Evidence In-Sight:
Best Practices in Providing Residential Treatment

Date: June, 2013
The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the question:

- According to the literature, what are best practices in providing residential services for youth with complex mental health problems?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.
1. **Overview of inquiry**

Residential services for children and youth in Ontario are provided by publicly funded agencies and privately operated organizations. The mental health system does not have a standardized model of residential care and services vary. To better understand what the research suggests are best practices in residential care, several agencies have requested a literature review of core practice elements in residential care.

The lead agency on this request provides a residential program for at-risk youth who present significant behavioural challenges. Most of the youth come to treatment with complex mental health and behavioural challenges and require individually tailored treatment plans. However, the agency has found it difficult to evaluate for long-term outcomes to demonstrate that the service is working for youth and helping them progress to less-intensive community based services. Given the difficulty of evaluating for outcomes, a summary of the best current research on residential programming will at least help ensure that residential program meets what standards might be indicated by the evidence.

To set this baseline of service, this Evidence-in-Sight report was researched and written to address the question: *According to the literature, what are best practices in providing residential services for youth with complex mental health problems? For instance, what essential elements should be provided by the services and what, if any, are the recommended treatment components?*

2. **Summary of findings**

- Several factors are associated with positive outcomes for children and youth in residential treatment including family involvement, the discharge environment and shorter length of stay.
- The Building Bridges initiative and the American Association of Children’s Residential Centers are actively refining residential treatment and recommended practice in the U.S. Resources include guidelines, indicators and an organizational self-assessment tool.
- The research literature recommends several essential components for consideration in residential treatment settings: use of performance indicators and outcome measurement; family driven service provision and decision making; and youth involvement in care planning and service decision making.
- There is limited literature to establish a single preferred model for residential treatment. However, models with some research evidence of effectiveness include positive peer culture, Re-Ed and the Stop-Gap Model.

3. **Answer search strategy**

- We used these databases for our literature search: University of Ottawa Library (PsychINFO, AMED – Allied and Complementary Medicine, Ovid MEDLINE® In-process & Other Non-Indexed Citations, PubMed, Scholars Portal, Cochrane Library), Google Scholar, EBSCO Host
- We used varying combinations of these search terms, residential treatment, residential care, complex mental health problems, mental health, youth adolescents, model, best practices, essential elements, programming, peer groups
4. Findings

There is a wide literature on residential treatment (RT) for children and youth with complex mental health difficulties, but the existing research research has a variety of methodological shortcomings that affect scientific rigour (French & Cameron, 2002). The programs or models that have been evaluated have limited longitudinal outcome studies (Knorth et al., 2008).

Residential treatment is not a uniform concept (James, 2010) and there is variability in programming (French & Cameron, 2002) and inconsistencies across settings (Magelian Health Services, 2008). These differences may account for why certain programs are more effective than others and limit the generalizability of findings (Magelian Health Services, 2008). A significant portion of the research on RT, especially on effectiveness, does not specify models or include description of the RT setting, which prevents the ability to compare across models and practices (James, 2010; Knoth et al., 2008; Child Youth Care Forum, 2009).

Despite these limitations, RT is widely used for children and youth with complex mental health concerns. Although there is no preferred treatment models, research on RT outcomes has highlighted components to be considered in treatment settings and initiatives to redefine RT are emerging. It is essential to evaluate program effectiveness to determine what works best and what is most beneficial for the population served in a particular residential setting. James (2011) highlights the importance of evaluation by suggesting that it remains in the best interest of RT settings to critically review their program in light of the needs of the youth they serve and to consider adopting or learning from the treatment models that already have an evidence base.

4.1 Best practices

Outcomes data

Literature on effective mental health treatment for children and youth in general suggests that positive outcomes are most often associated with a positive therapeutic alliance and coherent treatment models (McConnell & Taglione, 2012). In this case, a coherent treatment model means one that is theoretically-grounded and guides treatment implementation (McConnell & Taglione, 2012). Beyond these common factors, research on factors associated with positive outcomes for children and youth in RT does have some commonalities across studies. Many of these risk factors link with the suggested model components discussed later in this report. RT factors associated with better outcomes include:

- Involvement of families (James, 2012; McConnell & Taglione, 2012; Fresnch & Cemeron, 2002; Knoth et al, 2008; Magellan Health Services, 2008; Hair, 2005).
- Factors at discharge including having a positive, stable and supportive environment, availability and utilization of aftercare services and support, stable housing and stable post-discharge resources (James, 2010; McConnell & Tagilone, 2012; Fresch & Cameron, 2002; Magellan Health Services, 2008; Hair, 2005).
- Shorter length of stay in treatment (James, 2010; Fresch & Cameron, 2002; Hair, 2005).
- Program factors including the comprehensiveness of the program, positively oriented behavioural strategies and independent living skills-building (Hair, 2005).
- Youth fulfilling their treatment goals (Hair, 2005; Fresch & Cameron, 2002).
Best practices in providing residential treatment

