

# Creating Safety and Stability for High-Risk Adolescents: A Proposal for Short-term Secure Residential Treatment within a Comprehensive System of Care

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## Abstract

*When a teenager refuses to go or stay at a designated setting (e.g., home, foster care, open residential treatment, etc.), repeatedly runs away and engages in high-risk behaviours towards self and/or others, what recourse can family members have? For these families, the alternative can be the highly specialized services of a lockable or secure residence treatment center. I propose that lockable or secure residential treatment facilities need to be available for short-term intervention with high-risk, high-need adolescents. An overview of outcome research from open residential treatment settings provides a foundation for a discussion about the benefits of short-term secure treatment facilities.*

## Living with high-risk, high-need adolescents

I first met 14 year old Jennifer when she and her mother came for counselling at the southern Ontario children's mental health service where I practiced as a family therapist. Jennifer had been bumped up on the six month waiting list because two nights before she had slashed her wrists. Shortly after counselling began, Jennifer's defiant and unsafe behaviours determined that she could no longer live at home and she was sent to one of the two residential treatment group homes available for adolescent girls in the city. In spite of involved parents, supportive staff and an onsite school, Jennifer defied all attempts to remain in the facility and repeatedly ran away for days at a time. There was considerable evidence that she was engaging in high-risk behaviours but there appeared little we could do. Although all concerned adults agreed she needed to be kept in a safe place, it was not possible to get a bed in the locked treatment unit of the nearest secure facility. We quickly understood that in order to even be considered for admission in any locked setting, she would have to commit a violent crime and be charged as a young offender. Unfortunately, Jennifer was bright enough to not get caught committing an offence.

Cathy was 13 when she began to repeatedly run away from her foster mother. Her high-risk behaviours actually seemed to get worse after she was moved to the residential group home. Although Cathy was charged for various offences she was repeatedly sent back to the open facility with an order to remain, which she blatantly disregarded. Only with a psychiatric recommendation that she was endangering herself and the unflagging support of her child welfare worker did a secure assessment facility out of the city agree to admit her for two weeks. However, after the 14 days had passed, Cathy was again released into the care of the residential group home staff, although they clearly disagreed with the decision. The lack of availability and access to lockable treatment facilities left no alternative. Shortly upon her return, Cathy left the residence without permission and resumed her high-risk behaviours.

Fifteen-year-old Ryan came to my attention when I was doing court ordered assessments of young offenders. During the course of our time together it appeared that Ryan experienced little remorse

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for the violent assault he had been charged with or the school bullying he had been engaged in. His mother was able to express her fear of him and the risk to his younger brother if he was to come home after the charges were heard in court. She wanted her son to get counselling and agreed to participate with him. Ryan, however, disagreed and stated that he would refuse to attend. Although there were significant mental health needs and the apparent ongoing risk to others which warranted that Ryan reside away from home, there were no treatment centers that would admit him because he refused to go.

## **Putting the needs in context**

In a review of international epidemiological research, Waddell and Shepherd (2002) reported that 15 to 20% of children between 2 and 18 years of age are clinically identified with mental health disorders that cause both significant symptoms and impairment. For 3 to 8% of the 30% of the children who seek treatment (Burns, Hoagwood, & Mrazek, 1999; Hoagwood, 2003), the severity of social, emotional, and/or behavioural difficulties along with the need for community protection necessitates out-of-home placement in a residential treatment centre (Burns et al., 1999). In general, residential treatment facilities can provide a consistent, nurturing environment with predictable, consistent expectations that are designed to encourage desirable behaviours and emotional responses (Rosen, 1998).

The use of unlocked residential settings is an acknowledged option within the system of care philosophy that currently guides mental health services for children and their families in Canada and the United States (Stroul & Friedman, 1996). Although Stroul and Friedman (1996) have stated that “children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate” (p. 8), they have acknowledged that there are times when a community-based setting cannot meet the therapeutic needs of the child or adolescent. Therefore, open or unlocked residential treatment provides a valuable needed service for a small but significantly challenging group of children (Blau & Brumer, 1999; Itzkowitz, 1989; Rae-Grant & Moffat, 1971; Stroul & Friedman, 1996; Sunseri, 2001).

