Strengthening Children's Mental Health Residential Treatment through Evidence and Experience

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Introduction

In North America, residential treatment programs have a long history dating back to the nineteenth century. Such programs have evolved over time, as the mental health service delivery system has grown and the needs of children, youth, and families have changed. During this time, however, little evidence has emerged to indicate that residential treatment consistently and reliably contributes to improved outcomes for children and youth.

Though it is currently a routinely used intervention with children and youth in Ontario, the efficacy of residential treatment has been the topic of much debate given concerns about the risks of removing children and youth from their families for extended periods of time, along with the high cost of residential treatment relative to other mental health interventions. The lack of established evidence to support the use of residential treatment for children and youth with serious emotional and behavioural problems (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010), along with the emergence of a growing number of less intrusive, less costly family- and home-based treatment options provides a strong rationale for a review of residential treatment in Ontario at this time.

For the purposes of this paper, we define residential treatment programs as 24-hour out-of-home facilities that provide mental health treatment using an interprofessional, multi-disciplinary team approach that makes therapeutic use of the daily living milieu. As individual entities, they are less restrictive and less secure than hospital inpatient units and secure treatment. This definition distinguishes residential *treatment* programs from residential *care* programs, often called group homes, which focus on providing a home to, and meeting the daily care needs of, any child or youth requiring out-of-home placement without the element of mental health treatment (Bates, English, & Kouidou-Giles, 1997).

Over the past 30 years, the child and youth mental health system in the United States and Canada has moved toward a system of care model developed in 1986 by Stroul and Friedman (Pumariega, 2007). According to Stroul and Friedman, "children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate" (1996, p. 8). This approach to care advocates for an individualized, child- and family-centred practice that is provided by interprofessional teams (see Figure 1). These teams operate outside of professional office environments and deliver evidence-based interventions in a culturally and linguistically competent manner (Pumariega, 2007).

According to the Ontario Ministry of Children and Youth Services (MCYS), residential treatment services are a Core Service and are aptly classified as an "Intensive Out-of-Home Service" (see *Community-Based Child and Youth Mental Health Program Guidelines and Requirements #01: Core Services and Key Processes*, 2015).

> Intensive out-of-home services provide treatment in external settings (i.e., residential treatment settings) for children or youth who are affected by mental health problems that impair their functioning at home, school and/or in the community, and who require an intensive level of intervention. This may include children and youth who may require longer-term treatment (e.g., children and youth with complex mental health needs) (MCYS, 2015, p.22).

FIGURE 1. SYSTEM OF CARE FRAMEWORK

What is a System of Care?
First articulated in their 1986 work, *A System of Care for Severely Emotionally Disturbed Children and Youth*, Stroul and Friedman defined a system of care as a "spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families" (p. 3). Over the years, the definition has been revised to include its three core values, which are intrinsic to the system of care philosophy. By definition, systems of care are (a) community-based, (b) family-driven and youth-guided, and (c) culturally and linguistically competent (Stroul, Blau, & Friedman, 2010).

The system of care can be understood as a framework or approach to system reform. It acknowledges that children, youth, and their families have multiple and interrelated areas of need. Accordingly, the effectiveness of services in any one domain is associated with the accessibility and effectiveness of services in all others. It is therefore essential to deliver comprehensive, flexible, and effective services and supports in order to address the emotional, social, educational, and physical needs of children, youth, and their families (Stroul, Blau, & Friedman, 2010).

Source: Stroul & Friedman, 1986, p. 30

The MCYS *Program Guidelines and Requirements* outline a target population as well as minimum expectations of residential treatment settings; however, the specific approach and operation of the treatment facility is left to the service provider. MCYS encourages core service providers "to continue exploring innovative models of intensive treatment that allow children and youth to function to their best potential" (MCYS, 2015, p. 20).

Kinark Child and Family Services has been providing residential treatment to children and youth for almost 100 years, serving multiple geographic service areas across the province and providing clinical assessment and intervention to some of Ontario's most complex and high risk children, youth, and their families. During the past 30 years, our programmatic focus has shifted from a primarily residential emphasis to the provision of a broader continuum of mental health interventions. This shift has been driven by our commitment to the goal of providing effective interventions, at the right time and to the right children and youth, within the context of an environment for which child and youth mental health funding has not kept pace with inflationary pressures.

Across Ontario, a similar shift is occurring among many residential treatment providers and we are seeing a significant reduction in the number of residential treatment programs and beds. Bed closures do not often occur in the context of a coordinated provincial or local service plan, but through "one off" decisions that are driven by financial constraints.

Concurrently, system providers are identifying an increase in the complexity of the needs of children and youth who are seeking services. While empirical evidence required to substantiate the increase in client complexity is not yet available, families and providers are expressing concerns about the capacity of the current system of child and youth mental health services to contribute to better outcomes for complex clients along with the limited number of residential programs that are equipped to safely and effectively serve highly complex children and youth. In many circumstances, residential treatment has come to be viewed in the service system as a "placement of last resort" rather than an effective and valuable treatment tool.

> *"Yes, I definitely need it more than ever…because here I get one-on-one help."*
>
> *— Residential Treatment Client*

While the majority of children and youth can and should receive treatment while remaining with their families or caregivers, it nevertheless may be necessary – and appropriate – to treat a small percentage of children and youth with complex needs in a more restrictive residential environment where highly specialized and intensive treatment is possible. A comprehensive community-based child and youth mental health system must be equipped to effectively serve this small percentage of children and youth so they may benefit from residential treatment. However, no comprehensive framework currently exists that identifies which children and youth are in need of residential treatment, or which are the necessary components of a system that will effectively support them. As an experienced provider of residential treatment and a steward of public funding designated for residential treatment services, Kinark is questioning whether the current approach to residential treatment is effectively and efficiently meeting the needs of today's children and youth and whether it represents good value for money.

Given the intrusive and costly nature of residential treatment in Ontario, we believe that, during this time of change in child and youth mental health, it is critically important to undertake an examination of best practices with a vision of redeveloping Ontario's approach to residential services. This paper, grounded in the foundational considerations of "risk, need, and responsivity" as the "principles of effective treatment" for serious behaviour problems (Andrews et al., 1990), seeks to inform such an examination and contribute to the public discussion and debate about the best interests of Ontario's children and youth.

Risk

The risk principle states that level of service should match level of risk. Given that residential treatment is an intensive intervention, it should be reserved for high-risk children and youth, and children and youth with many risk factors. Longitudinal research by Andrews, Bonta, and Wormith (2006) indicates that important risk factors for serious behaviour problems include a history of antisocial behaviour, antisocial personality pattern, antisocial cognition, antisocial associates, specific family conditions, specific school conditions, leisure activities, and substance abuse. High-risk youth have more needs and, in accordance with this principle, should be offered more intensive treatment and resources than low-risk youth.

A well-established body of literature has demonstrated that reciprocal negative influences are consistently reinforced when youth with negative behaviours and attitudes are grouped together (Dodge, Dishion, and Lansford, 2006). This risk factor seems to operate specifically when low-risk youth are placed with high-risk youth (Lowenkamp & Latessa, 2008). In such cases, low-risk youth lose the influence of positive factors associated with their home and community environments as they are embedded in a context characterized by negative factors. High-risk youth placed in such environments do not experience the same effect because of the already increased risk they experience as a result of their individual multi-problem status.

Need

The need principle states that dynamic or changeable risk factors, such as substance abuse, educational deficiencies, and self-harming behaviours constitute suitable targets for intervention. Dynamic risk factors are differentiated from static risk factors, such as age, gender and socio-economic background, which cannot be changed. As such, dynamic risk factors should be systematically assessed in order to formulate an individualized treatment plan that aims to reduce the number of risk factors and thereby increase or improve positive functioning and pro-social behaviour. Family functioning, peer relations, and school functioning are key domains to target.

Responsivity

The responsivity principle distinguishes between specific and general responsivity. Specific responsivity states that interventions should consider individual differences and match the child or youth’s unique learning style, mental capacity, and mental health presentation. General responsivity implies that well-structured programs based on cognitive behaviour and social learning theories are better than other approaches if the program targets appropriate risk factors, such as social skills deficits, poor anger management, weak problem-solving skills, and antisocial attitudes (Dowden & Andrews, 2000; Gendreau, French, & Gionet, 2004). Motivational techniques, such as a token economy that rewards prosocial behaviour and does not punish antisocial behaviour, as well as motivational interviewing designed to encourage youth to reflect on the disadvantages of problem behaviour, have also been found effective (McMurran, 2009).

Effective use of the risk, need, and responsivity principles requires a treatment culture that is prosocial, highly structured, and mutually respectful (Fretz, 2007). Furthermore, youth-driven care, with a balance between adult control and youth autonomy, is key (Andrews & Dowden, 2004; Scholte & Van der Ploeg, 2000). A review of existing research has identified these as important characteristics of effective residential treatment interventions for youth with serious behaviour problems.

In this paper we have described in detail a number of fundamental principles and critical success factors (CSF) that have been distilled from our extensive review of research evidence and our own experience as a residential treatment provider (see Table 1). Taken together, these success factors offer what Kinark believes to be a blueprint for the development of an effective and efficient approach to residential mental health treatment for children and youth.

TABLE 1. CRITICAL SUCCESS FACTORS

CRITICAL SUCCESS FACTOR	FUNDAMENTAL PRINCIPLE
1. Clearly defined eligibility and suitability criteria	The provision of treatment of children and youth should first be attempted in the least restrictive and most natural setting possible. Residential treatment should be reserved for those who present with highly complex needs unable to be met in a less intensive and less intrusive setting.
2. Family-centred care	The most effective treatments for children and youth require some level of family involvement. Active family engagement in all aspects of the residential treatment program is therefore paramount.
3. Strong and cohesive interprofes-sional staff team	Evidence-based treatment should be carried out by an interprofessional treatment team that is knowledgeable, collaborative, nurturing, skillful, and does not exhibit harmful conduct that would serve to re-traumatize those who are most vulnerable.
4. Minimizing physical interventions	Residential treatment settings should create a safe and nurturing environment in which seclusion and restraint are used only in situations for which alternative, less restrictive interventions have been unsuccessful in promoting safety.
5. Cultural and linguistic competence	Residential settings must be capable of serving the diverse cultural and linguistic needs of children and youth so they feel welcome, understood, accepted, and safe.
6. Individualized and appropriate programming to match the needs of youth	A standardized assessment framework is required to identify the appropriate individualized treatment requirements unique to each child and youth. It must aggressively target factors that will swiftly facilitate community reintegration within a treatment milieu that is structured, strengths-based, and youth-guided.
7. Seamless transition and integrated aftercare	Preparation for transition out of residential treatment is an essential element of the individualized treatment plan and includes integrated after-care that supports family/caregiver reunification and community reintegration.
8. Connected residential and community partners in care	Residential treatment is a component within a continuum of care that must be integrated with programming offered by community partners. An identified primary care provider is to be responsible for the coordination of services and the overall treatment plan.
9. Performance measurement	To ensure that services and interventions for children and youth in residential treatment are effective, it is imperative that service providers develop and implement systems for defining and measuring organizational performance and client outcomes.

Brief Historical Review of Residential Interventions

1830s

Orphanages and reformatories originated in the late 1830s and were the predecessors to "residential programs" (Abramovitz & Bloom, 2003). The function of these early institutions was to house troubled youth or protect them from incompetent parenting. Youth were provided employment, education, and rehabilitation. Obedience was a central tenet and reformatories were well known for coercive approaches, such as isolation and severe corporal punishment.

1940s

In the 1940s, the first residential programs were developed in the United States as a response to the perspective that troubled youth could be "cured" through treatment of their "character disorders," such as psychopathic or sociopathic personality disorders (Abramovitz & Bloom, 2003; Fees, 1998). Furthermore, it was believed that youth problems were largely a result of incompetent and unfit parenting; therefore, treatment efforts focused on youth only and omitted parental involvement (Small, 2003).

Individual mental health therapy for the youth residing within residential facilities initially subscribed to psychoanalytic practice. The goal was to provide youth with an "emotionally corrective experience through a positive relationship with a mental health professional" (Abramovitz & Bloom, 2003). Outside of individual therapy sessions, the residential facility supported the youth in order to maintain treatment gains between sessions. However, it was eventually determined that this approach was too narrow, as it failed to consider the effects of the milieu and daily routines, as well as the influence of the peer group on youth overall functioning. In addition, the effectiveness of psychoanalytic therapy, as applied to youth in residential settings, was not adequately demonstrated (Foltz, 2004).

1950s

B.F. Skinner outlined behavioural therapy, which soon became a dominant approach in residential settings. Under this model, youth were expected to modify their behaviours based on established rewards and consequences for their actions. The first "point" or "level" systems were introduced; however, there was minimal support for these systems, as they had not been widely examined (Hair, 2005).

1960s

Early residential programs appreciated the significance of the residential milieu as a treatment environment for the youth. Direct service workers in the milieu were viewed as essential therapeutic agents during "the other 23 hours" outside of individual therapy (Trieschman, Whittacker, & Brendtro, 1969). Within the therapeutic milieu, youth were supported using adaptive life skills within a peer group "in the moment," which was viewed to be more effective than retrospective approaches used in individual therapy. Many group/milieu treatment models emerged that have shown positive outcomes in the areas of academics, behaviour problems, and parent-child relationships (James, 2011). However, for gains to be maintained over time, aftercare services have proven necessary (Oswalt, Daly, & Richter, 1992).

1970s

Residential programs began incorporating family therapy into their model in the 1970s. Research studies began to demonstrate the effectiveness of family engagement and the post-institutional environment in all phases of treatment (Hair, 2005). Despite this, the adoption of family therapy across the field was minimal. Providers were challenged by incorporating families into the intervention work with youth due to beliefs that the youth's struggles were directly related to poor and unfit parenting. It was difficult to appreciate parents as equal partners and understand that, even when parents make mistakes with their children, they remain invested in their overall well-being and health (Lieberman & den Dunnen, 2014).