- Experiencing improved academic achievement (Frensch & Cameron, 2002) and education during residence and continuing education after discharge (Hair, 2005).
- Gainful employment after discharge (Hair, 2005).
- Better outcomes from clinical work with family/caretakers (Frensch & Cameron, 2002).
- Parents/caregivers who made more contact with their child during treatment and were more positive in nature (Frensch & Cameron, 2002).
- Involving the youth with peers, staff and academic tasks (Frensch & Cameron, 2002).
- Matching behaviour-therapeutic methods (Knoth et al., 2008).
- Degree of caregiver support and continuity of significant relationship (Knoth et al., 2008).

In addition to the above mentioned factors, the Bay Consulting Group (2006) conducted a review of residential services for children and youth in Ontario for the Ministry of Children and Youth Services. The review identified effective practices in Ontario and other jurisdiction. Effective RT practices at the operational level in other jurisdictions included:

- Using effective intake and assessment practices
- Making appropriate placement decisions
- Having quality assurance mechanisms
- RT as part of a continuum of services
- Permanency planning for clients
- Involving foster parents, if relevant

Within Ontario, effective RT practices included (Bay Consulting Group, 2006)

- Mixing children and youth from different sectors
- Integrated service provider agencies
- Regional office databases
- Integrated access
- Regional operating frameworks
- Increased collaboration among agencies
- Providing culturally-specific services
- Providing short-term crisis intervention

Initiatives to streamline residential treatment

Research on effective residential treatment model is emerging, such as an initiative in the U.S. to define RT and evidence-informed components that are necessary in residential settings.

The Building Bridges Initiative (information at [http://www.buildingbridges4youth.org/](http://www.buildingbridges4youth.org/)) provides a framework to help residential and community programs achieve positive outcomes for the youth and families they serve (Blau et al., 2010). This framework includes a set of performance guidelines and indicators and an organizational self-assessment tool. The core principles of the framework require that residential services be:

- Youth guided (e.g. ensuring youth’s voice is heard/respected in all phases of services)
- Family driven (e.g. ensuring the family’s voice is heard/respected in all phases of services)
Best practices in providing residential treatment

- Culturally and linguistically competent
- Comprehensive, integrated and flexible
- Individualized and strengths-based
- Collaborative and coordinated (between providers, families and caregivers, youth advocates, policymakers)
- Research-based and evidence and practice informed (e.g. use of successful partnerships, reduced lengths of stay, youth and family engagement, skills development)

The American Association of Children’s Residential Centers (AACRC, information at [http://www.aarc-dc.org](http://www.aarc-dc.org)) is undergoing nation-wide efforts to redesign the role of RT in local communities (AACRC, n.d.). The association focuses on the needs of children with serious emotional and behavioural problems in residential or other milieu-based placements (AARCC, n.d.). As part of this initiative, the AACRC has put forth a series of papers to address critical issues and opportunities in the field of RT and listed some considerations regarding the creation of new models for policymakers and service providers. Considerations include:

- Comprehensive assessment processes should be used to determine whether RT is appropriate for a youth as families and communities have an interest in ensuring that RT is used only when necessary.
- Many children have not done well in community settings due to behaviours and needs that are too demanding for families. RT offers opportunities to help stabilize child and caregiver situations, to create the space for planning based on a comprehensive assessment of child and caregiver need, to provide a sanctuary when there are safety concerns, and to serve as a starting point for independent living.
- Shift culture and perception of the youth-serving community such that RT is seen as a specialized opportunity, not as a placement of last resort.
- Shift the perception of families/caregivers to help them see that RT can be used as an intervention to help restore equilibrium or establish greater stability, while providing clinically appropriate care and respite.
- Some programs are moving towards integral involvement in local coordinated systems of care working in full and active partnership with agencies, schools, parents/caregivers and the community.
- It is critical to ensure that continuing care is available to all children and youth leaving RT and is incorporated into the funding structure.