The option of open residential treatment is viable only if the resident remains in the setting. During adolescence, however, there can be occasions when even an open residential placement is not sufficient to provide safety, stability and treatment. Sunseri (2003) has reported that one out of three adolescents run away from residential treatment programs and never complete intervention expectations. Therefore, when a teenager refuses to go or stay at a designated setting (e.g., home, foster care, open residential treatment), repeatedly runs away and engages in high-risk behaviours towards self and/or others, what recourse can family members have (Gorske, Srebalus, & Walls, 2003)? For many families the only recourse has been the medical stabilization offered through psychiatric hospitalization (Baker, Archer, & Melnick, 2004; Sunseri, 2004). Alternatively, the highly specialized services of secure residential treatment can have an important role in a system of care framework (Blau & Brumer, 1999; Ontario Ministry of Community and Social Services, 1978, 1981; Stroul & Friedman, 1996; Sunseri, 2001).

## **Purpose of this paper**

In Ontario, Canada secure residential treatment settings have not been considered an essential part of care for high-risk, high-need adolescents. Recently, however, the provincial government has made a commitment to collaborate with community partners and improve services and access to services for children and families (Ontario Ministry of Children and Youth Services, 2004, 2005). My objective of this paper is to help strengthen the knowledge base of service providers and consumers across Canada who want to advocate for reforms that can actualize a comprehensive system of care for children. My perspective comes out of working more than 25 years in children’s mental health: first as a child care worker in open and secure residential treatment facilities for troubled adolescents and young offenders in Quebec, then as a family therapist at an inner city children’s mental health centre in southern Ontario.

Specifically, I propose that lockable or secure residential treatment facilities need to be available for short-term intervention with adolescents. An overview of outcome research from open residential treatment settings provides a foundation for a discussion about the benefits of short-term secure treatment facilities and their role in a comprehensive system of care. Although my focus is province specific, I believe the ideas are transferable to children's mental health services across Canada.

## **Outcome research: A challenge to the controversy about open residential treatment centers**

For decades residential settings have operated under a shadow of controversy due to mixed opinions about the benefit of separating a child or youth from family members as well as the considerable cost such a placement incurs (Abramovitz & Bloom, 2003; Burns et al., 1999; Rae-Grant & Moffat, 1971). Unlike outpatient psychotherapy research, controlled laboratory studies to determine treatment efficacy are not possible. Alternatively, the effectiveness of residential treatment has been the focus for outcome research (Nansel et al., 1998). Typical of research "in the field", there have been a number of identified methodological weaknesses including a predominance of single sample pretest or pretest-posttest or posttest only studies without a control or comparison group, small non-randomized sample sizes, and subjective judgments of outcome success (Bates, English, & Kouidou-Giles, 1997; Frensch & Cameron, 2002; Hair, 2005; Pratt & Moreland, 1996).

In spite of notable design flaws, over the last two decades residential treatment outcome research has identified common results that are promising for severely troubled children and adolescents (Chamberlain, 1999; Frensch & Cameron, 2002; Hair, 2005). For example, following discharge a number of adolescents go to live in a less intrusive setting, such as home with family members, treatment foster home, group home, or independent living. Moreover, many residential treatment graduates are able to maintain gains and, as best as they are able, stay away from trouble and further achieve life markers such as school completion and positive relationships (Franfort-Howard & Romm, 2002; Kaminsky, 1998; Larzelere et al., 2001). According to research the identified elements for successful discharge are:

1. Family involvement throughout treatment (e.g., family therapy) and the stability of the discharge placement are crucial for residents to make and maintain emotional and behavioural gains (Erker, Searight, Amanat, & White, 1993; Gorske et al., 2003; Landsman, Groza, Tyler, & Malone, 2001; Stage, 1999; Sunseri, 2001). A meta-analysis of 121 studies of residential treatment outcomes for young offenders found that participation by the resident and her or his family members in family therapy was the only significant predictor of successful discharge to a less restrictive setting (Garrett, 1995, as cited in Stage, 1999).
2. The need for a variety of easily available aftercare services including advocacy for school and/or gainful employment is strongly evident (Asarnow, Aoki, & Elson, 1996; Farmer, Wagner, Burns, & Richards, 2003; Kaminsky, 1998; Landsman et al., 2001; Larzelere et al., 2001; Peterson & Scanlan, 2002).
3. Academic success while in residence and successful completion of a program that has a psychoeducational component (Farmer et al., 2003; Franfort-Howard & Romm, 2002; Greenbaum et al., 1996; Hooper, Murphy, Devaney, & Hultman, 2000; Kaminsky, 1998; Larzelere et al., 2001).
4. Shorter lengths of stay (6-8 months) are a potential influence for success. One stay is often insufficient and shorter stays offer the option for return visits if needed (Asarnow et al., 1996; Landsman et al., 2001). Hussey and Guo (2002) have suggested that shorter, repeatable periods of stability in a residential facility may encourage treatment gains and educational achievement rather than using out-of-home placements as a "once and for all cure." Shapiro, Welker, and Pierce (1999) found four of their five measures indicated positive change during the first six months of treatment for adolescents and no further gains were identified later in treatment. Their results support previous research findings (Hoagwood & Cunningham, 1992).

5. A cohesive residential program philosophy, staff training and supervision, and the worker-client relationship are potentially untapped areas of influence on treatment outcomes (Asarnow et al., 1996; Farmer et al., 2003; Hooper et al., 2000; Kaminsky, 1998; Landsman et al., 2001; Larzelere et al., 2001; Wilmschurst, 2002).
6. Individual characteristics such as diagnosis identified at admission appear to have a negligible association with successful discharge (Franfort-Howard & Romm, 2002; Greenbaum et al., 1996; Peterson & Scanlan, 2002).

In sum, research results support that children and adolescents with severe emotional and behaviour disorders can benefit and sustain positive outcomes from open residential treatment that is multi-modal, holistic and ecological in its approach (Franfort-Howard & Romm, 2002; Peterson & Scanlan, 2002). Specifically, ongoing success after discharge appears closely associated with family involvement during placement combined with accessible aftercare programs and continued academic participation. These points are also relevant for the successful implementation of short-term secure treatment facilities within a comprehensive system of care.

## **So what's so therapeutic about locking up kids?**

The use of secure treatment settings for adolescents is particularly controversial due to the physical restrictions (for example, locked doors and highly structured programs) and the corresponding loss of self-determined freedom for the residents (Ontario Ministry of Community and Social Services, 1981). Central to the controversy is determining how being prevented from leaving a facility can be therapeutically helpful. However, when troubled adolescents do not voluntarily remain in a designated setting and continue to engage in impulsive, high-risk behaviours such as fighting, substance abuse, indiscriminant sexual behaviours, prostitution, self-mutilation, and/or suicidal ideation and/or suicide attempts then the need for physical containment and supervision is strongly indicated (Baker et al., 2004; Gorske et al., 2003; Larzelere et al., 2001; Ontario Ministry of Community and Social Services, 1978, 1981; Stroul & Friedman, 1996; Sunseri, 2001).

High-risk behaviours are often associated with trauma experiences that have robbed the victim of control, personal agency, and trust of adult caregivers (James, 1994). Consequently, it becomes the responsibility of others – often professionals in children's mental health services – who must find ways to contain the young person. This containment occurs in a safe environment that provides the adolescent protection from threatened or actual harm to self and from hurting others. In such a setting protective, therapeutic relationships can flourish (Herman, 1992; James, 1994, Rosen, 1998; Steinhauer, 1992). James (1994) has argued that such a protective environment along with appropriate clinical skills and therapeutic relationships “must remain intact throughout treatment” (p. 58). Herman (1992) has firmly stated that “no other therapeutic work should even be attempted until a reasonable degree of safety has been achieved” (p. 160). Thus, for troubled adolescents continuity of treatment depends on them staying and stabilizing in one place (Gorske et al., 2003; Sunseri, 2001).

