

RESIDENTIAL TREATMENT PROGRAM REVIEW

This past year has been one of considerable restructuring for the Residential Treatment Program. More resources have been directed towards supporting front-line staff, with the programs being supervised by 2 staff: one for the Child and Youth Workers (CYW) and the other for the Individual and Family Therapists (IFT). The management structure of the program has also changed to provide a more clinical and comprehensive model as both the Director of Milieu Services as well as a Director of Clinical Services are involved in directing the program. This model also allows for greater supervision and support as we move towards the implementation of evidence-based practices such as Dialectical Behaviour Therapy (DBT), and Cognitive Behaviour Therapy (CBT). Further, this model also allows for greater knowledge transfer among all programs that have clinical components.

While the clients served in our Residential Programs continue to exhibit rather severe impairments in a variety of areas, the client profiles have changed somewhat this year. For example, we are experiencing a higher number of referrals for youth with sexualized behaviors, learning disabilities, autism, and assaultive and/or aggressive behaviors. Many of the youth admitted are also experiencing considerable struggles regarding family breakdown, which has changed some of the discharge goals from returning to family home, to semi or independent living. At the same time, we continue to admit youth who are struggling within the school system as well as those who have undiagnosed mental health problems.

There were also some modifications that have led to successes within the program. For example, we have successfully increased family involvement in treatment with youth whose treatment goals have included returning to the family home after successful discharge. We have also put efforts in place to ensure clients remain involved in treatment. For example, when a youth experiences conflict to a degree that would likely lead to discharge, we will transfer clients between residential programs so they can remain in treatment, versus discharging clients.

Given that these youth are mandated to leave Residential programming once they reach a certain age, staff have also enhanced efforts related to client independence by teaching life skills such as budgeting, self care, hygiene, time management, medication management, job employment, and supporting post secondary education. This focus, particularly in terms of supporting post-secondary education has been successful as this year we have also experienced an increase of youth graduating high school and moving towards college at point of discharge from the residential programs.

While the CAFAS scores shown in the enclosed review indicate elevated scores from Time 1 to Time 2, there are two important patterns to note. Firstly, the second CAFAS scores were not conducted at the program closure point, but during treatment. Thus, clients are still involved in the program. Second, clients tend to score themselves lower at time of initial CAFAS scoring, as research shows that clients tend to minimize behaviors and events at time of admission and this elevation is indicative of disclosures and observations from staff.

It is also of importance to note that the youth in our Residential programs exhibit some of the most severe impairments with mean CAFAS scores of 104.55 at entry. These scores suggest many barriers are in place to successful treatment which may be exacerbated by being mandated to be in the program. In spite of these noted challenges, there were also some successes to note, such as the continued engagement of discharged clients and continuing to keep our beds full when many other agencies in the city struggle with this issue.

Moving forward, we are hopeful that the implementation of DBT and CBT in the residential homes will be reflected in these data for next year. We also recognize that implementing evidence based practices is a long term goal and that we anticipate more growing pains, changes and successes along the way. Efforts directed towards Accreditation will be a major focus for the Residential Treatment Program as will diversifying our referral base for the Residential Treatment program, particularly with Native Child and Family Services to provide culturally competent residential treatment services to the Aboriginal community.

Logic Model for Residential Treatment Programs

The Residential programs provide individualized treatment on both short and long-term basis's for youth who may be experiencing: serious mental health or complex, multifaceted problems that interfere with their ability to function effectively; psychiatric, emotional and/or behavioral challenges; verbal or physical aggression; or severe difficulties in their communities and family home.

Components

-segments of service
-reflect common purpose

- Intake and Assessment
- Goal Setting and Treatment Planning
- Psychological/Psychiatric Assessment if needed
- Treatment Implementation- CBT, DBT, Family Therapy, Psycho education, Therapeutic Milieu, , individualized treatment program, life/social skills training
- Discharge Planning- review of gains made, referrals to additional resources, Follow-up services range from individual and/ or family counselling, calling the residence, coming back to the residence to visit, scheduled meetings with residential staff

Target Group

-to be addressed by activities
-mandate, population, intensity

12-18 years old youth in need of residential treatment placement due to mental health, behavioural, and/or socio emotional difficulties.

