distracted.

Smell, Texture, and Temperature

- Smell is a sense that can trigger memories or physical responses. Not using overpowering perfumes or colognes is optimal for therapy sessions.
- Using textures in the therapy room can either create a soft and comfortable setting or a hard and unwelcoming perception.
- Soft textures should be used over heavy textures, e.g. cushions, pillows, throws, etc.
- Temperature is another important factor in the therapeutic environment. If a person is too hot or cold, a distraction may occur and the work may be interrupted. Having a wrap or afghan for use can be helpful.
- Using an average room temperature between 68-72 degrees Fahrenheit is shown to be ideal.
Creating Safety and Security

A therapeutic environment could not be complete without a sense of safety and security for persons. By establishing safety and security, a person will feel at ease during therapy sessions and can help the person move towards the path of healing. Safety and security involved both the physical space, connection, and communication. One of the prime locations for creating safety and security is with the clinical provider. The therapeutic milieu is described as the atmosphere in which services are provided. Milieu is a product of physical and non-physical aspects of the environment. Milieu is in play both in office-based settings and in community and/or home based locations.

Therapeutic Relationships

There has been much research conducted on therapeutic relationships. The therapeutic relationship is a mutual construction by both the clinician and the person served on the conscious and subconscious level. A discussion on how the therapeutic relationship impacts dressing for inclusion, establishing rapport, continuity of care, and integrated health care models will be disseminated below.

Dressing for Inclusion

The way a clinician dresses is often the first thing a person will notice when engaging with agency and clinical staff. A clinician should dress in a way that limits distractions for people and helps aid in rapport building. Dress of the clinician often gives the person a first impression of the clinician and the person begins making assumptions. Some considerations to make include:

- Not being overly dressed, especially in expensive or overtly stylish clothing. Many times, socioeconomic factors are a part of the lives of the people served and working with someone dressed in designer clothes and shoes is not conducive to a message of inclusion.
- Clinicians are trained to pay close attention to nonverbal cues, and a way to eliminate distractions from persons is to dress in a non-distracting way.
- Wearing lots of jewelry, especially large earrings, necklaces, and bracelets can be very distracting.
- The way a clinician should dress for inclusion should correlate with the population served. A good suggestion for clinicians would be to wear business casual attire.
- Be comfortable in what you wear, not too over the top or promiscuous,
- Avoid bold statements of personal identity, radical hairstyles, excessive makeup, overpowering colognes and perfumes, wrinkled or worn clothing, symbols of wealth, and clothes that emphasize sexuality.
• If the services are occurring in a community or home setting, clothing should be appropriate and should be conducive to safety, e.g., high heels should not be worn on home visits.

Establishing Rapport

Establishing rapport is the next step in creating a successful therapeutic relationship and conducive therapeutic environment. Connecting with people is the first way in which rapport can be established between the clinician and the person.

• It is important that the clinician be genuine and actively engaged in the therapeutic relationship, feel empathy for the person, and have unconditional positive regard for the person.
• The therapeutic relationship and alliance is among one of the key factors in treatment retention and success. Establishing rapport creates a mutual respect between the clinician and person in therapy, which can allow a therapeutic relationship to be developed and maintained.

Continuity of Care

Continuity of care is described as the quality of care over time. Continuity of care combines both the clinician’s and person’s perspectives and these perspectives come together to enhance the person-centeredness of care.

• Continuity of care increases an individual’s understanding of their psychiatric illness. This better understanding leads to better management of mental illness, reduces suicide risk, and leads to an enhancement of holistic health management.

Integrated Care Models

Integrated care models, also known as collaborative care, are quickly evolving and becoming popular in the United States. Integrated care combines both medical and behavioral health care. This recent development in the healthcare field is becoming popular in part because adults with severe mental disorders and substance use disorders also have higher rates of chronic physical illness.

• Currently, primary care settings often provide about half of all mental health care, so combining both mental and physical health care in one location and thorough a team approach will best serve the population.
• By providing integrated care, there is often a team-based approach to provide holistic care to individuals.
• This coordination of care is beneficial for individuals because they can receive services from both their primary care doctor for physical health and behavioral health care services all in one location.
• Integrated care models aid in the therapeutic relationship because both the behavioral and physical health care providers will, ideally, be able to effectively and efficiently coordinate care for people.