1980s

In the 1980s, the identification of post-traumatic stress disorder (PTSD) and the trauma paradigm shifted the psychological explanation of how children and youth came into residential care, from "protecting the child from want" and "protecting the society from the child" to psychological treatment related to psychological injury resulting from exposure to overwhelming life events (Abramovitz & Bloom, 2003). There was also an increasing distinction being made between hospitals which treated more disturbed patients, run by doctors and nurses, and residential centres or "other 24-hour facilities not licensed as hospitals that offer mental health programs" (Leichtman, 2006, p.286), frequently directed by psychologists and social workers.

It was during this time that the definition and role of "residential treatment" became increasingly unclear. The facilities to which the label was applied ranged from highly structured institutions closely resembling hospitals (yet not operated by medical staff and receiving much less reimbursement) to those that were indistinguishable from common group homes, half-way houses, and group foster care homes (Leichtman, 2006).

1990s

By the 1990s, the medical model had become well established in treating psychological disorders, and medications made it far more possible to manage disruptive behaviour, mood and anxiety problems, and disordered thinking (Baldessarini, 2000). In addition, alternative intensive outpatient programs, such as day treatment and wrap-around services, offered ways that parents could manage emotionally and behaviourally challenged children and youth in the community. Concurrently, short-term therapy was becoming increasingly popular (Leichtman, 2006). As a result, residential treatment programs were progressively losing their identity and utility as they had traditionally operated.

2000s - Present

Over the last decade and a half, residential treatment has been plagued with a myriad of criticisms, including extended separation from families and communities, lack of integrated family involvement, poor reintegration strategies, limited skill building, and an overutilization of punishment and restraint as a means to control behaviour (Blau, Caldwell, & Lieberman, 2014). Despite this, researchers have noted that the number of children and youth admitted to residential treatment programs has increased significantly since 1980 (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004). Given the number of vulnerable youth continuing to access residential treatment, there is a need for change to the way in which residential treatment programs operate in a radically altered environment.

Critical Success Factors for a Successful Residential Treatment System

1. Clearly defined eligibility and suitability criteria

KEY POINTS

FUNDAMENTAL PRINCIPLE

Treatment of children and youth should be first attempted in the least restrictive and most natural setting possible. Residential treatment should be reserved for those who present with highly complex needs that are unable to be met in a less intensive and less intrusive setting.

- A tiered mix of residential treatment programs that responds to the varying needs of children and youth should be used. This tiered system also facilitates seamless step up and step down movement. Eligibility program characteristics allow appropriate matching between the program characteristics and the needs of children and youth.
- Eligibility and suitability criteria that are standardized across the sector should be clearly defined within each tier. A standardized assessment framework that defines and designates a child or youth as 'complex' and appropriate for residential treatment is required. An interprofessional assessment team contributes to the development of a biopsychosocial formulation which, in turn, identifies the appropriate individualized intensive treatment targets.

Children and youth are placed in residential treatment for a number of reasons. Some placements are the result of challenging home environments and compromised parental capacity, while others are the consequence of significant emotion and behaviour dysregulation on the part of the child or youth that put others in the home at risk. In Ontario, there is an absence of consistent and clear-cut diagnostic and profile indicators for residential treatment placement. Without clear eligibility and suitability criteria, it is not possible to consistently determine (a) whether an individual will benefit from residential treatment, (b) the most appropriate treatment approach, (c) the appropriate safety plan, or (d) the impact that child or youth may have on other clients and staff within a program. To further complicate matters, assessment tools and guidelines are not available to help determine when residential care is an appropriate treatment option.

> *"Kids should not be in places they do not deserve to be."*
> *— Residential Treatment Client*

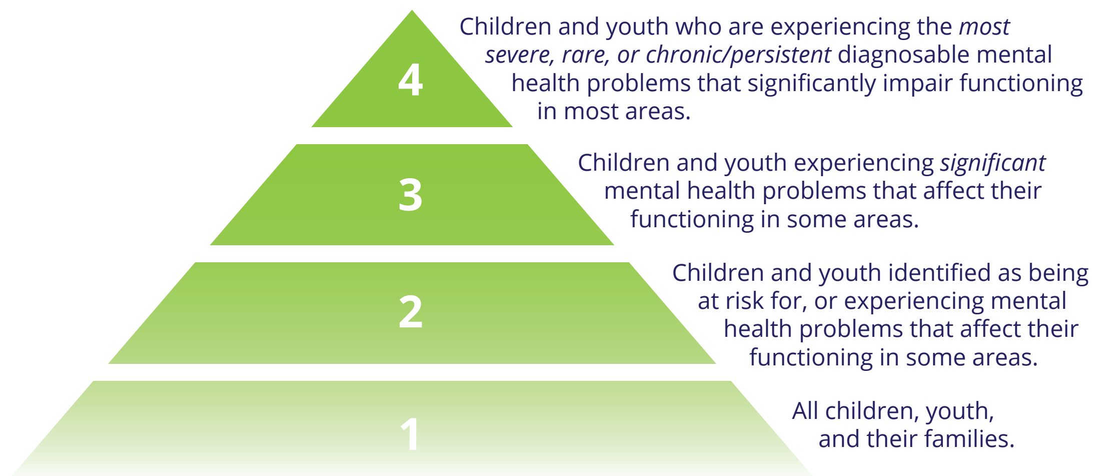
Although the effectiveness of residential treatment over other forms of treatment or alternative models of residential care has not been clearly demonstrated (James, 2011; Pumariega, 2007), there is general agreement within the literature that residential treatment should be maintained on the continuum of care for children and youth with significant and complex needs who require of 24-hour care and treatment (Leichtman, 2006; Pumariega, 2007; Stroul & Friedman, 1996). The question arises, then, of how to appropriately identify children and youth who require this level of treatment.

MCYS's *Community-Based Child and Youth Mental Health Program Guidelines and Requirements #01: Core Services and Key Processes* (MCYS, 2015, p.22) define the target population for children and youth accessing residential treatment settings as follows:

> The target population is children and youth under 18 years of age with treatment needs requiring highly intensive services due to mental health problems that impair their functioning at home, school and/or in the community. This includes children and youth who typically require services within levels three or four on the continuum of needs-based services and supports [see Figure 2].

As noted above, MCYS limits the population of children and youth accessing residential treatment services to those "under 18 years of age." This age threshold has proven to be problematic in practice, as it does not take into consideration the developmental needs of some children and youth, and can significantly interfere with effective long-term planning and continuity of care. This is an important area for focused consideration to ensure that current barriers to effective and needs-based treatment planning and plans of care are eliminated.

FIGURE 2. MCYS'S CONTINUUM OF CYMH NEEDS-BASED SERVICES AND SUPPORTS



Congruent with the risk principle presented above, residential treatment as a highly intensive intervention should be reserved for those who present with highly complex needs. At Kinark, we concur with this perspective and, for our purposes, define complex needs as the presence of significant social, psychological, emotional and/or behavioural difficulties at home, in school, and in the community, where children and youth are at risk of developing a range of negative health and social outcomes (Lyons et al., 2010).

> *"Before I moved here, it was more self-harm...but now the level of treatment is perfect because it was decreasing. I think this is the right level."*
>
> *— Residential Treatment Client*

Residential treatment services are also appropriate for children and youth when their caregiving system (family or surrogate) is not able to tolerate, manage, or support effective community or intensive in-home treatment, and/or the child or youth is in need of a high level of monitoring and containment due to significant safety and risk factors. In the latter cases, treatment outside of a structured and secure residential setting is not likely to be effective given such confounding variables, and the child or youth may deteriorate if placed in a less restrictive setting. Furthermore, in some rare cases, children and youth may require a highly specialized residential treatment that is not otherwise appropriately available in the community (e.g., treatment for sexually aggressive youth).

Per the system of care philosophy (Stroul & Friedman, 1996), treatment of children and youth should be provided first and foremost in the least restrictive setting possible, such as community-based programs targeting particular needs, and/or in family-focused intensive in-home programs. All too often, the residential system is used as an "end of the line" resource for many difficult-to-serve children and youth, including those underserved children and youth who present with neuro-developmental disabilities, such as dual diagnosis and autism spectrum, whose needs have not been met prior to reaching crisis levels and home placements have completely broken down. This represents a significant gap in the system and places substantial pressure on residential programs that are not adequately equipped to manage such unique presentations with a myriad of untended issues.

How can we determine who meets the criteria of experiencing "significant," "the most severe/ rare," or "complex" mental health needs?

> *A formulation is a summary statement based on current existing knowledge of a client. This includes a statement of the presenting problem with predisposing, precipitating, perpetuating, and protective factors using a biopsychosocial framework, which enables the generation of a treatment plan using multiple modalities that are biological, psychological, and social in orientation.*

To identify "significant" or "complex" needs in children and youth, a full interprofessional assessment is required, which generates a biopsychosocial formulation that, in turn, identifies the appropriate intensive treatment requirements (i.e., a treatment plan). However, without standardized assessment tools and related criteria that define and designate a child or youth as "complex," it is very difficult to ensure consistency across the sector and ensure that similar types of children and youth are being referred to, and accessing, residential care. In fact, evidence suggests that decision makers often use either overly generic and/or vastly differing standards when assessing whether residential care is warranted for any particular child or youth. For example, when comparing a group of residential treatment programs that varied significantly in restrictiveness and treatment intensity, Burns and Friedman (1990) found very few significant clinical differences among the residents across each program.

This suggests that there were no differentiating criteria applied when assigning children and youth to heterogeneous programs, meaning that severe acuity clients were placed in both high and low intensity treatment programs.

> *NOTE: These data are further complicated by York program's dual function within the community, which includes residential treatment as well as assessment for the local Children's Aid Society. As such, we are required to admit some children and youth into an intensive treatment milieu who may not be appropriate for such a program but who are difficult to otherwise place in the foster care system.*

Similarly, at Kinark, a comparison was made among youth residing in our various residential treatment homes between April 2012 and June 2013. Results indicated that just 67% of residential clients were rated medium to high risk on the Child and Adolescent Needs (risk) Scale (CANS). The remaining 33% were considered low or no risk. When comparing the clinical profiles of residential clients across Kinark's residential programs and geographies, it was found that, despite the programs' intention to serve similar complex profiles, there was a fair degree of variability in terms of both symptomatology and risk, as indicated by scores on the Brief Child and Family Phone Interview (BCFPI) and CANS. Kinark's York program, for instance, appeared to provide residential services to lower mental health acuity and lower risk clients. Thus, even within the same organization, there can be a marked lack of consistency across programs in terms of the complexity of youth accessing residential care.

It is important to highlight that Kinark's analysis revealed that one third of clients in residential treatment may be better served in community settings (i.e., 33% were rated low or no risk). These youth were therefore receiving residential treatment in the absence of any current or recent risk behaviours. What contributed to this? In the four geographic regions for which Kinark provides residential treatment, all referrals are presented to and approved by each of the local residential access committees established by the Ministry. These committees are intended to assist in the identification and prioritization of referrals to all residential treatment programs in the region; each committee has its own process for identifying and assessing a child or youth's priority for placement. Thus, while Kinark participates in four committees that serve four regions, there is no standardized process or tool to determine eligibility and/or suitability; where standardized tools do exist, they are focused only on risk.

In addition to discrepant standards and lack of standardized tools used to make placement decisions, a shortage of resources may also contribute to the profile inconsistencies of clients referred and admitted to residential treatment programs. Unfortunately, in some service areas, the demand for residential beds far exceeds availability. In other service areas, availability is not the problem; in fact, maintaining occupancy becomes a pressure point that forces programs to admit inappropriate clients. In MCYS's former Central East Region, most residential treatment providers currently have vacancies, not because there is an over supply of residential treatment beds, but because the highly complex needs of some children and youth requiring residential treatment exceed their capacity to safely and effectively respond. Current standards of training and resource allocations have simply not kept pace with the changing needs of the population. For these reasons, children and youth with complex needs are, at times, simply not able to access

the resource when it is needed. To further compound the issue, the decision to place a child or youth is often based on which program has an opening rather than on the match between the characteristics of the treatment program and the needs of the child or youth, thereby occupying a bed that might otherwise be available when an appropriate client is identified.

To ensure accurate and consistent placement decisions, it is important to use a standardized assessment framework as well as clearly defined eligibility and suitability criteria to help determine when residential care is appropriate. This assessment framework should be applied to all MCYS-defined Level 3 and 4 cases and should include a comprehensive interdisciplinary biopsychosocial formulation. Ideally, when determining eligibility and suitability for residential treatment, standardized criteria should consider:

- the nature and severity of the problem, considering frequency, intensity, and duration;
- developmental stage and adaptive functioning, considering home, school, and community environments;
- historical and current family pathology and functioning, considering home, work, and community environments;
- strength and resiliency/protective factors within the child or youth and family environments; and
- the availability of community supports after discharge from treatment.

In Durham region, based on a two year review of data, the Durham Residential Access Planning Committee (DRAP) has identified issues related to inconsistent placement decisions and recommended a standardized assessment framework be developed. The challenge, however, appears to be a lack of congruence and consistency in the assessments that the various child and youth mental health centres are providing and which form the basis for decision making.