Activities

-what program does to work towards desired outcomes

Short term goals: The youth demonstrates improvement in their social/life skills, emotional regulation skills, interpersonal effectiveness skills and distress tolerance skills, consistency and stabilization.
Long term goal: Successful re-integration into the family home or integration into semi or independent living, decrease in the severity/intensity of mental health/relationship problems.

Outcomes

-short and long-term objectives
-related to activities and within control of the program participants

- Individual and family therapy offered by therapists,
- Group therapy (CBT and DBT) offered by CYW and therapists, Life Skills provided by CYW
- Youth Engagement Model, Strength Based Approach, multidisciplinary team work/support
- Collaboration with child welfare and other relevant service providers
- Clear and consistent structure in a therapeutic milieu,

Residential Program Review

Our three Residential treatment programs accommodate adolescents between the ages of 12 and 18. The Megan Residence is a fully funded treatment program, and has the capacity to serve 7 clients. Our per diem funded treatment programs, D'Arcy and Ellesmere receive referrals from Child Welfare and both serve 8 clients. The Residential programs provide individualized treatment on both short and long-term basis' for youth who may be experiencing:

- Serious Mental Health or complex, multifaceted problems that interfere with their ability to function effectively;
- Psychiatric, emotional and/or behavioral challenges;
- Verbally or physically aggression; or
- Severe difficulties in their communities and family home.

Program Themes

This year in particular, there was an increase in youth who came to the Residences without a clear diagnosis as well as year referrals for youth with sexualized behaviors, learning disabilities, autism, and violent and/or aggressive behaviors. The identification of "family breakdowns" was also prevalent, which has led to changing discharge goals from returning to family home, to semi or independent living. Issues relating to "peer pressure" also arose this year as there have been greater disclosures from youth of "wanting to belong" and feeling the need to follow the guidance of their community peer groups in order to feel that sense of acceptance.

Program Objectives

Given the complexity of problems presenting by the youth in these programs, there are a variety of objectives of the Residential programs. These objectives are:

- To provide structure and safety to at-risk youth;
- To teach clients relevant life skills;
- To reunite families or help clients move towards independence;
- To reach treatment goals that are decided upon by the client and multi-disciplinary team;

- To help clients utilize community resources;
- To teach the clients emotional regulation and anger management; and
- To keep up to date on the most current approaches to treatment and implement best practices.

Program Successes

There have been many successes within the Residential programs. This past year we have successfully increased family involvement in treatment with youth whose treatment goals have included returning to the family home after successful discharge. Within this context, the Residential programs have been able to aid in helping families understand their child's limitations. This has allowed parents to redefine their viewpoint of "parent-child" relationship, and explore new definitions and foundations to build strong relationships with their child.

The Residential programs have also exhibited a "whatever it takes" modality. Through this modality we have shown inter-house transition plans to maintain youth engaged in our programs. For example, when a youth experiences conflict to a degree that would not lead to discharge; the Residential program will look at openings in other East Metro Youth Services houses, to transfer clients between residential programs so they can retain treatment, versus discharging clients.

Another noteworthy success of the program is the fostering and maintaining of long-term relationships. Many of our discharged residents stay in touch with staff and share information about their successes, struggles and life updates. This ability of staff to maintain relationships with youth after discharge exhibits the ability of the Residential programs to engage youth.

The Residential programs have also been successful in promoting client independence by teaching life skills such as budgeting, self care, hygiene, time management, medication management, job employment, and supporting post-secondary education. In addition to promoting client independence, we have also experienced an increase of youth graduating high school and moving towards college at point of discharge from the residential programs.

Further, we have successfully increased our capacity to promote and utilize Evidence Based practices. As Ellesmere and Megan house have been utilizing Cognitive Behavioral Therapy techniques and tools in their treatment practices;

whereas, Dialectical Behavior Therapy implementation has commenced at D'Arcy. Through the implantation of evidence based practices we are seeing youth adapt more effective skills and techniques to aid them with their anxiety, anger and depression.