**Home and Community Based Practice**

Trends in psychotherapy are, in some cases, moving towards home and community based practice. With this new trend, the environment cannot be controlled by the therapist, however, the therapeutic relationship can be controlled. A psychotherapist is able to utilize self in both the home and community based practice. Home and community based care reflects changes in the medical model, but can be translated to psychotherapy as well.

• Three main benefits of home and community based care versus institutional care are: *cost-effectiveness, more treatment options, and better care of the individual.*

Community based services can take place in community centers, but are likely to take place in individuals homes. Home based therapy takes place in the home of the individual that is receiving therapeutic services. There are several advantages of home based therapy including:

• Elimination of transportation issues
• Serving those with chronic illness
• Serving those who are older age
• Addressing lack of funds or other barriers that confines a person to the house

In regards to the therapeutic environment in home based therapy, the clinician cannot control the physical environment. This makes the therapeutic relationship that much more important to consider.

• The therapeutic relationship may form more quickly in home based therapy.
• The individual receiving therapy is usually more comfortable and relaxed because they are in their own environment.
• Boundaries are a very important consideration in home based work. Clinicians must make professional boundaries to ensure the success of home based therapy for both the individual and the therapist. Healthy boundaries are necessary for an optimal therapeutic relationship.
Interventions

Continuing education and trainings are important for clinicians’ professional practice. By participating in lifelong learning, clinicians are able to refine what is known and learn new interventions that are effective in helping persons in therapy. These learning opportunities may also present new information on interventions that are newly presented as evidence based practice. Continuing education and trainings can often be searched for online or found in organizational newsletters and emails. Being informed on new interventions can develop the skills of clinicians.

Person Centeredness

Person centeredness in therapy is based on a humanistic approach that was developed by Carl Rogers as a form of non-directive talk therapy. In person centered therapy, also known as Rogerian therapy, there are three main qualities that a clinician needs to possess. These qualities are:

- Unconditional positive regard
- Empathetic understanding
- Genuineness

Interventions for person-centered care will increase the therapeutic alliance and help the person progress through therapy sessions. Motivational interviewing is considered person centered and based in Rogers’ work. Person centeredness can also refer to using person first thinking and language. Thinking of those served as people with challenges rather than their diagnoses is important. Saying that a person has schizophrenia is different than saying he is a schizophrenic.

Practice Based Evidence, Evidence-Based Practices

Practice Based Evidence and Evidence Based Practice are important to utilize during psychotherapy. Clinicians should have knowledge on these practices and implement them during therapy sessions.

- Evidenced based practices are interventions that have been tested and retested with positive results - usually for particular diagnoses.
- Practice based evidence often emerges when a clinician begins to realize that particular ways of doing intervention has some effectiveness. This may lead to the development of new or refined interventions. It is important to be responsive to each individual person.
Follow-Up

Creating Good Endings

Termination is the final stage in the therapeutic process. Termination of the therapeutic relationship ideally happens once mutually agreed upon goals of the clinician and person in therapy has been accomplished or problems the person was dealing with prior to counseling is either now resolved or being properly managed. Creating good endings is part of the termination process.

- From the beginning of therapy, clinicians should remind people in therapy that the goal of treatment is for them to be able to function without the clinician.
- The clinician should speak with the person in therapy about termination about 2-3 sessions prior to the final therapy session and before termination of the therapeutic relationship takes place. This allows both the person and clinician to start working through a transition to the end of therapy.
- Clinicians should model a healthy ending of a relationship by preparing the person for the end of therapy. As a clinician, allowing the person to work through their feelings of terminating the relationship is an important consideration to be made.
- Another way to create a good ending is to review with the person how much progress has been made. Review the tools and skills that the person has gained while going through therapy and remind them that these tools will help them with handling problems that may arise in the future.
- Encourage the person in all that they have accomplished, and if the agency allows, have an open-door policy. By having this policy in place, a person that has terminated in the past may have the opportunity to return a few months or years later for a check-in.
- Termination can be hard for both the clinician and person, but that acknowledgement can lead to good discussion.