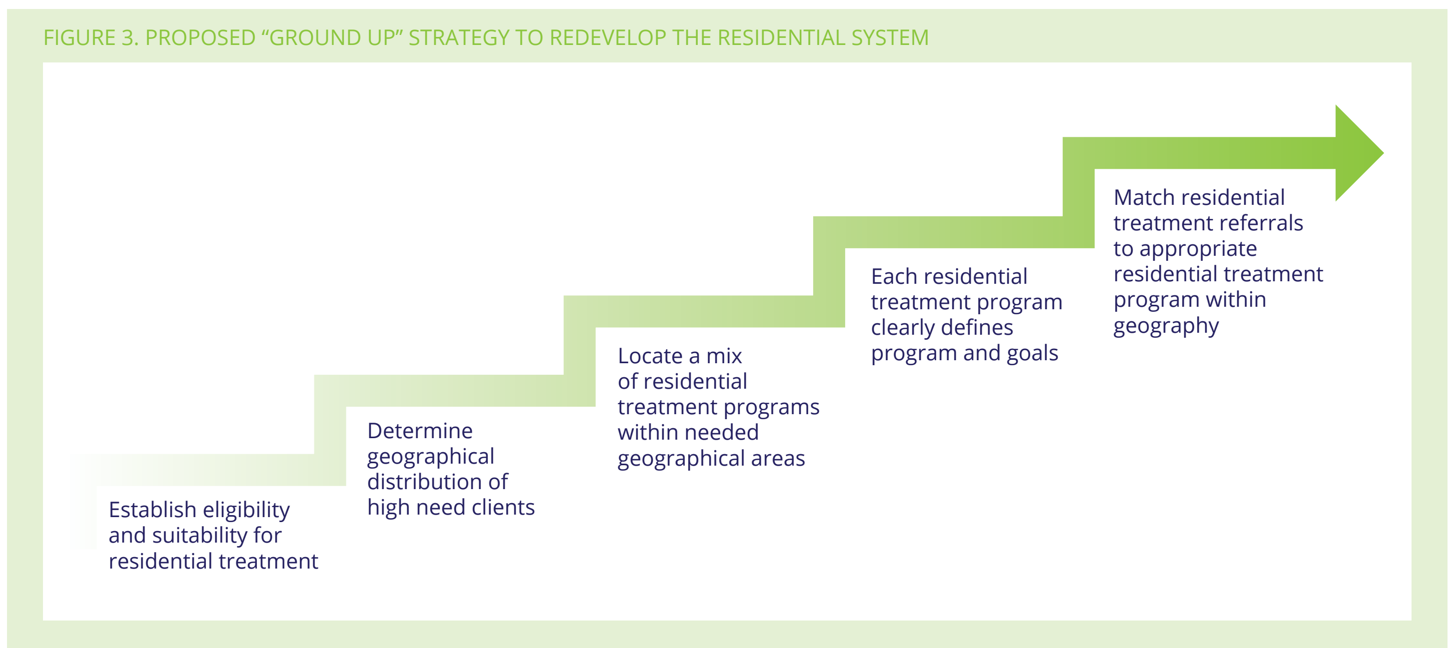
A redevelopment of the residential treatment system is required to clearly identify appropriate children and youth and determine how the system as a whole is best able to meet their needs. Historically, the residential system developed in a fragmented and opportunistic manner, where providers typically designed and developed residential programs based on their own skills, philosophies and priorities, which were often informed by local demand at the time. The resulting programs were likely not comparable in terms of program design, types of therapeutic services and professional disciplines involved, clinical profiles, staff-to-client ratios, characteristics of the living environment, lengths of stay, age requirements, geographical boundaries, and bed availability. Furthermore, they had limited capability to adapt as local needs evolved. In addition, as access to mental health services is not mandated, providers are not required to develop programs for children and youth whose needs are not well met by existing programs, meaning that providers may accept or decline referrals based on agency capacity rather than acuity of need.

Once a common understanding of the children and youth who will benefit from residential treatment is established, and a mechanism to forecast their prevalence locally and across the province is developed and applied, standardized eligibility and suitability criteria must be created. Appropriate residential treatment programs should be made available in accordance

with local need. At the provincial level, an appropriate mix of resourced residential treatment programs, tiered to meet the needs of the population, is required. This would include a few high-capacity programs and a greater number of lower capacity programs. While these programs may not necessarily be "close to home," per se, or in close proximity to the family's home or community, having such programs in each geographic service area reduces the need for families to travel great distances and supports the transition of children and youth returning to their home communities.

Following this, each residential treatment program within the sector must clearly outline and subsequently align their program's mission and goals in accordance with the needs of the service area, including the specific components of the program and the kinds of presenting problems the program treats most effectively and why (Wells, 1991). Age and developmental stage must be taken into consideration, and criteria for short (less than 6 months) and long-term (between 6 months and 2 years) placement should be distinguished (Wells, 1991). This would allow placement decisions to be based on the match between the characteristics of the program and the needs of the child or youth in congruence with the specific responsivity principle presented above. This proposed strategy for redeveloping the residential treatment system is presented in Figure 3.

FIGURE 3. PROPOSED "GROUND UP" STRATEGY TO REDEVELOP THE RESIDENTIAL SYSTEM



2. Family-centred care

KEY POINTS

FUNDAMENTAL PRINCIPLE

The most effective treatments for children and youth require some level of family involvement. Active family engagement in all aspects of the residential treatment program is paramount.

- Family contact, via visits and other communication, should be maximized during the residential stay.
- Families must be active participants in both treatment planning and intervention. Family therapy and/or parenting education/treatment sessions are important and necessary components.
- Strengthening transition and after-care preparation and support promotes the practice and generalization of new skills and facilitates reunification.

The term "family-centred care" is multi-faceted in its meaning. Fundamentally, it understands "every child as part of a family, and every family as a valued partner" (Hust & Kuppinger, 2014, p. 15). However, the application of this tenet varies. It can include ensuring that each treatment plan is individualized to the family's needs, abilities, and resources; facilitating a reconnection between the child or youth and the family; assisting families who have lost hope to re-engage; and even identifying and building a new family system for the child or youth. At the heart of it is the central importance of the family as the primary decision maker for the care of its own children.

It is common for clinicians to identify active and sustained engagement of families as an ongoing challenge when treating the emotional or behavioural problems of children and youth (Hoagwood, 2005), yet there is growing acknowledgement among clinical professionals that the most effective treatments for children and youth require some level of family involvement (Herman et al., 2011). The literature specific to residential treatment points to the positive correlation between family engagement and outcomes for children and youth in residential treatment with respect to both the maintenance of treatment gains and facilitation of the transition home (Nickerson, Salamone, Brooks, & Colby, 2004; Knorth, Harder, Zandberg, & Kendrick, 2008). How, then, does a residential treatment program, where a child or youth resides apart from their family, ensure that the care provided holds the family at the core of the work?

Walter and Petr (2008) suggest various strategies to create a family-centred residential environment. These include, at a minimum, maximizing family contact, ensuring families contribute to the planning and delivery of treatment, and enhancing transition and after-care preparation and support.

- *Maximize family contact*
- *Include families in planning and treatment*
- *Enhance transition and after-care preparation and support*

— Walter & Petr (2008)

Maximizing family contact

Many children and youth in residential treatment programs experience infrequent and/or inconsistent family visits. A number of factors contribute to the extent to which families are involved, including distance, strained family relationships, the age of the child or youth, and the presence of psychiatric disorders and developmental delays. Not surprisingly, families who live greater distances from the residence have less in-person contact with the residential setting (Baker & Blacher, 2002). In addition, personal and parenting issues are barriers to involvement, with strained family relationships and youth behaviour problems being significant contributors. In addition, younger children are more likely to have more frequent family visits, as are children and youth with psychiatric disorders, while families of children and youth with developmental delays struggle with their ability to visit their child's residence (Baker & Blacher, 2002). These findings suggest that facilitating transportation and the use of technology should be a priority, as is the requirement to support the family's needs, which includes a strong focus on parent-child relationship building and enhancing parenting skills.

Including families in planning and treatment

Empowering families to be active participants in their child's care is imperative at the onset of treatment within the residential program. This should begin with a comprehensive pre-admission orientation for the family that includes visits and the opportunity for the family to ask questions of all members of the interdisciplinary team (Hust & Kuppinger, 2014). At this time, requirements for family participation in the program are presented and potential barriers to participation are problem-solved collaboratively.

Family participation in the intervention efforts include such elements as family therapy, caregiver education, caregiver coaching, and/or individual therapy for caregivers. These are important and necessary components to residential treatment. In their white paper review of several residential treatment programs, Affronti and Levison-Johnson (2009) found parenting education and/or family therapy to be "common elements" across all of the programs that demonstrated positive outcomes. When engaging families in family intervention, staff must begin with the clear expectation of family involvement and then make every effort to "meet the family where they are." This is particularly difficult when families are under a great deal of stress and the bond between the child or youth and the family has been significantly compromised. However, there is a substantial increase in the likelihood of family reunification when parents participate in parent education and involvement programs during the time their child is in residential treatment (Carlo, 1993). These efforts translate into a more stable and supportive environment for the client when discharged, thereby leading to better long-term outcomes (Frensch & Cameron, 2002; Pfeiffer & Strzelecki, 1990).

Enhancing transition and after-care preparation and support

Spending time with family at home and active integration in local community settings are important elements that promote the practice and generalization of new skills for the child or youth and the parents (Affronti & Levison-Johnson, 2009). It is in this way that intervention efforts are best sustained once the client leaves the residence. Therefore, residential resources should be viewed as a **short-term intervention** for children, youth, and their families to acquire a range of practices and skills that can easily generalize to the home and the community. Further approaches,

such as the provision of in-home support to alleviate family stress and teach the skills needed to prepare for the child or youth's return, and having parents practice learned strategies within the residential treatment milieu, should also be delivered (Affronti & Levison-Johnson, 2009).

> Practices inconsistent with family-centred care include keeping the child or youth separated from the family for long periods of time with arbitrary rules about how soon or often the child or youth can visit home; requiring the child or youth to "earn" time outside the residence with the family; using point and level systems that focus on punishment; not allowing children and youth to use cell phones to contact their families as frequently as needed; and holding treatment team meetings without families in attendance (Hust & Kuppinger, 2014).

Additional strategies can be employed to ensure a more family-centred approach to treatment. For instance, the support of an individual who has lived through a similar experience is a powerful influence. Implementing a "family partner" or "family mentor" within the residential treatment program is a promising practice that has seen very good outcomes in the medical field. Parents of children with disabilities, for example, have been partnered with a supportive mentor who is also a parent of a child with a disability. Results from this mentorship relationship included higher scores on parent-child interactions, parental responsiveness, quality of home environment, and lower anxiety scores in comparison to a control group (Singer et al., 1999). Other studies reported declines in parental mental health symptoms and fewer worries regarding disease management; a decreased negative influence of the disease on the family; and a greater availability of community resources relative to those who had not been linked to a mentor (Ireys, Sills, Kolodner, & Walsh, 1996; Sullivan-Bolyai, Bova, Leung, Trudeau, Lee, & Gruppuso, 2010). One study in the mental health literature revealed that a psychoeducational and system navigation workshop that was co-facilitated by both a professional and a parent significantly increased the participants' perceived self-efficacy on obtaining mental health treatment and knowledge of available services (Brannan, Heflinger & Bickman, 1997). When programs have family mentors working as colleagues alongside professionals, the stigma of mental health can be drastically reduced. Furthermore, trust, hope, and engagement are significantly enhanced (Hust & Kuppinger, 2014).

Aligned with the "family partner" model, Kinark has recently implemented the *Family Support Provider* (FSP) program in two community mental health sites after a successful pilot project that was funded by MCYS between 2011 and 2013. The FSP program partners family support providers, who have lived experience and are trained in the FSP model, with families who are currently receiving service. The role of the family support provider is to work as part of the treatment team, focusing exclusively on helping the family navigate children and youth services, building advocacy skills, and expanding the family's resource network.

Evaluation findings from the pilot demonstrated that the FSP program provides positive support to participant families. There was evidence to suggest that the program helped families navigate a complex system of mental health services and enhanced their access to other supports. At the end of the program, families reported reduced stress and were connected with a greater number of community and personal supports than they were prior

to beginning FSP. Moreover, the majority of Kinark staff members indicated that, because of the FSP program, they were able to focus more of their time on clinical work. Staff agreed that the FSP program was effective for families, children, and youth and would likely refer clients to this program in the future. Results and learnings from the pilot have been used to refine the program and inform the provision of FSP as part of regular service delivery in Peterborough and York. The evaluation work continues to ensure fidelity to the FSP model and to monitor outcomes for children, youth, and their families.

3. Strong and cohesive interprofessional staff team

KEY POINTS

FUNDAMENTAL PRINCIPLE

Evidence-based treatment should be carried out by an interprofessional team that is knowledgeable, collaborative, nurturing, skillful, and does not exhibit harmful conduct that may serve to re-traumatize those who are most vulnerable.

- Child and youth workers play a central role in residential treatment; however, they often lack the education and clinical experience required to work with the most complex and vulnerable children and youth. Appropriate training, supervision, and support is paramount.
- Child and adolescent psychiatrists, nurses, psychologists, behaviour therapists, social workers, child and youth workers, and educators with clear roles and responsibilities all have unique and important contributions to make to the treatment of children and youth in residential settings.

Given the clinical complexity of children and youth accessing residential services within a 24/7 living milieu, the skills that staff must demonstrate and the roles that they must perform go far beyond what would be expected within a general community mental health outpatient program. This includes operating not only as frontline clinicians – which includes treatment delivery, supervision, coaching, ensuring safety and security, upholding rules and regulations, and completing paperwork – but as clinical consultants and collaborators to other professionals and families.

Once children and youth are placed in residential treatment, frontline staff assume responsibility as primary caregivers, providing basic care in addition to creating a therapeutic environment in which the child or youth can develop and grow. Frontline staff are typically child and youth workers who have been trained to help children, youth, and their families better cope with personal and daily living challenges. These workers have an enormous influence over, and responsibility for, the children and youth in their care. It stands to reason, then, that these caregivers need to be knowledgeable, empathetic, nurturing, skillful, and not exhibit harmful conduct that may serve to re-traumatize those who are most vulnerable. Rabley, Preyde, and Gharabaghi (2014) have highlighted the importance of building strong and meaningful relationships with youth, particularly those who present with features of insecure attachment,

as this may help build resiliency. In their study, youth were more likely to connect positively with staff who made them laugh, shared similar interests, had a caring and nurturing disposition, were trustworthy, communicated openly, and were consistent with the enforcement of rules and expectations. Shealy (1995) outlined personal characteristics of child and youth workers critical to competent child and youth work care. These include flexibility, maturity, integrity, responsible, self-control, predictable, nurturing, non-defensive, self-aware, empowering, cooperative, and a good role model. Undesirable characteristics include exhibiting pathology, selfish, defensive, dishonest, abusive, uncooperative, rigid, irresponsible, critical, passive-aggressive, inappropriate boundaries, unethical, authoritarian, inconsistent, avoidant, angry, and poor role model. Shealy (1995) further noted that, while it is advantageous for child and youth workers to embody and demonstrate the positive personal characteristics, it is far more critical that the negative characteristics never be exhibited. An Ontario study completed by Stuart and Carty (2006) identified seven core competencies for residential child and youth care workers in children's mental health. These include competencies related to self-awareness, communication, relationships, intervention, professionalism, systems, and child development.

Studies of staff turnover in residential treatment facilities over the past 30 years report annual rates between 32% and 72%. Staff turnover in residential treatment is difficult for youth who have histories wrought with attachment losses, as it challenges the safety and stability of the therapeutic environment.