Lastly, the Residential programs have experienced an increase of youth requests to postpone discharge dates, so that they can maintain and attain complete stabilization and skill development prior to exiting the programs. As a result, we have seen an increase in long-term admissions into all three Residential programs.

These successes account for our ability to keep our beds full when many other agencies in the city continuously struggle with this issue. Our occupancy rates for January and February 2009 were D'Arcy 100 per cent, Ellesmere 100 per cent and Megan at 99 per cent occupancy rate.

Program Changes

When exploring the various components of the Residential programs, there have been some changes throughout all three programs. The creation of the Clinical Supervisor role for the residential program was introduced this past year. This has allowed for an increase of support for clinical and front-line staff on clinical work involved in all three programs.

The Residential programs also faced changes in staff this past year. In order to support low staffing levels at one of the residences, several full-time front-line staff were rotated to other houses. This created an impact of a systemic level because it created a supportive system in the houses; however, some clients expressed feeling frustrated with the changes as their primary workers were changed. The concerns of the youth were addressed with transferring meetings, and special days with past primary workers, to allow clients to have closure.

Lastly, this past year Dialectical Behavior Therapy (DBT) implementation has commenced at D'Arcy residence. Nine staff have been intensely trained and formed the DBT consultation team. In addition to the intensive training, frontline staff members from D'Arcy, Ellesmere, and Megan have been enrolled in online training for DBT. With the implementation and practice of DBT at D'Arcy we are all excited to explore the outcomes of success and change over the next year.

Client Statistics

The Residential programs, serve clients with a variety of psychiatric, emotional and behavioral difficulties. Such as:

- Parent-child conflict;
- Depression/bi-polar disorder;
- Psychosis/ thought distortion;
- Anger/explosive disorders;
- Personality Disorders;
- PDD/Delays;
- Learning Disabilities;
- Substance Use concerns;
- Attachment Issues;
- Conduct Disorder;
- ADHA/ADD; and
- Prodromal Psychosis.

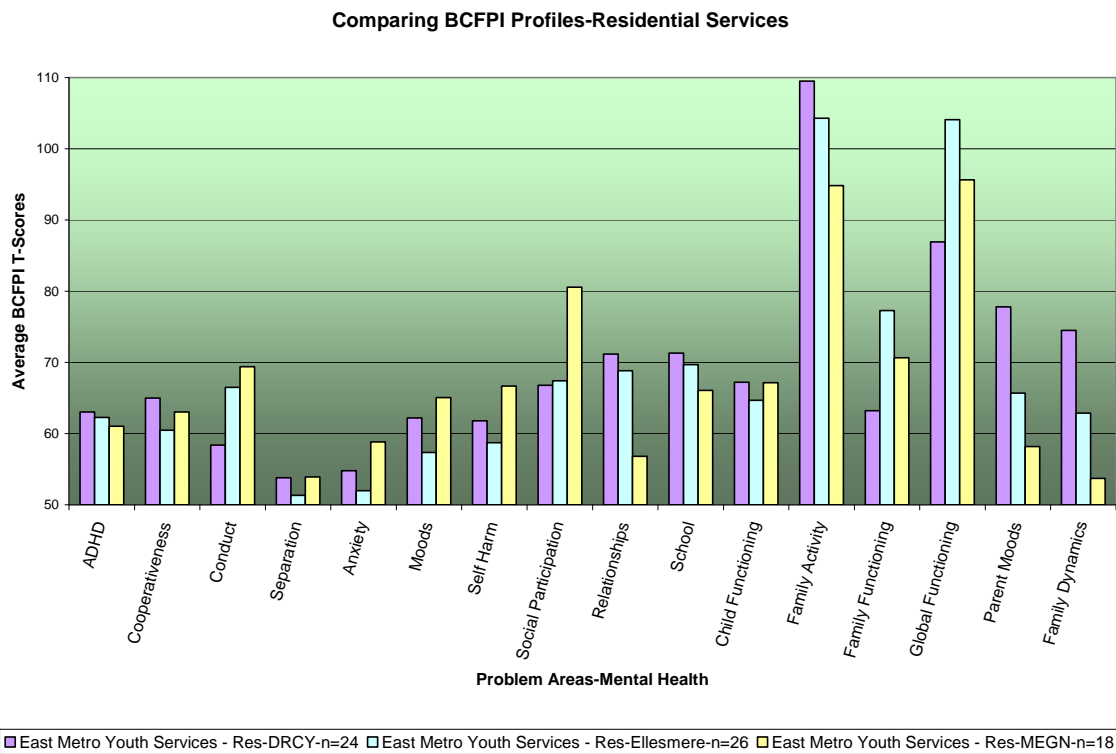
The programs vary slightly in that Megan has had a higher number of clients with psychiatric difficulties, while Ellesmere and D'Arcy often have a higher volume of clients with attachment concerns as well as behavioural difficulties. Although it should be noted that over the past year, we have identified few variations between client profiles in all three houses, as both Ellesmere and D'Arcy have been receiving referrals of clients with psychiatric difficulties. The Residential Programs referral sources for D'Arcy and Ellesmere are Child Welfare: Catholic Children's Aid Services, Children's Aid Services, Jewish Child and Family Services, Native Child and Family Services. Megan's referral source is Centralized Access to Residential Services (CARS).