For most youth, an emotional connection can be achieved with an adult caregiver in an open treatment setting. Containment is therefore achieved without physical limitations. Unfortunately, adolescents such as Jennifer, Cathy, and Ryan appear to need more tangible and immediate measures of safety. A lockable treatment setting literally provides the physical container within which therapeutic relationships can have the time and opportunities to develop. The achievement of stability, predictability and safety means that residents and their family members can begin to address emotional and psychological issues so that interpersonal relationships can improve and education can be effectively pursued. Moreover, therapy in various forms (e.g., family, individual, psychopharmacological) can have a stable window of opportunity for effectiveness. For adolescents engaged in high-risk behaviours, the challenge is to weigh the value of personal freedom against their need for safety from themselves and others (Ontario Ministry of Community and Social Services, 1981).

## **The value of supportive legislation for secure residential treatment**

In Canada, federal statutes such as the *Youth Criminal Justice Act* (Department of Justice, 2003, 2004) as well as provincial legislation determine the use of secure settings for adolescents. Specifically, the development of children's mental health services is the jurisdiction of each province (see Canadian Policy Research Network, 2004, for links to government sites). This is an advantage for persons who want to advocate for changes, since the sphere of action is limited to the provincial landscape, rather than the political mosaic across the country.

In Ontario the *Child and Family Services Act* (Revised Statutes of Ontario, 1990a, 1990b) addresses secure treatment under Part VI, Extraordinary Measures, Sections 113 to 119. Secure treatment is defined as "programs for the treatment of children with mental disorders, in which continuous restrictions are imposed on the liberty of the children" (Revised Statutes of Ontario, 1990a, Part VI, ss 113:1). Assessment protocols for admission, instructions for placement review, and discharge criteria are clearly outlined in the legislation and do not appear in need of change. For example, Section 117:1 states that admission to a secure treatment program is appropriate to prevent and treat a child from causing or attempting to cause serious bodily harm to himself, herself or another person and when no other less restrictive method of providing treatment is appropriate at the time of referral.

Most importantly, in Ontario admission to a secure treatment program cannot occur except by a court order (Revised Statutes of Ontario, 1990a, Part VI, ss 114). The involvement of the court helps to provide assurance that the rights of the child are respected, particularly during a time when children would feel extremely vulnerable.

## **The current status of secure treatment in Ontario**

If provincial legislation is established, then why visit the issue of secure, short-term residential treatment? First, available facilities are often inadequate to fulfill the need for secure residential treatment. Currently in Ontario, there are only four mental health centers with lockable facilities offering about 50 secure treatment beds for the whole province. Their locations in major cities demonstrate the continued under-servicing to other areas of the province (J. Finlay,<sup>1</sup> personal communication, April 27, 2003; G. Floyd,<sup>2</sup> personal communication, November 23, 2004).

Secondly, the selection procedures for secure residential treatment are often bias towards adolescents who have committed violent crimes (J. Finlay, personal communication, April 27, 2003). The federal *Youth Criminal Justice Act* (Department of Justice, 2003, 2004) has made provision that adolescents who commit offences such as manslaughter, aggravated sexual assault, or attempted murder and who are considered to have a mental health disorder can be given a sentence of intensive mental health treatment and supervision. The referral of these youth typically takes priority over community referrals for secure treatment facilities.

Thirdly, the need for lockable treatment facilities has also increased due to the "dramatic changes" in the number of adolescents with identified medically complex problems such as neuro-developmental disorders and neuro-psychiatric disorders (J. Finlay, personal communication, April 27, 2003). These adolescents are noticeably coming before the courts, not in response to their treatment needs for containment and safety, but because of criminal charges due to indiscriminant and impulsive acting out behaviours. The outcome in court is often placement in lockable treatment facilities due to the combination of criminal offences and the complex medical needs of the adolescents.