Facilitating Use of Resources

A clinician must have a good knowledge of resources to know what would be best for the person in therapy. Having a variety of resources can help connect the individual with services that may be needed. Having a good network of peers is also valuable when locating resources for persons in therapy. A clinician that is open to researching resources for persons in therapy is also a valuable asset.
Documenting follow-up efforts

Documenting follow-up efforts is an important process for a clinician. As a clinician, documentation is one of the most important parts of the job. If what you did is not documented, it did not happen. Documentation of follow-up is important because it can be proven that follow-up efforts were tried. If a call is made or a letter is sent, documentation is vital to prove that effort was taken on the clinician’s behalf.

Special Population Considerations

Cultural Competency

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), cultural competence is, “the ability to interact effectively with people of different cultures.” The National Association of Social Workers (NASW) hold such high regard for cultural competence that an ethical standard is, “Cultural Awareness and Social Diversity.” This ethical standard sets the precedent that cultural competency is essential to consider when practicing clinical work.

Clinicians often work with special populations that need careful consideration and planning before implementing clinical practice. Some examples of special populations are: children, elderly, LGBTQ+ individuals, and individuals with diverse cultural and ethnic backgrounds. Cultural competency, sensitivity, and knowledge area crucial when working with those who are different than the clinician. By being culturally competent and informed about special populations, the therapeutic relationship will be further developed and the person in therapy will continue towards the path to healing.

Multicultural competence involves two important parts: recognition of the clinician’s cultural bias, cultural values and an understanding of the person’s worldview.

The RESPECTFUL model was developed by Michael D’Andrea and Judy Daniels in 1997. This model involves ten factors that clinicians should consider and understand how these factors impact an individual’s psychological development. The ten factors are:

- Religious
- Economic
- Sexual identity
- Psychological maturity
- Ethnic/cultural/racial identity
- Chronological developmental challenges
- Trauma
Family history and dynamics
Unique personal characteristics
Location of residence and language differences

The first letter of each word spells out “respectful.” Being aware of and informed on these factors can enhance the therapeutic relationship and allows the clinician to progress through therapy appropriately.

Ultimately, cultural competency is important when considering the therapeutic relationship and the therapeutic environment. Having an open and accepting attitude for all persons coming to therapy will cultivate a positive therapeutic relationship, which will enhance the therapeutic environment.
Additional Information on Each Section/ Resources:

**Background and Rationale**

**Sources:**

**Website Links:**
Facilitation Skills: Therapeutic Environment
History of Counseling Timeline
[https://www.slideshare.net/CounselingNU/history-of-counseling-timeline](https://www.slideshare.net/CounselingNU/history-of-counseling-timeline)
Therapeutic Environments
[https://www.wbdg.org/resources/therapeutic-environments](https://www.wbdg.org/resources/therapeutic-environments)

**Context of the Therapeutic Environment**

**Sources:**

**Website Links:**
Facilitation Skills: Therapeutic Environment
Intellectual and Developmental Disabilities
[http://www.devereux.org/site/PageServer?pagename=intellectual_and_developmental_disabilities#community](http://www.devereux.org/site/PageServer?pagename=intellectual_and_developmental_disabilities#community)
Levels of Mental Health Care Descriptions
[https://apps.cignabehavioral.com/cignabehavioral/media/consumer/educationAndResourceCenter/articles/levelsOfMentalHealth.pdf](https://apps.cignabehavioral.com/cignabehavioral/media/consumer/educationAndResourceCenter/articles/levelsOfMentalHealth.pdf)
Outpatient Substance Abuse Treatment Programs

Types of Mental Health Treatment Settings and Levels of Care
https://www.northtexashelp.com/mental-health-treatment-settings.html

Types of Programs Regulated by DHS
https://www.nj.gov/humanservices/ool/programs/

**Recommendations for Optimal Therapeutic Environments**

**Sources:**
Booth, R., Thompson, L., Campbell, B. K., Developing the Therapeutic Alliance as a Bridge to Treatment.
Iye, O. T., The therapeutic impacts of environmental design interventions on wellness in clinical settings: A narrative review.