To improve community adaptation outcomes for youth leaving RT, the Partnerships for Children and Families Project (2012) funded by the Ministry of Children and Youth Services conducted a review and included recommendations for developing an integrated community adaptation program model for RT. These recommendations included:

- Youth advocates who can build a relationship with the youth, facilitate the development of a youth support network (e.g., adults taking a more assertive approach to supporting youth and finding appropriate community adaptation resources) and advocate for youth (i.e., provide information and intervene on behalf of youth in systems and settings).
- Education advocates who maintain relationships with the youth at school.
- Tutors and academic enhancements to support youth academics reduce frustrations and keep youth connected with school.
- Parent/caregiver training and support groups.
- Life skills development for youth.
Core components
The outcomes literature on children and youth in RT suggests some components of an effective treatment program. For example, McConnell and Tagilone (2012) suggest that an effective residential treatment program may include family involvement, after care support and placement stability. These components happen with a coherent treatment framework accepted by agency staff and should be supervised with ongoing feedback (McConnell & Taglione, 2012).

A review of the literature on children and adolescents receiving residential treatment between 1993 and 2003 found that children and youth and their families benefit from RT that is multi-modal, holistic and ecological in its approach (Hair, 2005).

The reviewed literature provides a variety of evidence-informed practice components. A cross-section of the literature suggests the following are important elements in RT:

- Use of performance indicators and outcomes (AACRC, n.d.)
- Developmentally focused programming (Holden et al., 2010)
- Family involvement and family driven care (Holden et al., 2010; Blau et al., 2010; Magelian Health Services, 2008; AACRA, 2006; AACRA, 2009; Leichtman, 2008)
- Relationship based programming (Holden et al., 2010)
- Competence centred programming (Holden et al., 2010)
- Trauma informed programming (Holden et al., 2010)
- Ecologically oriented programming (Holden et al., 2010)
- Youth guided care (Blau et al., 2010)
- Culturally and linguistically competent programming (Blau et al., 2010)
- Comprehensive, integrated and flexible programming (Blau et al., 2010)
- Individualized and strength-based treatment (Blau et al., 2010)
- Discharge planning that starts at the beginning of treatment (Magelian Health Services, 2008)
- Community involvement during admission to RT to facilitate transition back to the community (Magelian Health Services, 2008; Leichtman, 2008)
- Availability of short-term programs (Magelian Health Services, 2008; Leichtman, 2008)
- Integration of evidence-based practices (AACRC, 2008)

4.2 Examples
The research on RT models is in early stages, which means that there are too few rigorous studies available to establish a single recommended treatment model (James, 2011). James (2011) conducted a review of treatment models (Table 1) that are relevant to group care and RT settings of children involved with the child welfare system. The level of evidence for each model was rated using the California Evidence-Based Clearinghouse for Child Welfare levels, available at http://www.cebc4cw.org/ratings/.

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Peer Culture</td>
<td>Developed in response to the failure of conventional treatments to effectively deal with negative peer</td>
<td>Evaluation is limited but model is rated as supported by research evidence.</td>
</tr>
<tr>
<td><strong>Best practices in providing residential treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best practices in providing residential treatment influences among troubled youth. Grounded in social psychology theories and states that social context is a powerful determinant of thoughts and behaviours. This model aims to transform negative peer context into a positive peer culture while deemphasizing adult authority. Through developing trust and respect, group norms reinforcing mutual responsibility, prosocial attitudes and social concern are fostered. Treatment components include building group responsibility, the importance of group meeting, service learning and the importance of teamwork.</td>
<td>Outcomes primarily focus on child and family well-being.</td>
<td></td>
</tr>
</tbody>
</table>
| **Teaching Family Model** | Most known for its use at Boys Town ([http://www.boystown.org/](http://www.boystown.org/)). Model is characterized by clearly defined goals, integrated support and a set of core elements. Elements include:  
- Selection of teaching parents (i.e., married couples working as a treatment team) who live in the unit  
- Skill-based training of these treatment providers  
- Role of teaching parents as professional practitioners  
- 24-hr professional consultation  
- Proactive teaching interactions focused on positive prevention and youth skill acquisition  
- Client peer leadership/self-government system  
- Professional and community evaluation of each parent/caregivers performance  
- Annual reaccreditation based on these evaluations  
- Emphasis on family style living and learning in a normalizing care environment. | Most described and researched model. Rated as promising and outcomes primarily involved domains of child and family well-being. |
| **Sanctuary® Model (Bloom, 1997)** | Trauma-informed method for creating or changing an organizational culture to more effectively provide a cohesive context where healing from psychological and social traumatic experiences can be addressed. Uses a whole system approach designed to facilitate the development of structures, processes and behaviours on part of staff, children and community that can counteract the biological, affective, cognitive, social, and existential wounds suffered by children in care. The model emphasizes nonviolence, emotional intelligence, inquiry and social learning, shared governance, open communications, social responsibility and growth and change. Recovery from trauma uses cognitive-behavioural strategies and is conceptualized as occurring in four stages that focus on safety, emotional management, loss and future (SELF). | Has been implemented and modified in a range of settings. Evaluation is limited and model is rated as promising. Outcomes measured typically include child and family well-being. |
| **Re-Ed** | An ecological competence approach to helping troubled children/youth and their families. The model emphasizes a strengths-based approach, an ecological orientation, and a focus on competence and learning, Few outcome studies conducted. Findings indicate improvement in various domains of functioning, but model was not rated due to a lack of |
relationship building, development of a culture of questioning, and informed decision making. Model is intended to be implemented as a group approach where intensity and duration can vary depending on setting. The model also includes a parent/caregiver component.