— Connor et al., 2003

Children and youth who access residential treatment typically struggle with challenging behavioural presentations that significantly affect those around them. When critical resources, such as support and supervision, are not available to frontline workers who endure these challenges daily, their ability to perform duties at the level required for such an intensive intervention is compromised. Consequently, the work and the clients suffer. The limited research in this area confirms that staff who are consistently subjected to challenging behaviour are quicker to experience burnout and medical challenges, as they often feel unsupported, agitated, and overwhelmed (Van Oorsouw, Embregts, Bosman, and Jahoda, 2010). Furthermore, Willems and his colleagues (2010) found that, over time, residential treatment staff can exhibit signs of depression, hopelessness, and indifference. Based on findings such as these, combined with the appreciation that frontline workers have the most interactions with the child or youth on a daily basis, Braxton (1995) noted that frontline staff benefit from sufficient compensation, adequate training, regular supervision, as well as clear expectations to guide their work. These strategies, in addition to employee incentives such as regular salary increases, positive performance evaluations, and opportunities for promotion, would go a long way to strengthening and stabilizing the residential treatment milieu and combating concerns related to reliance on inadequately trained and transient shift workers (Connor et al., 2003). Moreover, frequent staff trainings and consultation should be offered to create a culture that supports the work of frontline staff (Zelechoski, Sharma, Beserra, Miguel, DeMarco, & Spinazzola, 2013). Reports from residential staff indicate that the majority of training provided are the preservice and mandatory trainings prescribed by MCYS related to crisis intervention, first aid, CPR and other health and safety oriented certifications,

as well as relevant policy reviews. Supplemental in-service trainings are primarily clinical and diagnostic in nature and very few focus on themes and issues specific to working in residential group care, such as therapeutic alliances, residential milieu, and team work (Gharabaghi, 2010). One Canadian study determined that training and professional development opportunities for residential treatment staff are sorely underdeveloped and that these initiatives are largely unsupported at an organizational level. Scheduling and the substantial costs associated with backfilling residential staff, which are not supported by the funder, are cited as primary obstacles (Gharabaghi, 2010).

> *Within health care, the terms interdisciplinary, interprofessional, multidisciplinary, and transdisciplinary are often used interchangeably. While there are differences in the meanings of each of these concepts, they reflect common goals or values essential to providing effective, holistic, culturally sensitive care. Delineated and hierarchical positions which are common in hospital settings are inappropriate for community-based care, where teamwork is essential to addressing complex and diverse needs of clients.*
>
> *— Cooper, Carlisle, Gibbs, & Watkins (2001)*

Given the complexity of care in residential treatment settings, front-line child and youth workers must be effectively supported clinically by an interdisciplinary team. Pumariega, Winters, and Huffine (2003) recognize various professions and scopes of practice necessary to support the residential system of care and outlines the way in which they “work together to contribute to an interprofessional model of care through flexibility in their roles beyond their prescribed clinical role, as collaborators, advocates, administrative/service delivery leaders, consultants, evaluators, and researchers” (p. 407). **Child and adolescent psychiatrists** have key psychodiagnostic, psychotherapeutic, and psychopharmacological roles. **Nurses** may act as “psychiatric extenders” and provide necessary medical care, including liaising with hospitals and other medical professionals. **Psychologists** contribute to the identification of symptomatology and corresponding psychosocial evidence-based interventions. While psychologists provide functional behavioural analyses and corresponding behaviour modification plans, the assessment and execution of behaviourally-based therapeutic work may best lie with specialized **behaviour therapists**. **Social workers** and other master’s-level professionals provide crucial family- and community-focused assessment and treatment and are typically regarded as the primary clinician for individual clients. These clinicians are in the best position to facilitate family engagement as well as community engagement, including the engagement of the front-line workers in the residential treatment setting. **Educators** are included in the interdisciplinary team as important supporters and informers of the treatment plan, as are recreational and art therapists, who play a prominent role with children and youth who are compromised physically and verbally. Other professionals may also enhance the interdisciplinary team, depending on the needs of the child or youth. These include, but are not limited to, occupational therapists, speech and language pathologists, nutritionists, and physicians.

To enhance effectiveness of the interdisciplinary team, clear definitions of the providers’ roles and expectations regarding the shared care of children and youth is critical. Ensuring clear role definitions reduces the possibility of ambiguity and misunderstanding concerning responsibility,

authority, policies, and procedures (Paquette-Warren, Roberts, Fournie, Tyler, Brown, & Harris, 2004). Research has shown that, when functioning well, interdisciplinary collaborative work promotes better outcomes for patients, provides opportunities for informal professional development and education across disciplines, and increases understanding and respect among team members (Paquette-Warren et al., 2004). When not working well, interprofessional contributions to the treatment plan may be viewed as interference by others and team discord may result (Gharabaghi & Phelan, 2011).

The benefits of receiving interdisciplinary team care are significantly greater for those individuals with complex mental health issues and needs, including their caregivers, families, and professionals involved in the delivery of care. Schultz, Walker, Bessarab, McMillan, MacLeod, and Marriott (2014) list the advantages of interdisciplinary care, presented in Table 2.

TABLE 2: BENEFITS OF INTERDISCIPLINARY TEAM CARE

FOR CLIENTS	
Improves care by increasing coordination of services, especially for complex problems	Uses time more efficiently
Integrates health care for a wide range of problems and needs	Empowers clients as active partners in care and enhances satisfaction and outcomes
Can serve clients of diverse cultural backgrounds	
FOR CAREGIVERS AND FAMILIES	
Provides the best possible outcome for the physical and psychosocial caregivers (as well as clients with mental illness)	Involves caregivers with a range of professionals in the process of developing a mental health plan
Addresses the needs of caregivers, siblings and the children of those with mental health problems	Considers everyone's concerns and identifies resources for supporting someone with mental health issues
Assists with broader social, cultural and health issues experienced by families	
FOR HEALTH CARE PROFESSIONALS	
Increases professional satisfaction	Encourages innovation
Facilitates shift in emphasis from acute, episodic care to long-term preventive care	Allows providers to focus on individual areas of expertise
Enables the practitioner to learn new skills and approaches	
FOR THE HEALTH CARE DELIVERY SYSTEM	
Holds potential for more efficient delivery of care	Facilitates continuous quality improvement efforts
Maximizes resources and facilities	Reduces health expenditure
Decreases burden on acute care facilities as a result of increased preventive care	Facilitates seamless transition between care sectors (such as acute and community care)

4. Minimizing physical interventions

KEY POINTS

FUNDAMENTAL PRINCIPLE

Residential treatment settings should create a safe and nurturing environment where seclusion and restraint are only to be used in situations when alternative, less restrictive interventions have been unsuccessful in promoting safety.

- If restraint is considered necessary, it should be the minimum required to deal with the presented risk, applied for the minimum time possible.
- Residential treatment settings should not contribute to the criminalization of mental illness by using the justice system as a means to control unwanted or high risk behaviour.

The use of physical restraints and isolation in child and youth residential programs dates back to the earliest orphanages and reformatories. In Ontario, all residential staff providing direct service to clients require annual training in a crisis intervention/de-escalation program recognized by MCYS that includes a physical restraint component. At Kinark, Understanding and Managing Aggressive Behaviour (UMAB) is used. Under provincial regulations, physical restraint of children and youth is only appropriate to prevent injury to themselves or others, or to prevent significant property damage. Additionally, requirements stipulate that less intrusive methods must have been attempted first and deemed ineffective before moving to restraint.

> *"Restraint should only be used to prevent real danger. Restraints hurt."*
> *— Residential Treatment Client*

In July 2015, the *Toronto Star* newspaper published an investigation of serious occurrences in Toronto "group homes," including residential treatment centres. The *Star* noted that restraints were often used in such situations as "spilling your popcorn and becoming rude and disrespectful." Similarly, Nunno, Holden, and Tollar (2006) examined 45 child and youth fatalities related to restraints in residential placements over a 10 year period in the United States. The authors reported that, in 23 of the 45 cases, the standard of using restraints to prevent danger to self or others was not met. The researchers concluded that "all restraints present considerable risk to the youth, are intrusive to the youth, have a negative effect on the treatment environment, and have a profound effect on those youth who have experienced trauma in their lives" (Holden, Nunno, & Leidy, 2008). LeBel (2011) asserts that restraint use leads to further restraint use and produces more violence and conflict within the residential treatment program than the issues they attempt to resolve. There is further evidence that the use of restraints humiliates clients (Wright, 1999), reinforces aggressive behaviour as a coping mechanism (Murray & Sefchik, 1991), and is *not* clinically effective (Goren, 1991).

There is consensus that many children and youth in residential treatment programs have histories of overwhelming stress and trauma prior to placement (AACRC, 2014), and a primary goal of residential treatment settings should be to create a safe and nurturing environment

where residents are therapeutically supported to work through mental health issues and learn new skills. With safety being a major priority, and trauma having such a high prevalence among residential children and youth, it seems clear that, whenever possible, the least restrictive strategies are to be utilized with clients in the residential milieu. Kulkarni, Deshmukh, and Barzman (2010) assert that seclusion and restraints with vulnerable children "should be used only when other less restrictive interventions have failed to work in promoting safety and controlling aggression" (p. 168). Furthermore, according to Pumariega, Winters, and Huffine (2003), "the principle of least restrictive measure of care result in children actually achieving high quality services (with less disruption to their development) and at a lower cost than when higher, more restrictive levels of care are utilized" (p. 419).

A review of data collected at Kinark shows that residential clients are about four times more likely than other Kinark clients to have experienced physical abuse, sexual abuse, and neglect.

The use of physical restraint is a costly means for managing challenging behaviours, with respect to both time and money. A one-hour restraint can result in over thirteen hours of staff time, taking into account the multiple staff members assisting with the incident as well as the time spent debriefing and completing required paperwork following the event (LeBel & Goldstein, 2005). In fact, instances of seclusion and restraint within a residential treatment setting can claim as much as 23% to 50% of total staff time and the program's operating budget (LeBel, 2011).

A significant proportion of a program's operating budget may be set aside for the provision of relief staff when regular staff are unable to perform their duties due to injury from involvement in restraints. At Kinark, this occurred in our Peterborough residential program this past year as large cost overruns (along with a discontinuity of care for clients) ensued due to the need for casual staffing services to fill vacancies for staff who had been injured in the program. According to Weiss, Altimari, Blint, and Megan (1998), restraint practices in residential settings produce higher rates of staff injury than those reported in "high-risk" industries. However, incidents of injuries to children and youth remain significantly higher than injuries to staff (Garinger, 2009). Of further concern, however, is when incidents escalate to the point at which staff feel unable to manage the situation safely on their own and resort to utilizing police services. In the July 2015 *Toronto Star* article, a high rate of police service use was reported when residential children and youth – many of whom suffer from trauma and mental health issues – act out or cause property damage. Unfortunately, this practice of being "too quick to call police" leads to the criminalization of mental illness among already-vulnerable young people.

Clients with the most complex needs are also the most likely to engage in behaviours that require physical interventions (e.g., violence/aggression, self-harm). Although MCYS sets out clear standards for the use of physical restraint and seclusion, providers must commit to using strategies to minimize the use of seclusion and restraint. A variety of recommendations have been provided by researchers, which includes gaining a thorough understanding of

the client through a comprehensive case conceptualization (Cotton, 1989); providing regular staff trainings to promote competence in managing aggressive clients (Perkins & Leadbetter, 2002), which includes information on alternatives to restraint, such as verbal de-escalation strategies and methods to circumvent provocative situations from clients (Gournay, 2002); functional behavioural assessments and positive behaviour management strategies, as well as understanding what aspects of the therapeutic milieu are triggers for clients and working to reduce those environmental triggers (Horner & Carr, 1997). According to Measham (1995), a rich, engaging therapeutic milieu that empowers clients to make choices is a critical component of restraint reduction.

One evidence-based practice approved by the National Registry of Effective Programs and Practices (NREPP) is called the "Six Core Strategies to Reduce Coercion, Violence, and the Use of Seclusion and Restraint" (Huckshorn, 2013). The six core strategies include full leadership commitment to preventing/reducing the use of seclusion and restraint; using data to inform practice; comprehensive staff training on trauma and trauma-informed care; use of a variety of tools and assessments designed to prevent and reduce seclusion and restraint; active participation and engagement of children, youth and families in all aspects of care; and the use of rigorous debriefing techniques. This or a similar evidence-based practice should be a key component of any residential treatment program.

Kinark has learned, first hand, the value of consistent and well-trained staff in managing children and youth with complex needs in residential treatment programs. In the 2013-2014 fiscal year, several residential staff were injured while attempting to manage the aggressive behaviours of residents. Following a review of these injuries and the context in which they occurred, it was found that the approach to de-escalation was not sufficiently matched to the behaviours of the residents. A number of steps were taken to address the situation. First, the implementation of an alternative form of crisis de-escalation and management was undertaken. Staff were formally trained on a new way of managing aggressive and unsafe behaviour. Second, reliance on third party staffing services was significantly diminished. To fill vacancies due to illness, vacation and other leaves, program management began utilizing staff within the agency who were trained in the same skills, thereby ensuring consistency in addressing crisis situations. Third, increased communication within the staff team and a focus on a team-oriented approach increased staff's sense of safety, thereby reducing anxiety among the residents and improving confidence among the staff team. While more improvement is needed, a change in culture was found to have a positive influence on clients' behaviour and, as a result, the need for seclusion and physical intervention.

5. Cultural and linguistic competence

KEY POINTS

FUNDAMENTAL PRINCIPLE

Residential settings need to be competent in serving the diverse cultural and linguistic needs of children and youth so they feel welcome, understood, accepted, and safe.

- Practitioners must develop the necessary attitudes, skill, and knowledge base to serve diverse children and youth; policies and procedures must be developed to make services more responsive to the values of diverse communities.
- An investment in culturally diverse staff may facilitate an increase in trust and comfort on the part of the families, making them more readily available for service.

Ontario communities are becoming increasingly diverse, both culturally and linguistically, and the children and youth who receive residential services, as well as their families, reflect that diversity. There are limited demographic data for Ontario residential programs, however, studies in the US have shown that, compared to white youth, non-white youth are under-represented in mental health outpatient settings and over-represented in child welfare and youth justice settings and placements, even when they are equally psychiatrically impaired (Alegria, Vallas, & Pumariega, 2010).