Soothing Spaces Research Article
https://www.researchgate.net/publication/254724357_Soothing_spaces_and_healing_spaces_is_there_an_ideal_counselling_room

**Website Links:**

5 Practical Considerations in the Counselling Process
https://www.ncbi.nlm.nih.gov/books/NBK304189/

7 Reasons Why Clients and Counselors Prefer Home Based Counseling

Benefits of Community Based Services vs. Institutional Care

Chapter 3: Settings for Therapy
https://psychcentral.com/find-therapist/chapter-3-settings-for-therapy/

Person Centered Therapy+ Carl Rogers’ #1 Person-Centered Technique
https://positivepsychologyprogram.com/person-centered-therapy/

Community Based Support Services
https://www.nfinorth.com/services/community-programs/

Connecting with persons
https://ct.counseling.org/2014/08/connecting-with-persons/

Continuity of care protects mental health patients

Counselor Attire: 8 Things Not to Wear
http://recnok.com/counselor-attire-8-things-wear/

Designing healthcare spaces: the therapy room
https://psychbc.com/clinical-blog/designing-healthcare-spaces-the-therapy-room

Engaging Patients, Families, and Communities
https://www.ncbi.nlm.nih.gov/books/NBK207234/

Environment Of Psychotherapists' Offices May Affect person Attitudes

Home Based Therapy
https://www.goodtherapy.org/learn-about-therapy/modes/home-based-therapy

Home Based Therapy- Mode of Therapy
https://careersinpsychology.org/home-based-therapy/

How Should a Therapist Dress?
Integrated Care

Lobby
https://www.wbdg.org/space-types/lobby

Moving toward termination of therapy
http://soe.syr.edu/academic/counseling_and_human_services/modules/Termination/moving_toward_termination_of_theory.aspx

Outpatient Clinic
https://www.wbdg.org/building-types/health-care-facilities/outpatient-clinic

Parking: Surface
https://www.wbdg.org/space-types/parking-surface

Person-Centered Therapy
https://www.psychologytoday.com/us/therapy-types/person-centered-therapy

Psychiatric Facility
https://www.wbdg.org/building-types/health-care-facilities/psychiatric-facility

Termination: Ending the Therapeutic Relationship- Avoiding Abandonment
https://naswcanews.org/termination-ending-the-therapeutic-relationship-avoiding-abandonment/

Therapeutic Environments
https://www.wbdg.org/resources/therapeutic-environments

Therapist Waiting Room Etiquette

What is ‘continuity of care’?

What Should a Therapist Wear?

**Special Population Considerations**

**Sources:**

**Website Links:**
Best Practices for Mental Health Facilities Working With LGBT persons
Cultural Competence
https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence

Microaggressions and their effects on the therapeutic process

Multicultural Counseling and the Respectful Model
https://onlinecounselingprograms.com/blog/multicultural-counseling-model/

NASW Code of Ethics

Psychotherapy and Older Adults

Religion and spirituality in the treatment room
https://www.apa.org/monitor/dec03/religion.aspx

Working with Refugee Children and Families
Appendix A

In 1896, Freud developed psychoanalysis and psychotherapy. This new development revolutionized the field of mental health treatment. Freud believed that mental illness was the result of repressed emotions and memories that impeded development and that psychotherapy, bringing the unconscious to the conscious, would help a person start walking the path to healing. Sigmund Freud saw the benefit of using psychotherapy during his couch conversations with people who were his patients, many being women. Freud saw the importance of space and how that impacted the success of therapy sessions. Pictures of his office in Vienna reveal that his small sofa was a focal point in the room, which was decorated in accordance with the greek revival and Victorian influence of the time. Far from being medically sterile, Freud’s office was much more home-like and welcoming. Thus, the precedent for the therapeutic space was established as being non-threatening, home-like, and visually interesting. Freud did not sit in view of his patients; rather, he usually sat behind them as they lay on his couch. Certainly, engagement with the people we serve has come far since that time, yet there are glimmers of this approach of being removed from the patient as we focus on boundaries and limits. If we examine early social work practice - happening about the same time as Freud’s psychotherapy was being developed - we see something very different.

Jane Addams and company often lived with the people they served and encouraged involvement in people’s lives as a means of supporting and encouraging collaboration and connection. Hull House was a hub of activity and it is likely that if you were to have visited, you would not have been able to distinguish between the patient and the staff. This engaged approach is still evident today in community organizing efforts, psychosocial interventions, and participatory action research. Mary Richmond and her “friendly visiting” approach put the social worker in the person’s home. Such close, personal interaction was not a part of the approach being used by psychology at the time. Thus, the debate and tension between office and home based intervention began.