| Stop-Gap Model | Re-conceptualizes treatment as a short-term arrangement (defined as 90 days to one year) aimed at stabilizing youth sufficiently for discharge to a lower level community-based treatment. Incorporates evidence-based practices within a three-tiered approach (i.e., environment-based, intensive, and discharge related) of service delivery. The goals of the model are to interrupt the youth’s downward spiral caused by increasing disruptive behaviour and to prepare for the post-discharge environment and reintegration. This model recognizes the importance of a community-based service delivery approach while providing intensive and short term support. | studies that used a comparison group. Evaluative work still in early stages, but model is rated as promising |

Other examples of existing models
The Restorative Healing Model at the Woodbourne Centre in Baltimore integrates three evidence-informed components into RT: aggression replacement training, community restorative justice and trauma-focused care (Park et al., 2008). The program is based on the principles of positive behaviour support, achievement of prosocial behaviours, positive character traits and coping skills as clients progress through their own stages of change. Administrators at Woodbourne Centre report seeing improved connections between clients and families, deepened staff-client relationships, less violence and fewer coercive behavioural control measures. However, there is no research evidence to support the model as a cohesive whole.

McConnell and Taglione (2012) looked at the outcomes from four years of implementing the Relational Re-enactment Systems Approach to Treatment Model (REStArT). Results indicate a significant increase in the proportion of youth discharged to a family home while the proportion of discharges resulting from youth running away from treatment was reduced by half. The model emphasizes family-centered consultation, therapeutic alliance, and understanding and actively addressing youth and family ambivalence about discharge. Principles include:

- Developing a working therapeutic alliance
- Relational re-enactment
- Systems-orientation
- Working with ambivalence about discharge
- Restoring balance
- Interrupting the conflict cycle
- Expecting health through trusting the youth’s ability to determine their own goals, tolerate disappointments and repair disruptions in relationships
- Ownership of the model by staff members at every part of the system
- Evidence-based
- Dynamic and reflexive process.
Best practices in providing residential treatment

Gharabaghi and Groskleg (2010) discussed a social pedagogy approach to residential care that resulted from a program development process undertaken by Renfrew County Family and Children Services in Ontario. This service model goes beyond the traditional approach to residential care and education for children and youth in RT by replacing psychotherapy with learning-focused living arrangements as the core intervention and support system (Gharabaghi & Groskleg, 2010). The social pedagogy approach is based on the assumption that everyday experiences make up the learning process where each child or youth integrates knowledge and understanding into their worldview. The Renfrew County project was a unique initiative in the child welfare sector because it integrated public and private sectors and regulatory frameworks to support a non-traditional model of RT.

Underwood et al. (2004) discussed a promising community-based residential treatment program that uses cognitive-behavioural and behavioural approaches, case management, psychoeducation, and pharmacological and skill-based methodologies as the contributing treatment components. The authors refer to the delivery of culturally and developmentally appropriate assessments, diagnoses, treatment planning, ongoing treatment interventions, and transitional planning. Service delivery consists of individual, group, family, psychiatric, medical, educational, crisis intervention, and case management services. Treatment interventions are systematic and incorporate all successful treatment indicators for residential care describe by the United States General Accounting Office:

- Individual treatment plans
- Involvement of a caring adult
- Self-esteem building
- After care planning
- Teaching social and life skills
- Coordination of residential and aftercare services
- Family involvement
- Positive peer influences
- Use of a behavioural management system
- Community support
- Creating a family-oriented environment.

The model stresses the importance of community reintegration and allows adolescents to engage in the community for recreational and vocational activities.

5. Next steps and other resources

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the
implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit:

http://www.excellenceforchildandyouth.ca/what-we-do or check out the Centre’s resource hub at http://www.excellenceforchildandyouth.ca/resource-hub.

For general mental health information, including links to resources for families:

http://www.ementalhealth.ca
Best practices in providing residential treatment

References