***Cultural competence** is defined as "the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths and religions, in a manner that recognizes, affirms, and values the worth of individuals, families, and communities, and protects and preserves the dignity of each."*

— https://www.childwelfare.gov/pubs/acloserlook/culturalcompetency/

***Linguistic competence** is defined as "the ability of an organization and its employees to successfully communicate information in a manner that is uncomplicated and easily understood by diverse individuals and groups, including those with limited English proficiency, low literacy skills or who are illiterate, and those with disabilities."*

— http://www.buildingbridges4youth.org

Race, ethnicity, sexual orientation, gender identity/expression, faith community, socioeconomic status, national origin, primary language, and geographic community are all factors that influence attitudes and behaviours in the day-to-day lives of children, youth, and families (Jackson, Fisher, & Green, 2014). This naturally affects their experiences and interactions with residential staff and all services within the residential milieu. Programs that embrace and integrate culture and language in all aspects of the work can therefore facilitate commitment and engagement in the therapeutic process, thereby contributing to positive outcomes.

There is a dearth of literature that focuses on diversity awareness within residential treatment programs, however, diversity offers the potential to enrich experiences, enhance personal and social interactions, and enrich the community through an offering of multiple perspectives (Manning, 2000).

Because the Ontario population is becoming increasingly diverse, it is incumbent on social service agencies to consider and integrate the needs of diverse communities into their programs and services. Practitioners must develop the necessary attitudes, skills, and knowledge base to serve culturally diverse children, youth, and families in their communities, and policies and procedures must be developed within these systems to remove barriers for access to services and be more responsive to the values of diverse communities.

In 2008, MCYS released *Achieving Cultural Competence: A Diversity Tool Kit for Residential Care Settings* as a way to help organizations who provide residential services to better meet the needs of the diverse children and youth in their care. It offers an organizational self-assessment tool, as well as a 10-point plan to guide organizations in their journey to become more diversity-competent.

The Building Bridges Initiative (BBI) is a national initiative within the US that aims "to identify and promote practice and policy that will create strong and closely coordinated partnerships and collaborations between families, youth…and residentially-based treatment and service providers." This group has provided a series of recommendations and practices aimed at enhancing cultural and linguistic competence in residential treatment programs. Such recommendations include championing diversity from the highest levels of the organization, including boards of directors, as well as integrating diversity into every aspect of the operations of a residential program. For example, within the living environment, culturally oriented decorations, social activities, recreational activities, and hair-care and grooming options can be provided. Reading materials, music, television programs, and movies can be made available in preferred languages. Children and youth can be offered opportunities to engage in religious practices and dietary requirements can be accommodated.

Diversity considerations should be applied to the assessment process, clinical treatment plan, and discharge plan in terms of the ways in which cultural background may have contributed to the challenges, as well as the ways in which they serve as protective factors. Treatment plans should be implemented in a culturally and linguistically appropriate manner that ensures that the intervention has evidence supporting its success with diverse populations. In addition, discharge plans should include preparations for potential discrimination that children, youth, and families may experience in their next stage. Appropriate language access for children, youth, and their families is paramount.

In addition, measures of diversity should be considered when collecting data and measuring performance for the purpose of assessing outcomes among various cultural groups. Such information can be used to better inform program goals and inform improvements to programs and interventions (Jackson, Fisher, & Green, 2014). This is particularly important for determining whether residential treatment programs produce positive outcomes among the various cultural,

ethnic, and racial groups served, as the literature evaluating most evidence-based practices does not take into consideration such factors when drawing conclusions about program effectiveness (American Association of Children's Residential Centers, 2008). Dishion and Kavanagh (2003), for example, reported that clinicians may inadvertently alienate some clients and increase the chance of dropout when they apply an evidence-based practice that was developed for an ethnic group dissimilar to that of their clients, without the necessary adaptations.

Staff who reflect the cultural diversity of the children and youth they serve may establish trust and comfort more readily with clients and their families. In addition, these staff can function as "cultural brokers" between other program staff and clients (Jackson, Fisher, & Green, 2014). Unfortunately, parents of diverse ethnic backgrounds often develop a mistrust for social services due to previous experiences that have been wrought with cultural disconnections between the family and the treatment clinician, which may have arisen from the clinician's inexperience with the family's culture or a general lack of sensitivity to cultural differences (Dishion & Kavanagh, 2003).

It is crucial that all staff receive supervision, mentorship, and/or coaching to move the workplace towards cultural and linguistic competence. This includes the provision of opportunities for staff to increase their own self-awareness related to diversity and to address issues such as bias, prejudice, and discrimination. Job descriptions and performance evaluations must clearly integrate cultural and linguistic competence functions and goals. Furthermore, staff accomplishments in this area must be highlighted and reinforced (Jackson, Fisher, & Green, 2014).

A final strategy for helping meet the needs of children and youth in residential treatment includes establishing partnerships with key external supports, such as relevant cultural and ethnic community groups to which children, youth, and their families can be connected to support their stay while in residence and to facilitate transition upon discharge. Such efforts support the ongoing development of a strong ethnic identity, which itself serves as a protective factor against potentially damaging social biases and discrimination (Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003).

> *"They tell us when we get here that if we need any accommodations, we will be accommodated."*
>
> *— Residential Treatment Client*

While Kinark has implemented diversity training and education for staff, and has formed partnerships with community organizations and services to increase religious, cultural, ethnic and linguistic awareness, there is more to be done. In 2014, Kinark first surveyed the diversity of our entire staff group. This survey established a benchmark for a diversity profile of our 850 employees and was used to direct training needs for specific areas in which a need for professional development was identified among respondents. Kinark is in the process of further developing the key competencies, including cultural competence, required in our job descriptions. These standards will inform recruitment and hiring decisions, and will be used to measure and evaluate performance.

6. Individualized and appropriate programming to match the needs of the youth

KEY POINTS

FUNDAMENTAL PRINCIPLE

A standardized assessment framework is required to identify the appropriate individualized treatment requirements unique to each child and youth, aggressively targeting factors that will swiftly facilitate community reintegration within a treatment milieu that is structured, strengths-based, and youth-guided.

- Milieu-based interventions should be grounded in sound theoretical rationale and developmental principles with knowledgeable and well-trained staff.
- Engaging the child or youth in shared decision making and problem solving is essential at both the direct care and organizational levels in order to enhance self-efficacy, buy-in, and engagement among children and youth, which in turn lead to better functioning and overall outcomes.

Research has demonstrated that a discontinuity exists between the mental health needs of children and youth and the services provided to them (Burns & Friedman, 1990; Julian, Julian, Mastrine, Wessa, & Atkinson, 1992). Specifically, residential treatment programs often use a "one-size-fits-all" treatment and milieu management style, regardless of the levels and types of need among clients (Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998).

Individualized assessment and treatment of youth's clinical needs

To ensure that the individual needs of children and youth are met, a standardized assessment framework, as described previously, is required at each intake. Such assessments function to identify the appropriate treatment requirements of each client, targeting risk factors and strengthening protective factors. The need principle states that the risk factors amenable to change (as opposed to static, historical risk factors), such as antisocial attitudes, antisocial peers, antisocial personality, poor familial relationships, and low educational or vocational achievement, are appropriate targets for intervention and should be systematically assessed in order to inform an individualized treatment plan. In addition, children and youth in residential care have been found to have high rates of emotional disorders as well as histories of trauma and suicide risk (Zelechoski et al., 2013; Duppong Hurley, Wheaton, Mason, Schnoes, & Epstein, 2014). We know that strong predictors of future suicide attempts are previous attempts or ideation (Handwerk, Larzelere, Friman, & Mitchell, 1998); it is therefore imperative that this risk is thoroughly assessed and mitigated through safety planning and intervention efforts. Assessment only at admission may not be sufficient for predicting suicide attempts and, to better identify suicidal intent, staff must pay attention to important events and mood changes for all children and youth in residential settings (Handwerk et. al, 1998). An active suicide prevention protocol is essential to keep children and youth safe while in residential settings.

Trauma is another important area that requires concentrated assessment and individualized intervention. A significant proportion of children and youth in residential settings have a trauma background (Hummer, Dollard, Robst, & Armstrong, 2010) and are often retraumatized by multiple failed placements in out-of-home and/or residential treatment programs. Frequent school and peer changes are also contributors (Stewart, Leschied, den Dunnen, Zalmanowitz, & Baiden, 2013). Trauma-informed care is essential to directly address complex trauma in these children and youth, as well as to ensure that the milieu does not have the unintended consequence of retraumatizing the client or triggering traumatic reenactments (American Association of Children's Residential Centers, 2014). Individual and milieu interventions should focus on achieving safety in one's environment, skill development in the area of emotion regulation, and enhancing resiliency and protective factors (Hummer et al., 2010).

When considering the intervention framework of a residential treatment program, attention must be paid to the appropriate length of stay. There is evidence to suggest that unnecessarily long lengths of stay in out-of-home group care can cause institutionalized behaviour, including greater risk taking, poor educational achievement, disengagement from positive peer influences, and social isolation (Altshuler & Poertner, 2001). Given financial pressures in the system, the high cost of 24/7 residential care, and the limited availability of residential treatment beds, reducing lengths of stay for any particular client is advantageous. However, there are no evidence-based benchmarks in the literature that offer insight into the appropriate length of stay in residential treatment.

Traditionally, treatment philosophies have centred on the idea that treatment continues until all symptoms are resolved (Leichtman & Leichtman, 2001); however, this view perpetuates unnecessary lengths of stay. Alternatively, assessments must be used to determine which of the client's problems are most salient and intervention efforts must target these problems aggressively rather than allowing treatment to unfold at an easier pace. Goals for treatment must be modest, tightly targeted at community reintegration, and not intended to "cure" the child or youth of all problems. The primary aims during a residential treatment stay should include stability, essential skill building, preparing the child or youth to continue the therapeutic work in a less costly setting, and moving to a less restrictive treatment option within the continuum of care. This approach neccesarily includes helping the family manage and support the ongoing treatment work that will be required once the child or youth returns home. Hence, it is essential that discharge plans be developed early and concurrently with the initial treatment plan, which includes outlining the required treatment elements within the entire continuum of care for the child or youth.

Structured but normative therapeutic milieu setting

Once a child or youth is placed in a residential treatment setting, he or she will interact on a daily basis with other complex-need individuals. It is incumbent on the residential treatment program to determine the structure and nature of these interactions, with the ability to swiftly manage any potential conflicts. Furthermore, ensuring all children and youth are supported in their individualized treatment plans within the 24/7 milieu is paramount.

There is little evidence in the literature related to milieu best practice in residential treatment programs, however, there is consensus about the tremendous importance of what Trieschman, Whittaker and Brendtro (1969) call the "other 23 hours" outside of individual therapy. Some argue that the milieu itself is the treatment, while others view the milieu as a treatment facilitator. As Paul (2000) put it, milieu therapy is "treatment by the environment" (p. 251). If the environment is stable and safe, it is more likely to serve as a supportive structure for the residents (Crouch, 1998; Lyman & Campbell, 1996). Rosen (1998) emphasized the importance of safety, and suggested that if children and youth do not feel safe in a residential treatment centre, it may exacerbate issues of their home environment, where the child or youth may not have been safe. Other factors, including establishing clear boundaries, consistency, and nurturance, have also been identified as necessary for a therapeutic milieu to be therapeutic (Lyman & Campbell, 1996).

Points and level systems are designed to control clients' behaviour through the rewarding of points for approved behaviour and the removal of points for violations of rules or unwanted behaviour. Points are recorded daily and periodically assessed to determine the client's earned level. Levels have stipulated privileges associated with them. The greater the net number of recorded points translates to a higher level, which awards more privileges.

— VanderVen, 1995

Over the history of residential treatment, there have been a variety of milieu strategies developed and implemented. Behaviour management strategies, including token economies and level systems, have become commonplace. However, recent literature has demonstrated detrimental effects of "point" and "level systems" within residential settings due to their punitive nature, negative focus, lack of individualization, and the impracticability of transferring the strategies to the home environment (Drumm et al., 2013; Mohr, Martin, Olson, Pumariega, & Branca, 2009; Affronti & Levison-Johnson, 2009).

"Level systems should not be happening. Everybody should be treated according to their needs."

— Residential Treatment Client

Structure, along with predictability, have been shown to be positive attributes for residential treatment models, especially for children and youth with trauma backgrounds (Briggs, Greeson, Layne, Fairbank, Knoverek, & Pynoos, 2012). Rather than demanding conformity to externally-imposed control, the primary goal of the residential treatment milieu, other than safety, should be the encouragement and promotion of self-control in the child or youth (Levin, 2009).

In addition to shifting the milieu programmatic focus away from control, there is consensus in the literature that programming and interventions adopt a more strengths-based model. Griffin and colleagues (2009) evaluated risk factors and strengths in a population of traumatized children and found that strengths had a large moderating effect on behaviour and that the more strengths the child developed, the less likely he or she was to engage in high-risk behaviours. Similarly, Lyons, Uziel-Miller, Reyes, and Sokol (2000) determined that building strengths for children in residential treatment programs, such as sense of humour, ability to enjoy positive life experiences, and having a strong relationship with a sibling, improved overall functioning

independent of any reduction of diagnostic symptoms. Thus, focusing only on clinical problems is not adequate and a stronger concentration on strength building is key within the overall treatment approach of a residential treatment setting.

James (2011) reviewed popular treatment models within group care and residential treatment settings, largely as they pertained to children involved in the child welfare system who presented with high needs. Due to the variability in client population, including age range, treatment approach, lengths of stay, services provided, and targeted outcomes, aggregating all data to determine program effectiveness was deemed inappropriate. However, several treatment components were identified as important ingredients. These included short-term lengths of stay (from three months to one year), an adult-mediated treatment model as opposed to a peer-mediated model, and a unifying and consistent treatment approach.

It is crucial that milieu-based interventions are based on sound theoretical rationale and developmental principles. Staff within the milieu should be able to explain why they intervene with a client in a particular way and why the intervention should work (Johnson & Hauser, 2001). To do this, staff are required to have well developed assessment skills and knowledge of milieu intervention techniques, including interventions that target maladaptive and dysfunctional behaviours, cognitions, and emotions (Delaney, 2006).