As psychotherapy evolved through the 20th Century, more efforts to engage the person served emerged with cognitive-behavioral interventions intentionally involving interaction between the patient and therapist. Moreover, humanists not only engaged with people through conversation, they reached into the person’s being through believing that the people they served all had great potential. Rogers’ “unconditional positive regard” became somewhat of a standard of care relative to how one should approach therapeutic work. Other postmodern approaches involved identifying and highlighting the strengths of a person or family as to reinforce the idea that solutions are already known - they just have to be discovered again. Currently, many therapists are teaching the people they serve how to engage in practices rooted in ancient meditation, e.g. mindfulness, which is far from Freud’s free association techniques. Of course, there is a wide spectrum of approaches to intervention and therapeutic style.
Appendix B

Severe and Persistent Mental Disorders

There are several locations that serve those who are affected by severe and persistent mental illness:

- Outpatient programs
- Day programs
- Residential programs

There are several examples of outpatient programs:

- Adult partial care services
- Intensive family support services
- Intensive outpatient services
- Assertive Community Treatment (ACT) Teams
- Community mental health centers
- Private-practice with individual and group counseling
- Services that provide medication evaluation and management

These settings provide a variety of services to those who live with severe and persistent mental illness and are often office or facility based. Within these contexts, it is important to consider location, building design, compliance with ADA standards, interior design, and all aspects of the built environment. Counseling and clinical care are provided to individuals who seek outpatient care. Currently, there is an evolution toward integrated care models, which blends behavioral and physical health providers in several different ways.

There are also day programs that serve those with severe and persistent mental illness. Some examples of this are:

- Community mental health centers
- Intensive outpatient programs
- Partial hospitalization programs
- Psychosocial rehabilitation/ Clubhouse model programs

In these contexts, people often attend the program several days per week and, in some cases, engage in social and vocational activities as part of the intervention approach. Again, most of these services are facility based and require attention to all aspects of the physical space.
Lastly, there are *residential programs* that serve those who have severe and persistent mental illness. Some examples of this are:

- Family care homes
- Group homes
- Supportive housing

Physical space is essential in these contexts and safety, security, and accessibility are extremely important. Often, residential care is augmented by more intensive levels of care such as an ACT team.

**Non-Severe Mental Disorders**

Many people who have particular mental disorders are considered “non-severe” by a variety of sources including third party payers. For these people, it may be more difficult to successfully access third party payment for their concerns. It is important to mention here that providing services to people with non-severe disorders can be challenging for clinicians and administrators from a fiscal perspective. Sometimes, visits are limited, state funding may be used, or the person must pay out-of-pocket. Nonetheless, the therapeutic environment remains just as important and must be attended to for an optimal experience. Most of the time, these contexts are private offices or offices within the context of an agency. Of course, as integrated care emerges, offices are often located within a medical clinic.

**Developmental Disabilities**

Locations that serve those affected by developmental disabilities are:

- Outpatient settings
- Day programs
- Residential settings

*Outpatient settings* that serve those with developmental disabilities are facilities that can provide outpatient counseling, respite for family and caregivers, clinical and educational assessments for the individual, family counseling, medication management, and employment and transitional services.

*Day programs* that are available to those with developmental disabilities are special education day schools, adult development vocational programs, and day activity programs at adult day centers.
There are also *residential facilities* that serve those who have developmental disabilities. There are community-based living facilities, private residential facilities, and group homes that serve those that have developmental disabilities.

**Substance Use**

There are several different locations that serve those affected by substance use concerns such as:

- Outpatient settings
- Intensive outpatient settings
- Residential settings

There are several examples of *outpatient settings* for those who have substance use concerns. Support groups such as the 12-step program offers support to those who have struggled and continue to struggle with substance use concerns. There are also outpatient treatment programs, detoxification programs, individualized treatment programs, and group counseling.

*Intensive outpatient settings* are also offered for those who suffer from substance use. Some examples of this are opioid treatment programs, IOP models, and partial hospitalization programs.

There are also *residential settings* that provide care to those who are dealing with substance use concerns. Some examples of residential settings are long-term residential treatment, extended care facilities, halfway houses, short-term residential treatment, and inpatient residential treatment. In these contexts it is vital to consider safety, security, and accessibility.