Given these various issues, for adolescents without criminal charges, who repeatedly run away and present a high risk to themselves or others the availability of a bed in a secure treatment setting continues to be disturbingly slim.

## **A proposal for short-term secure treatment for high-need high-risk adolescents**

At the present time, secure treatment facilities that are available in Ontario are not adequate or suitably utilized to meet the mental health treatment needs of troubled youth with or without criminal charges (G. Floyd, personal communication, November 23, 2004). Secure residential treatment settings need to be readily available, not as a last resort or only because of violent offences but as a short-term treatment intervention utilized at the time of need, and repeatedly if necessary (Asarnow et al., 1996; Burns et al., 1999; Stuck, Small, & Ainsworth, 2000).

In order to keep adolescents as close to their own communities as possible, I propose that a small (e.g. five to eight beds) secure residential treatment facility is needed in each of the nine provincial regions designated by the Ontario Ministry of Children and Youth Services. These community based settings would be used as alternatives to psychiatric hospitalization while still providing intensive treatment (Baker et al., 2004). Similar to an open residential treatment center, each secure facility would provide a therapeutic environment and on-site schooling, employ trained personnel, and have as a goal the return of residents back into a less restrictive environment. Moreover, multidisciplinary consultation, assessment, and treatment opportunities would be available to the resident and her or his family (Burns et al., 1999; Larzelere et al., 2001).

The effectiveness of a short-term length of stay is supported by researchers of open residential programs. Outcome studies have demonstrated that significant gains occur during the first six months of treatment (Hoagwood & Cunningham, 1992; Hussey & Guo, 2002; Shapiro et al., 1999). Moreover, Leichtman and Leichtman (2004) have identified that when an open residential program is intentionally short-term, and the goal of discharge is no longer the eradication but the sufficient control of the problem behaviours, then residents are usually ready to leave the setting by the third month of treatment. Thus, given the intensity of a secure environment, three to four months of treatment would provide a valuable period of stability with opportunities for the resident and family to engage in a variety of therapeutic relationships.

### *Creating Safety, Stability, and Opportunities for Change through Relationships*

The multidisciplinary staff team of each secure residential facility would be unified through a strength based, time-sensitive, collaborative treatment philosophy and the associated skills (Jacobson & Cervine, 2001). For example, due to the intensity and time-sensitive duration of secure placement, staff would share a theory of change that would guide program planning and treatment decisions (Abramovitz & Bloom, 2003; Durrant, 1993; Radmilovic, 2005; Rosen, 1998). All personnel would be expected to share a commitment toward clarity, consistency, and cohesiveness between the mission statement, philosophy of care, and services provided. Staff training, peer consultation, and clinical supervision would be highlighted as valued activities to help meet the many challenges for effective service delivery (Rosen, 1998; U.S. Public Health Service, 2000). Desirable outcome results would be clarified as all secure setting personnel worked collaboratively with youth, their families, and other interested community members on how to make the secure treatment program most helpful and successful.

Specialized mental health interventions would be available including family, group, and individual therapy, as well as psychopharmacological treatment. Although the contributions of various professionals such as social workers and psychologists would be valuable, the effectiveness of treatment would rely significantly on the relational skill of child and youth care workers (Anglin, 1999; Fewster, 2002; Pazaratz, 2000).

*The pivotal role of child and youth care workers.* The security features of a short-term closed facility, although designed for the safety and physical containment of high-risk adolescents, can mean nothing more than loss of freedom and “doing time” for the residents. Moreover, the highly structured program and the use of psychiatric and psychological knowledge can create an atmosphere of empty routines and pathologizing diagnoses. Child and youth care workers (CYWs) have the challenging task of transforming a potentially depersonalizing and punitive setting into an intensive therapeutic milieu. Their

interactional role with the youth is pivotal if treatment needs are to be effectively and meaningfully addressed (Pazaratz, 2000).