A recent independent review of one of Kinark's residential treatment programs touted the use of a defined treatment approach within the residential milieu, citing the following:

- *A defined treatment approach uses a **common language** that staff are able to learn and apply consistently regardless of who is on duty;*
- *A defined treatment approach brings **belief in the value of the therapy**, when observable, positive change within individuals occurs as a result of exposure to the approach;*
- *A defined treatment approach offers **structure and consistency** for each resident;*
- *A defined treatment approach places **emphasis on the individual's role** in reaching success. In the case of Dialectical Behavioural Therapy, this means an emphasis on self-control, stress tolerance, emotional regulation, mindfulness, being in the moment, avoiding multi-tasking and working on interpersonal relationships;*
- *A defined treatment approach **strengthens frontline staff team dynamics** and provides a sense of unity. This was most evident at the Vanier site; and*
- *A defined treatment approach usually comes with **specific training, tools, incentives, templates and evidence-based assurances** that the approach being taken will bring the desired changes or outcomes. This increases the confidence levels of staff and allows them to be proactive in their responses.*

— PMG Consulting/Angela Byrne Consulting, 2015

With respect to the physical environment, some literature has provided suggestions related to ideal space arrangements, size, and appearance (e.g., AACAP, 2010). A normative environment will facilitate transition for the child or youth. This includes supporting practices that promote

integration into the community and facilitate access to the community as much as possible, developing opportunities to pro-socially interact with positive peers in the community, and encouraging the use of phone and social media technologies that connect the client with their family and peer networks.

Evidence-based practice in residential settings

Children's residential treatment has come under increased scrutiny for its lack of use of evidence-based practices, lack of measurement of outcomes, and inability to demonstrate positive outcomes (Butler & McPherson, 2007; Hair, 2005), however, research on the implementation and effectiveness of evidence-based practices in residential treatment is scant. There are no randomized control trials (RCTs) from which to draw strong conclusions. As a proxy to RCTs of residential treatment programs, one can separately examine individually-based interventions from milieu-based interventions, though it is clearly advantageous for both to operate on harmonious and consistent principles. Accordingly, the evidence below should be interpreted with caution when applying to residential practices.

Individually-based interventions focus on the specific presenting problems of the individual, such as trauma, depression, and anxiety. Delivering these sorts of interventions via clinicians working individually with residential children and youth is cost-effective and considerably easier to implement than changing the orientation of an entire treatment milieu. James, Alemi, and Zepeda (2013) reviewed research on individually-based interventions used in residential treatment care and found only 13 eligible studies that reported on 10 interventions. The interventions varied with respect to treatment approaches and, overall, the studies reported significant improvements in such areas as program completion, trauma, depression, aggression, substance abuse, and family functioning. However, due to "considerable bias," significant "methodological weakness" and "lack of methodological clarity," results are considered by James to be preliminary at best.

James' (2011) review of milieu-based interventions yielded no better results. Despite using stringent inclusionary criteria and identifying five residential treatment models developed specifically for residential youth, James' review "indicated a painfully small knowledge base considering the decades that some models have been in existence" (James et. al., 2015, p. 151). He concluded that the research is far too weak to make a recommendation for any one milieu treatment model.

While organizations invested in improving quality would benefit from guidance on which intervention model is best to implement in residential treatment facilities, more rigorous research is clearly required to determine the effectiveness of both individually-based and milieu-based interventions in residential treatment care.

Youth-guided care

Youth-guided care is a core concept in the system of care approach (Stroul & Friedman, 1996) and is an essential framework for all children-and-youth-serving systems. The Substance Abuse and Mental Health Services Administration of the United States (SAMHSA) defines youth-guided care to mean that "youth are engaged as equal partners in creating systems change in policies and procedures at the individual, community, State and national levels" (SAMHSA, 2013).

Organizations that develop and implement youth-guided strategies enhance self-efficacy, buy-in, and engagement among children and youth which, in turn, leads to better functioning and overall outcomes (Lulow, Harrington, Alexander, & Kendrick Burk, 2014). Empowering youth to be equal decision makers in their own treatment is particularly important in health-related fields, including residential treatment programs, where traditional structures have created inherent power differentials between youth and caregiving adults. Supporting this activity has been recognized in the literature and by the Canadian government, which has developed the Centre of Excellence for Youth Engagement (CEYE, 2009).

Perceived self-efficacy is defined as a belief in one's ability to produce a desired effect in one's own life; it is a strong determinant of how one feels, thinks, gets motivated, and behaves (Bandura, 1994). There is a strong research base supporting the notion that an increase in perceived self-efficacy significantly improves a person's functioning (Schwarzer & Luszczynska, 2005). Therefore, integrating children and youth as important partners in all aspects of residential operations supports them in developing a higher sense of self-efficacy, which in turn enhances their sense of accomplishment and personal well-being.

> People with high assurance in their capabilities approach difficult tasks as challenges to be mastered rather than as threats to be avoided. Such an efficacious outlook fosters intrinsic interest and deep engrossment in activities. They set themselves challenging goals and maintain strong commitment to them. They heighten and sustain their efforts in the face of failure. They quickly recover their sense of efficacy after failures or setbacks. They attribute failure to insufficient effort or deficient knowledge and skills which are acquirable. They approach threatening situations with assurance that they can exercise control over them. Such an efficacious outlook produces personal accomplishments, reduces stress and lowers vulnerability to depression (Bandura, 1994).

To embrace and implement youth-guided practices and cultures in residential treatment programs, it is important to assess the organization's current state. Roger Hart (Fletcher, 2011) developed a model called "Harts Ladder" in 1969. This model has been adopted and further developed by CEYE, termed "The Level of Youth Engagement," and is an important tool in helping organizations understand the nature of "authentic" youth participation and youth engagement. Use of this model can help organizations develop goals and strategies to become more youth-guided. According to Brown, Allen, Barrett, Ireys, and Blau (2010), residential treatment programs that promote equality and engage young people in higher levels of participation share a number of common practices such as:

- strength-based individualized treatment planning;
- integration of family members;
- preservation of family relationships through regular family visiting;
- collaboration with community-based providers to connect children and youth with home and community-based services and supports;
- mentoring children and youth, as well as peer-to-peer mentoring; and
- participation of youth in oversight activities, such as agency advisory boards, management, staff training and hiring, and quality assurance reviews.

To be youth-guided, concerted efforts must be made at the individual, organizational, and systems levels. Lulow et al. (2014) offer the following suggestions:

- At the individual level, each youth and family must be involved at the referral and intake stages; they must have a full understanding of the services and options available to them, thus enabling them to make decisions about the care they receive;
- Intervention and discharge plans need to be individualized, with youth and families engaged in all aspects of the goal-planning process;
- A strong emphasis should be made on spending time with family and friends in the community; intervention efforts in the milieu should be strength-based, non-hierarchical, and provide a large amount of validation;
- The key is respecting the youth's voice when arriving at mutually acceptable decisions and teaching the youth to engage in a similar fashion with adults;
- Similarly, clinical intervention practices must also be consistent with youth-guided principles; and
- Collaborative, person-centred approaches that involve engaging youth and families in dialogue from which they learn to solve problems are favoured.

At the organizational level, having youth peer support and/or youth advocate staff who have had experience in similar service-delivery systems enhances buy-in to program activities and helps improve the self-efficacy of residents. These peer supports can be a part of the intake process to provide program descriptions and expectations to admitted children and youth. They can also function to facilitate conversations between residents and staff and assist in the development and implementation of youth-centred activities. Allowing youth to participate on boards and committees is key at the organizational structure level, as well is developing a youth advisory council to give children and youth a voice and engaging them as agents of change.

Given that youth-guided means that children and youth are involved at all levels of decision-making, it is important for children and youth to have a voice in the community and engage in greater system involvement. Allowing children and youth to take an active role in informing community leaders of important issues that affect children and youth in the system and to develop leadership skills are critical. This is exemplified at Kinark by the adoption of a stakeholder engagement policy. The purpose of this policy is to ensure that communication and participation processes for employees and external stakeholders are consistent across the agency and meet MCYS expectations for family and youth engagement and Canadian Centre for Accreditation standards of youth engagement.

7. Seamless transition and integrated after-care

KEY POINTS

Preparation for transition out of residential treatment is an essential element of the individualized treatment plan and includes integrated after-care that supports family/caregiver reunification and community re-integration.

FUNDAMENTAL PRINCIPLE

- Transition planning needs to occur at the onset of the residential treatment stay and include commitment from community partners and the caregiving system.
- Transitional support services and integrated after-care needs to be recognized as integral to successful outcomes for residential children and youth and funded accordingly.

Many residential treatment programs appropriately focus on skill development in the areas of self-control, daily living, and healthy relationships within the milieu. Existing research suggests that therapeutic residential programs produce positive gains in adolescents while they are in the residence, however, the limited follow-up research available shows that these successful changes are seldom maintained after discharge (Frensch & Cameron, 2002; Kirigin, Braukmann, Atwater, & Wolf, 1982). Residents who are placed in a good quality treatment program flourish in the safe, structured, and therapeutic milieu but often struggle once removed from this environment. Leichtman and Leichtman (2001) offer a number of explanations for this finding. First, children and youth who access residential treatment programs present with chronic and severe psychopathology that are resistant to change and may require longer-term intervention than the residential treatment placement offers. A second explanation is related to the environments to which children and youth return. Such environments are often characterized by poor social conditions, particularly family pathology, which is frequently the main contributor to the resident's problem development. Children and youth are therefore re-subject to these problematic conditions, leading to recurrence of the original pathology. Another reason for poor long-term results lies with the fact that treatment gains need to be maintained by good continuing treatment and supports, which are often difficult to secure.

Each of these explanations points to the importance of preparing children and youth for life beyond residential treatment. Preparation includes individualized treatment plans targeting individual skills building, family functioning, and community integration, as well as supporting families to gain the necessary skills they need for reunification, allowing regular opportunities for community visits, and providing time-limited treatment that promotes community re-integration.

> One major implication in the studies reviewed is that residential treatment represents an event within a larger process, a disruption of the usual adaptive process that occurs between a child and his or her environment. This disruption may well be justified when the adaptive process has been impaired, and extremely valuable learning and development may occur in the residential centre. But placement in residential treatment is not likely, in itself, to lead to good future adaptation. **In order for the placement to have optimal results, support for the child in the future environment must be enhanced** (Curry, 1991, p. 352).

Engaging in community activities should be an integral part of the residential treatment program to enable children and youth to develop their psychosocial skills and gain confidence in their ability to manage in the community. Further benefits include easing the transition out of the residential facility by promoting comfort in a community setting, allowing staff to identify and treatment plan for psychosocial problems not able to be presented within the confines of the residential setting, exposing children and youth to expectations of authority figures other than the staff or parents (e.g., teacher, employer), fostering prosocial relationship building, and enabling children and youth to remain integrated in their home communities (Leichtman & Leichtman, 2002: Nickerson et al., 2007).

> *Residential care should be as close to home as possible in order to preserve all available family and community connections. This effectively lays the foundation for a community of support post-residential intervention.*
>
> *— Nickerson, Colby, Brooks, Rickert, & Salamone, 2007*

> *"I am glad I'm being connected to other programs and supports that will carry on when I leave."*
>
> *— Residential Treatment Client*

Once residents are settled and determined to be safe and ready for community participation, integration activities should be promoted in such areas as spiritual needs, specialized treatment (e.g., substance abuse), recreation, and education, beginning in a modest manner and monitored carefully. As residents demonstrate their ability to manage appropriately, more frequent exposure is warranted, particularly nearing the transition phase of treatment (Leichtman & Leichtman, 2002).

> *"I am worried about less support from staff when I leave treatment."*
>
> *— Residential Treatment Client*

> *"Transitions need to be individualized. They can be very hard."*
>
> *— Residential Treatment Client*

A discharge-related intervention and transition plan that is carefully prepared early in treatment is crucial and must include ongoing support for the client transitioning out of the residence as well as for the receiver of the client, whether it be the family or another caregiver. In one of its residential programs, Kinark has piloted the addition of a child and youth worker to support residents and their families during visits to the home, particularly over the weekend. The role functions to support the development and practice of skills and interactions that are consistent with treatment goals and interventions practiced in the residence. Additionally, residents and their families are provided intensive in-home support for a period of time following discharge.

A key challenge in Ontario is the current residential treatment system's insufficient recognition and resourcing of appropriate transitional support services. Generally, funders and providers have not recognized the importance of transitional support and aftercare as a part of a comprehensive and effective residential program (Leichtman & Leichtman, 2001). Yet, research

has demonstrated the effectiveness of transitional support work, including the implementation and coordination of wrap-around community-based services post-discharge, to significantly contribute to success and positive outcomes within a variety of effective residential programs (Hoagwood & Cunningham, 1992). This is considered one of the biggest limitations of residential treatment. Per the example of the additional child and youth worker at Kinark, described above, there is no designated funding within the residential program budget. In practice, this means that services are subsidized from mental health dollars designated for other children, thus, the provision of transitional support to children and youth in residential treatment comes at the expense of the delivery of other core services and waitlisted clients.

As research has demonstrated that a large proportion of children and youth are readmitted to a hospital inpatient or residential treatment setting within the first three months of discharge (Simon & Savina, 2005), it is of critical importance that the ongoing treatment needs are clearly understood and services, supports, resources, and connections are firmly in place well in advance of discharge. For example, a youth discharging from residential treatment to family should have already met with a therapist and/or psychiatrist in the community and been involved in a number of home visits supported by the residential staff who have modeled nurturing and effective discipline in the home. Families would have already taken part in skill building and other relevant treatment interventions themselves, with a plan for ongoing support. Fairhurst (1996) suggests strategies such as these for successful continuity of care.

Continuity of care should be initiated by residential treatment staff well in advance of discharge. Strategies include:

- *Assisting families in obtaining needed services and supports;*
- *In-home staff support during home visits, modeling nurturing and discipline;*
- *Planning recreation activities with the family;*
- *Helping families connect to a new therapist and other supports;*
- *Validating the families' efforts;*
- *Organizing and mobilizing families' existing support systems; and*
- *Rewarding families for gains made post-discharge.*

— Fairhurst (1996)

Transferring gains from a residential treatment setting back into the community is challenging and requires clear coordination among the residential treatment facility and community services, particularly schools, medical care, and other service support providers. Nickerson and his colleagues (2007) evaluated the implementation of a transitional process in a residential treatment home that included key strategies, such as skill building for youth while in residential treatment program, family involvement in treatment planning, educational support, and community engagement prior to and throughout the discharge process. Despite overall positive perceptions of the transitional process among staff, youth, and families, it was clear that additional work was necessary, such as increased family education, post-discharge follow-up, and better communication between the residence and community providers, including schools. This study underscores the importance of transition planning and aftercare; however, it also highlights the challenges from an implementation perspective. In a plan to redevelop Ontario's residential treatment system, it may be important to explore which type of provider is best positioned to effectively provide aftercare - the residential provider or others within the continuum of care.

While the supports noted above in the Kinark Peterborough program are helpful, there continues to be inconsistent capacity across the agency in providing the supports required for seamless transition and integrated aftercare. Kinark is making steps toward improving this situation by implementing a new system of intake and assessment accompanied by a new approach to case management and the provision of therapeutic interventions. Using existing resources and funding, Kinark is shifting to a model in which clients will be provided with a consistent case manager from intake to discharge, regardless of the length of time or services they require. Our goal is to provide continuity of care and competent navigation and guidance throughout their treatment at Kinark. Such a model is intended to address the previous shortcomings of transition and discharge from our residential programs. Having a consistent case manager should aid in the client's preparation for discharge, return to their home/ community, and establishment of aftercare support and resources.

8. Connected residential and community partners in care

KEY POINTS

FUNDAMENTAL PRINCIPLE

Residential treatment is a component within a continuum of care that needs to integrate with programming offered by community partners, with an identified primary care provider responsible for the coordination of services and the overall treatment plan.

- Residential treatment is best used as a targeted, short-term, and intensive intervention and support option that serves to diagnose, stabilize, and triage to less restrictive community care providers.
- An integrated treatment plan requires the cooperation and coordination of the children's mental health, health, education, youth justice, and child welfare systems.

Historically, community-based residential treatment has operated, to some degree, in isolation and at a distance from other community partners who are involved in the care of the youth and their families. This separation can contribute to fragmentation within the system of care. Residential providers can feel unsupported by their community partners who have used the resource as a destination rather than an intervention that continues to require the sustained involvement of the entire system of care (Levison-Johnson & Kohomban, 2014). Residential providers then find themselves working in isolation for the duration of the placement. This becomes particularly problematic at the time of discharge, when it is necessary to work intensively with the community receiver and associated supports. Conversely, community-based providers may be reluctant to receive a youth back to the community as they have been detached from the treatment plan and may lack confidence in the effectiveness of or their ability to sustain residential treatment outcomes (Harrington, Williams-Washington, Caldwell, Lieberman, & Blau, 2014).

To successfully integrate residential and non-residential community-based programming, it is imperative that there be a shared understanding of when a residential treatment placement is appropriate and what the treatment program intends to achieve (Levison-Johnson & Kohomban, 2014). As a critical component of the required continuum of family- and community-based intensive interventions for children and youth with complex needs and their families, residential treatment must be reconceptualized as a "targeted high-efficacy (and high cost) emergency intervention that diagnoses, stabilizes, and triages" (Levison-Johnson & Kohomban, 2014, p. 98), much like a hospital emergency room is available as a treatment and support option within a broad and long-term treatment plan.

To guarantee appropriate services and placement for complex needs children and youth while ensuring continuity of service for families before, during, and after a residential intervention, a primary care provider, or case manager, must be responsible for the coordination of services and the overall treatment plan (Levison-Johnson & Kohomban, 2014; Lourie & Katz-Leavy, 1991). Stroul and Friedman (1996) identified several factors that contributed to the inadequate response of the system to the needs of challenging children and youth. Such factors include a lack of clarity regarding the service agency that was ultimately responsible for the client, agencies that have not had experience working collaboratively with each other, inappropriate professional attitudes, and failure to advocate on behalf of child and youth mental health services. Barriers to coordination such as these have led to the conclusion that case management is an essential mechanism to ensure comprehensive and integrated services that respond adequately to the needs of children, youth, and their families (Illback & Neill, 1995).

Case management is the coordination of services for individual youth and their families who require services from multiple providers. Case managers can assume a number of roles. Moxley (1989) delineated the primary functions of a case manager that are necessary for good system care, including assessment of client need, planning, intervention, monitoring, and resource development. These are conceptualized according to the needs of a client in residential treatment, presented in Figure 4.

FIGURE 4. CASE MANAGEMENT FOR CLIENTS IN RESIDENTIAL TREATMENT

Assessment of Client Need
Conducts a comprehensive evaluation of the client's strengths and needs, the client's social network, and the informal and formal service providers and their capacity to respond to the needs of the client.

Planning
Using the results of the assessment, develops a comprehensive community/service plan.

Intervention
Links clients to providers, acts as a broker of services, and advocates for client needs.

Monitoring
After the client has been linked to services, continues to monitor the status of the client and the services provided and evaluates the client's progress toward accomplishing the objectives of the treatment plan.

Resource Development
Maintains an awareness of ongoing community programs and their impact on the service needs of the client, and works to develop new resources as required.

Several studies demonstrate that case management contributes to improvements in children and youth's positive adjustment, family functioning, and stability of community living environments (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). In addition, the use of case managers has been shown to reduce the likelihood of future psychiatric hospitalization admissions (Burns, Farmer, Angold, Castello, & Behar, 1996; Evans, Armstrong, & Kuppinger, 1996), residential treatment placements (Potter and Mulkern, 2004), the number of foster care placement changes, as well as the number of elopement episodes (Hoagwood et al., 2001). Other studies have found that case management services result in lower delinquency rates and improved emotional and behavioural adjustments (Clark, Lee, Prange, & McDonald, 1996).

With an identified case manager in the community fulfilling all of the functions suggested by Moxley (1989), communication and integration of the various service providers will be facilitated. In addition, insisting on high and ongoing involvement of family in the child or youth's treatment, as well as promoting consistent community engagement (previously presented), will serve to enable a more integrated plan. Maximizing this integration requires cooperation and coordination of the child and youth mental health system with the health, education, youth justice, and the child welfare systems. Embodied in these systems are ideological, political, and philosophical differences which are historical in nature and are perpetuated by inequitable funding and arbitrary regional boundaries. Systemic linkages are critical in order to best meet the needs of children and youth.

> Establishing partnerships that link efforts between all providers, inclusive of residential and community, while collaborating as equals with the youth and family, helps create a shared vision of what success should look like and creates a shared responsibility to achieve positive long-term outcomes (Blau, Caldwell, & Lieberman, 2014, p. 223).

Across Kinark' large catchment area, we experience significant variability in the capacity of communities to establish effective and seamless service partnerships. Developing and establishing supports and resources for children, youth, and their families following discharge from one of our residential treatment programs often depends upon where one lives rather than your needs. From a resource perspective, we see great variation in resources and supports available to our clients in the rural areas versus the urban/suburban locales. Often children and youth in smaller and more remote regions are put on waitlists for services or have difficulty accessing them due to proximity. Where we have found success is in the establishment of protocols and/or agreements for the prioritization of clients between or among service providers. Often these protocols/agreements allow for such clients to move to the "front of the line" in accessing supports.

9. Performance measurement

KEY POINTS

FUNDAMENTAL PRINCIPLE

To ensure that services and interventions for children and youth in residential treatment are effective, it is imperative that service providers develop and implement systems for defining and measuring organizational performance and client outcomes.

- Performance at both the organizational level and the person level should be measured.
- A common set of performance indicators across the residential treatment sector should be developed and implemented.

To ensure that services and interventions for children and youth in residential treatment are effective, it is imperative that service providers are supported to develop and implement the measurement of program performance and client outcomes. Referred to as *performance measurement*, this process involves the systematic collection and analysis of information for the purposes of measuring progress toward specific organizational goals (Adair et al., 2003). Within the US mental health care sector, performance measurement systems are used to gauge the efficacy and effectiveness of programs and services, as well as the extent to which best practices and supports are in place to facilitate treatment efforts (American Association of Children's Residential Centers [AACRC], 2014). However, there is no such system in Ontario or nationally. This is an area for significant future development.

The four broad categories of performance measurement specific to residential treatment identified by the American Association of Children's Residential Centers (AACRC) provide a useful framework for determining priorities and guiding the development of performance indicators (AACRC, 2009). The first two – *process* and *organizational indicators* – are organization-centred and measure clinical and direct care practices, as well as the supports required to deliver treatment. *Functional outcomes* and *perceptions of care* indicators, on the other hand, are person-centred. These measures are intended to capture outcomes and perceptions of residential youth, families, and the community. Examples of indicators for each of the four categories, as described by AACRC (2009), are presented in Table 3.

TABLE 3: FRAMEWORK FOR THE DEVELOPMENT OF PERFORMANCE MEASUREMENT INDICATORS FOR RESIDENTIAL PROGRAMS

CATEGORY	EXAMPLES
ORGANIZATION-CENTRED	
Process indicators: Measure processes and practices of care that occur in the course of residential treatment.	• Areas of risk (e.g., seclusion and restraint, medication management, elopements, incidents, and injuries) • Dimensions of family and client involvement (e.g., family inclusion in the milieu, client participation in treatment, parent contact) • Continuum of care (e.g., access to services and supports, participation of community partners, continuity of care, timeliness and comprehensiveness of diagnostic assessments, and discharge planning
Organization indicators: Measures of organizational phenomena that directly affect quality of care.	• Staff retention • Job satisfaction • Work environment • Fiscal performance • Safety programs
PERSON-CENTRED	
Functional outcomes: Measures short- and long-term change in the client's level of functioning as a result of the intervention.	• Severity of symptoms • Safe and stable living environment • School performance • Legal involvement • Peer relationships • Physical health and well-being • Meaningful daily activities
Perceptions of care: Experience and satisfaction of clients, families, and the community regarding the services provided.	• Benefits of treatment • Experiences and learnings • Overall improvement

Source: AACRC (2009)

Given that the purpose of residential treatment is to achieve positive and sustainable outcomes for children and youth (Dougherty, Strod, Fisher, Broderick, and Lieberman, 2014), implementing a performance measurement system that captures short- and long-term functional outcomes is crucial. Yet the collection of valid and reliable data that measure outcomes, particularly in the long-term, is a challenge in the residential care sector. Accessing information about children and youth following their exit from a residential facility is a challenge; the cost associated with data collection and analysis can be an enormous barrier for some organizations, and factors outside of treatment that contribute to client outcomes must be taken into consideration (AACRC, 2014). These issues must be carefully considered when designing and implementing a performance measurement system.

In spite of these challenges, performance measurement is critical to the success of residential care as an intervention for children and youth with severe and complex mental health needs. Residential programs that measure long-term outcomes “are better prepared to assess how changes in their own practices can improve outcomes post-discharge. They are also better positioned to articulate their value in a system of care and respond to changes in the health-care and youth and family servicing systems” (Dougherty et al., 2014, p. 183). It is therefore incumbent upon service providers to collect and use valid and reliable data that measure performance. Such data provide valuable insight into an organizations progress toward goals, as well as areas for which improvements are needed.

The Ontario context

The adoption of a performance measurement system has implications for ensuring and demonstrating the efficacy of a residential treatment program. In its *Child and Youth Mental Health Service Framework* (2013), MCYS outlines a series of expectations for residential treatment settings, which includes requirements related to the:

- target population;
- availability of service;
- legislative/regulatory compliance;
- planned and transparent admission process;
- interdisciplinary treatment process;
- client-focused, strength-based approach;
- normalized treatment environment/program;
- structured, individualized interventions;
- positive and safe approach to crisis intervention and monitoring;
- continuity of staffing; and
- planned discharge to support successful transitions.

At present, there are no performance measurement indicators specific to residential treatment within the children’s mental health sector. Furthermore, there are limited expectations for residential treatment providers in Ontario to develop, implement, collect, or disseminate performance indicators.[1] Many of the expectations outlined above, however, are well-suited to data collection and performance measurement. It would therefore be of benefit to use these expectations as a guide to the development of a common set of performance indicators that can be implemented across the residential treatment sector.

[1] While the Ministry requires regular reporting in a variety of areas, such as days of care and staff hours, such data are not indicators of performance.