A key ingredient to successful treatment is the active participation and commitment to change by the adolescents. In residential settings this investment is stimulated and actualized according to how well CYWs are able to initiate and sustain a therapeutic relationship with residents (Fewster, 2002; Radmilovic, 2005). These relationships are particularly pivotal while high-risk adolescents are residents in a lockable treatment center. Short-term, secure settings provide a unique opportunity for at-risk youth to experience empathic, supportive relationships with adults. A few months of day-to-day interpersonal experiences with caring, skilful, and reflective CYWs provides residents with numerous novel opportunities to think and feel differently about themselves and others and for new behaviours to be initiated and explored (Pazaratz, 2000; Radmilovic, 2005).

Residents' experiences of emotional connection and a positive, safe environment in such an intense setting are only possible because of the knowledge, skills and use of self unique to child and youth care (Anglin, 1999). However, for CYWs the intensity and structure of a secure facility creates emotional, psychological, and physical demands that can challenge how to be warm and caring while remaining mindful about safety. For example, the need to maintain vigilance about where residents are at all times, to keep all potentially harmful objects (such as cutlery) locked or supervised, and to respond to intense, potentially harmful, and disturbing behaviors by residents can be emotionally exhausting. The likelihood that CYWs will need to lock youth in their bedrooms and also keep other living settings secure can create strong mixed feelings. Finally, the possibility at any time that small behaviours such as garbage left on the floor could indicate increased risk that any resident could initiate or react with violence either towards self or others can drain energy, motivation, and hope from empathic relationship development.

Given the uniquely pivotal role for child and youth care workers in secure residential settings, particular considerations and supports need to be addressed at the inception of service development. Planning will need to determine the selection criteria for residential staff, the purpose and time-frame of clinical supervision, and the use of peer consultation and mentor programs. In addition, implementing and maintaining staff up-grading and training individually and for the whole CYW team would be essential. Suggested topics could include learning how to prevent and respond to different aspects of adolescent intimidation and violence (McAdams & Foster, 1999), how to adjust to the security aspects of the setting (for example, carrying keys and counting cutlery), and how to use the unique contexts of the setting as opportunities for intense-in-the-moment therapeutic conversations and interactions (Krueger & Stuart, 1999). Finally, the CYWs' awareness of personal boundaries, and their commitment to their own development and growth will be vital to treatment effectiveness (Fewster, 2002; Pazaratz, 2000; Richmond & Padgett, 2002).

#### *Final Considerations*

As part of a comprehensive system of care, an important component of short-term, secure treatment would be the availability of and ongoing collaboration with a variety of aftercare services (Anglin, 2004; Blau & Brumer, 1999). It would be essential that the transition of adolescents to the community be intentional and well integrated into the daily life goals of the secure treatment program (Leichtman & Leichtman, 2001a, 2001b). Thus, a key objective for each resident during treatment planning would be to identify appropriate community supports. Consequently, the successful use of short-term, secure residential treatment would include how well collaborative relationships are maintained with community partners (Osher, 2002).

## **Concluding thoughts**

The addition of secure, short-term residential treatment facilities as part of a comprehensive system of care can provide much needed stability and safety for adolescents like Jennifer, Cathy, and Ryan. These distinctive services and the staff who work for them offer youth the means to stop engaging in repeatedly destructive and dangerous behaviours that threaten their own lives and/or the lives of others.

Equally important, when adolescents can no longer run away, skilled child and youth care workers are able to reflectively and empathically use multiple day-to-day moments to relationally encourage youth to experience novelty and positive differences about themselves and others. Thus, a lockable setting provides the unique opportunity to create supportive relationships with adolescents who might otherwise remain “untouched” by a significant adult relationship (G. Fewster, personal communication, September 26, 2005). Simply, unless we are able to provide adequate physical containment, daily predictability, nurturance and structure high-risk, high-need adolescents will likely not receive the treatment they so desperately need.

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## Footnotes

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