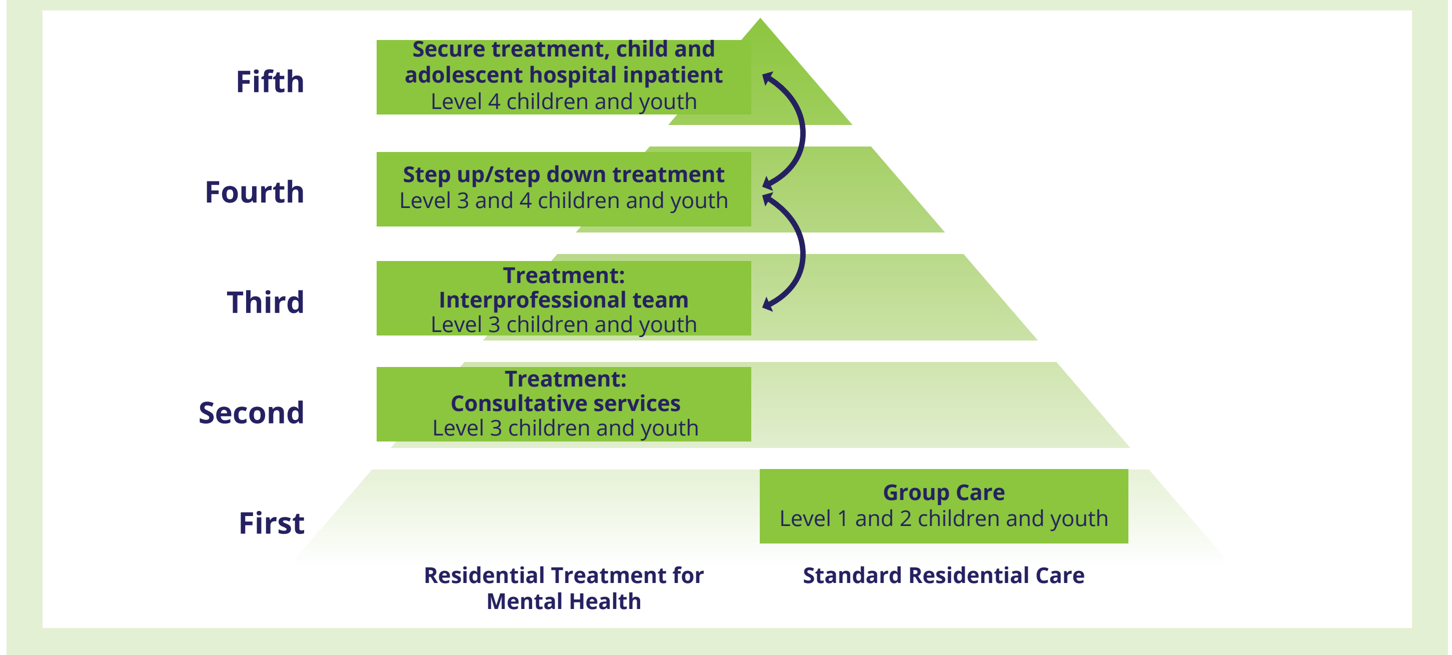
Where to From Here

The task of redeveloping the current Ontario residential treatment system to become more responsive, effective, coordinated, and appropriately positioned within the broader continuum of mental health services for children and youth is considerable and potentially daunting. There have been a number of efforts over the last several decades to strengthen Ontario's system of residential services. None have resulted in tangible and sustainable improvement. While there may be a number of reasons for this, undoubtedly one is the size and complexity of the challenge that is posed. Mindful of this, we propose an approach to change that focuses initially on two key change strategies: the introduction of a multi-tiered system of residential services and an exploration of alternatives to residential treatment. These two approaches arise from the synthesis of three decades of research detailed in this paper and the experiences of residential providers and other parts of the child and youth-serving system. We believe that the grounded and focused nature of this approach to change can be used to begin building a stronger system of services immediately, as well as to gain momentum over time.

Introduction of a Multi-tiered System of Residential Services

In proposing a shift to a multi-tiered system of residential care, the key goal is to differentiate services with the intention of appropriately matching services with the needs of Ontario's children and youth. In the current, largely undifferentiated system, children and youth must fit into the services that providers have built and government has agreed to resource. In Figure 5, below, a five-tiered system of residential services is proposed. These tiers are described in terms of their

FIGURE 5. PROPOSED MULTI-TIERED RESIDENTIAL SYSTEM



alignment with MCYS's pyramid of mental health needs (Levels 1 to 4) and differentiated on the basis of clinical resourcing and the capacity to safely manage children and youth with challenging and risky behaviours.

Static containment refers to the residential facility's physical environment and its capacity to provide a safe environment, as determined by such factors as the perimeter, security, and line of sight observation.

Dynamic containment refers to the capacity to provide varying degrees of monitoring and supervision that is commensurate with the needs of individual clients, typically through heightened or reduced monitoring by staff.

The first tier is a residential group home that provides care for the basic needs of residents, such as food, shelter, and activities of daily living. Children and youth referred to this tier of service are not referred because they require mental health treatment, but because they require out-of-home placement. The second through fifth tiers provide mental health treatment in increasing intensity and complexity. The second tier provides care to children and youth who do not require high levels of risk management and whose treatment needs can be appropriately met through consultative services on an as-needed basis. Tier 3 has increased capacity to manage higher risk behaviours because monitoring and supervision can be adapted to the needs of individual clients and because some interprofessional clinical capacity is available. Fourth tier services are "step up/step down" programs that support clients to readily transition between a higher tier program (Tier 5) or a less intensive program (Tier 3). This tier offers dynamic containment and significant interprofessional capacity. Finally, Tier 5 is secure treatment/hospital inpatient unit. Tier 5 services have significant capacity to manage very challenging and risky behaviours through both static and dynamic containment and a high level of specialized interprofessional resourcing.

In this model, service providers would be licensed by government to provide residential services in one or more tiers. Children and youth would be referred to the appropriate tier of services, based on their needs, complexity, and risk. In practice, a residential program may be licensed to provide services on two or more tiers, thereby enabling children and youth to readily move between tiers as their assessed needs change. Licensed residential programs at all tiers will be distributed across the province based on the needs in the child and youth population, as they may change over time.

Evidence and experience suggest that the number of children and youth requiring residential treatment will be smallest at Tier 5 and will increase with each lower tier. Accordingly, the most intensive Tier 5 services will be required to serve a large catchment, perhaps in some areas of specialization. Tier 5 services could have a provincial catchment. This is analogous to the provision of health care more broadly, where there is general acceptance that primary care may be available in people's home communities but to access more specialized treatments, significant travel may be required. While having a provincial catchment for some specialized services means that services may not be physically located "close to home," particular attention will need to be paid to ensure that distance is not a barrier to family engagement and eventual reintegration to home communities. In all cases, consultation and communication among programs within and across tiers will be critical; clear clinical pathways must be established and maintained.

To be successful, a multi-tiered model of residential service will require a range of enablers, including appropriately differentiated licensing provisions, a performance measurement framework (as described previously), policy and operational shifts, as well as resources that are commensurate with the level of intensity of service.

Currently, provincial licensing standards and practices function to ensure that minimum standards be met within residential programs. While this serves to ensure that basic rights and safety measures are in place for children and youth in care, it does not address issues related to treatment quality and the unique needs of individual clients.

In addition, the present funding model for residential programs has not kept pace with inflationary growth in “bricks and mortar” and staffing costs. Historically, the capacity of residential treatment facilities in Ontario has largely been determined by the amount allocated by the province rather than need (Auditor General’s Report, 2008) and budgets have typically been based on expenditures rather than on actual costs of program delivery. Anecdotally, it is understood that many residential programs funded by MCYS operate at a deficit, drawing on dollars earmarked for other less expensive programs, private fundraising, and leaving beds unfilled to manage cost over-runs.

The implementation of system redevelopment that encompasses this paper’s identified critical success factors undoubtedly has resourcing implications in multiple domains, including location, physical plant, staff skill and capacity, specialized clinical resources, evidence informed programming, and safety. Work needs to be undertaken to understand the actual costs to implement the critical success factors. The development of a funding framework aligned with intensity of service and costed against critical success factors could provide a systematic and rational approach to funding levels. In some circumstances, it may mean reallocating existing resources to operate differently and more effectively.

Exploration of Alternatives to Residential Treatment

There is general agreement that, because of the intrusiveness and cost of residential treatment, its use should be reserved for those children and youth who are assessed as having the most complex needs and only when all appropriate and less intrusive interventions have been considered. It is crucial to note that this does not mean that residential treatment should be viewed as an “end of the road” intervention that is only used as a “last resort.” Rather, it means that admission to a residential treatment program should be one component of a carefully considered plan for which the benefits and risks to the client are the paramount consideration. To support this, it is critical that there be a range of intensive, non-residential treatment approaches that can effectively address the complex needs of children and youth while supporting them in their family or care settings.

The expansion of a menu of treatment programs and services that serve children and youth in their natural environments has the potential to reduce what some have framed as an over-reliance on residential treatment for children and youth with complex mental health needs. Additionally, as most non-residential interventions will be less expensive than most residential programs, a realignment of resources to less-expensive, intensive alternatives will likely allow more children and youth to receive more effective services more quickly and with a higher level of family engagement.

In the available literature, and in our own experience as a service provider, there are a number of programs and approaches for which some evidence of effectiveness has been demonstrated and documented. While some have not been designed or used explicitly as alternatives to residential treatment, they have been designed for children and youth who might be considered "at risk for" out-of-home placement. They are documented in this paper to provide a sense of the range of options that could be deployed to expand our system's alternatives to costly and intrusive residential treatment. Several examples are described below.

TABLE 4. ALTERNATIVES TO RESIDENTIAL TREATMENT

Wrap-around

The Wrap-around approach is a "philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes" (Burns & Goldman, 1999, p. 10). This approach is designed to help families, children, and youth with complex needs find solutions. Teams of family, friends and professionals are built and come together to "wrap" individual families in community supports. A Wrap-around facilitator tries to work as "glue" for the family, friends, community and services. A number of studies have demonstrated the efficacy of this approach. In the US, 15 studies across 10 states have shown reduced restrictiveness of living situations, reduced cost of care, lower delinquency and improvement in social, school, and community functioning (Burns & Hoagwood, 2002).

Multi-Systemic Therapy (MST)

This evidence-based program works intensively with youth and their families who present complex emotional, social and behavioural needs. These services are delivered in the natural environment (e.g., home, school, community) and provide 24/7 therapist availability with multiple family contacts occurring weekly for three to five months. The goals of the program include separating youth from deviant peer units, improving school or vocational attendance and performance, and developing natural supports for the family to preserve therapeutic gains. MST has been shown to reduce the number of psychiatric hospitalizations, arrest rates and out-of-home placements, and lower recidivism to juvenile correction facilities (Hoagwood et al., 2001).

Functional Family Therapy (FFT)

Functional Family Therapy is offered for three to five months in a clinic or home and targets externalizing youth who are involved in the youth justice system or who are at risk of becoming involved, as well as their families. FFT focusses on family alliances, parenting, problem solving and eliminating or reducing problem behaviours. It has demonstrated successful outcomes in the areas of violence, drug abuse/use, conduct disorder and family conflict (Mercer, 2008) and in reducing residential treatment placements and juvenile involvement with the corrections system (Alexander et al., 2000; Aos, Barnoski and Lieb, 1998).

Assertive Community Treatment (ACT)

Assertive Community Treatment is an evidence-based community model for youth with serious mental health needs that provides case management and strives to avoid the use of residential treatment or hospital admissions while also providing transitional support. ACT is often directed towards youth who are at the highest risk for institutional or other forms of residential care. The program has shown increased engagement in treatment, better social functioning and improved school attendance as well as higher employment (Bridgeo, Davis, & Florida, 2000).

Multidimensional Treatment Foster Care (MTFC)

Multidimensional Treatment Foster Care is an effective intervention for youth with severe emotional disturbance, delinquency or chronic antisocial behaviour and who are in need of out-of-home placement. With regular training and supervision, MTFC parents employ behaviour management and other therapeutic methods. Research results have shown that youth in MTFC have significantly fewer days incarcerated or subsequent arrests, less hard drug use, quicker community placement from more restrictive settings (e.g., hospital, detention) and better school attendance and homework completion (Leve, Chamberlain, & Reid, 2005). Furthermore, the cost per youth is up to one-half less in MTFC when compared to residential, group, or hospital placements (Chamberlain and Mihalic, 1998; Chamberlain, Leve, & DeGarmo, 2007).

In 2010, Kinark participated in the development of a program to support foster families of children under the age of 12 where there was an identified risk of foster placement breakdown due to the child or youth's behavioural issues and/or conflicts within the family. This program, called the *Behavioural Stabilization Consultation Team (BSCT)*, was designed and implemented by Kinark in collaboration with Family and Children's Services of Guelph and Wellington County, Peel Children's Aid Society, and Halton Children's Aid Society with successful results, including reduction of placement breakdown.

In 2013, the BSCT was expanded to our Durham program as a pilot project when we closed our Durham residential program, a residential treatment for children under the age of 12. The pilot project provided up to six months of intensive in-home consultation and coaching services for caregivers of children under age 12 who were at risk of residential placement or family breakdown due to severe behavioural issues, or who were returning home after a period of time in a foster placement. The majority of clients referred to the BSCT have a history of trauma or attachment disorder. The service is uniquely designed to train and support caregivers in their efforts to stabilize their child's behaviours within the home by combining elements of therapeutic treatments such as Trauma-Focused Cognitive-Behavioural Therapy (TFCBT), Triple P, Dan Hugh's PACE model (playfulness, acceptance, curiosity, and empathy), and Applied Behavioural Analysis (ABA). In this service, staff provide flexible support to children and youth in the community and other milieu settings (e.g., school) with continuity of care and increased or decreased service intensity, as needed.

Early evidence suggests that caregivers participating in the BSCT program demonstrate increased use of BSCT strategies as well improved confidence in parenting, commitment to supporting their child, awareness of the parenting role, understanding of their child, and family relationships. For children, outcomes have been reported in the areas of housing stability, reduction in problematic behaviour, and improved emotion regulation and family relationships. As the initial two years of this program in Durham has now passed, Kinark is in the process of sharing the recent evaluation with our community partners to gain community input for determining next steps in supporting this complex population while continuing to work collaboratively with community partners.

Conclusion

We believe that the evidence outlined in this paper constitutes a strong and compelling call to action. There are growing challenges experienced by mental health service providers and little, if any, indication that the significant financial investment in residential service contributes to positive and sustained outcomes for children and youth. For policy makers, funders, service providers and others committed to better outcomes for some of Ontario's most at risk children and youth, as well as for those dedicated to the efficient stewardship of scarce public resources, there is an opportunity now, in the context of child and youth mental health transformation, to begin redeveloping our decades-old system through the formation of a clear policy framework and a comprehensive provincial service plan.

The nine critical success factors outlined in this paper, when taken as a whole, provide a blueprint for this redevelopment. Across the province and outside of Ontario, providers have demonstrated initiative and leadership in one or more of the critical success areas. These examples serve as an excellent resource that we can draw from to inform redevelopment.

Taking a focused approach to what will be a change process of considerable duration may be an important contributor to success. To prioritize the best interests of children and youth and their families, we believe that it is important to focus on the development of a multi-tiered residential system and alternatives to residential care, concurrently, from the earliest stages of this work. The evidence is clear that when we unnecessarily separate children and youth from their families and for long periods of time, we make their road ahead harder, not easier. As a result, children and youth who require residential care wait longer for treatment and the quality and quantity of the treatment they receive may be diluted.

Through this paper, we call on government and our service provider colleagues to commit to a vision of a true system of services for children and youth with mental health issues that is rooted in strong capacity for individual assessments and clear service pathways, that equips providers to be partners with families in their children's care, and that effectively balances the investment of resources in both non-residential and residential services. Kinark is pleased to contribute our perspective to this effort through this paper and we look forward to the discussion and debate that will propel this redevelopment forward.

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