The total number of clients served in the Residential Program this past year is 41. D'Arcy serviced 14 clients, Ellesmere serviced 14 clients, and Megan provided services to 12 clients. These numbers are indicative of clients staying longer term in our programs, as well as the increase this year of youth who, once treatment commenced, are identified as inappropriate fits to the capacity of our services. Additionally, 8 clients received follow-up service, as per the discharge plan to continue with counseling and follow-up services provided by East Metro Youth Services.

Client's that are referred to our programs typically range in age from 12-17. The Residential programs client population made up, on average 60 per cent females and 40 per cent males. These clients on average participated in the programs from six weeks to three (or more) years.

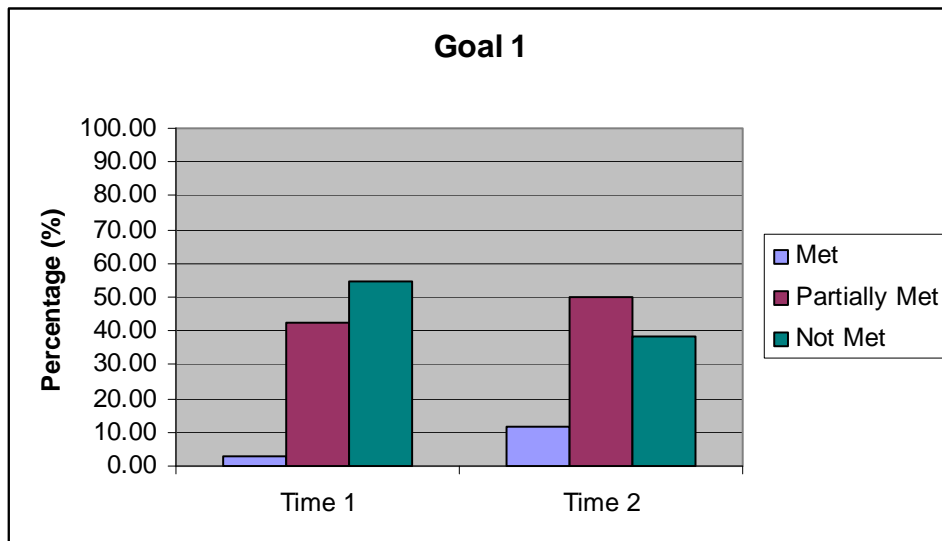
Aggregate Data

In exploring the BCFPI profiles, it is evident that the majority of generally clients referred to the Residential programs struggled within the areas of family activity, and global functioning. Clients referred to D'Arcy struggled in areas of family activity, global functioning, parent moods, family dynamics, school and relationships; whereas, clients referred to Ellesmere struggled in areas of family activity, family functioning, global functioning, school, and conduct. Clients referred to Megan struggled in areas of social participation, family activity, child functioning, global functioning, conduct and self-harm. The following graph illustrates the BCFPI t-scores from all youth in the 3 homes.

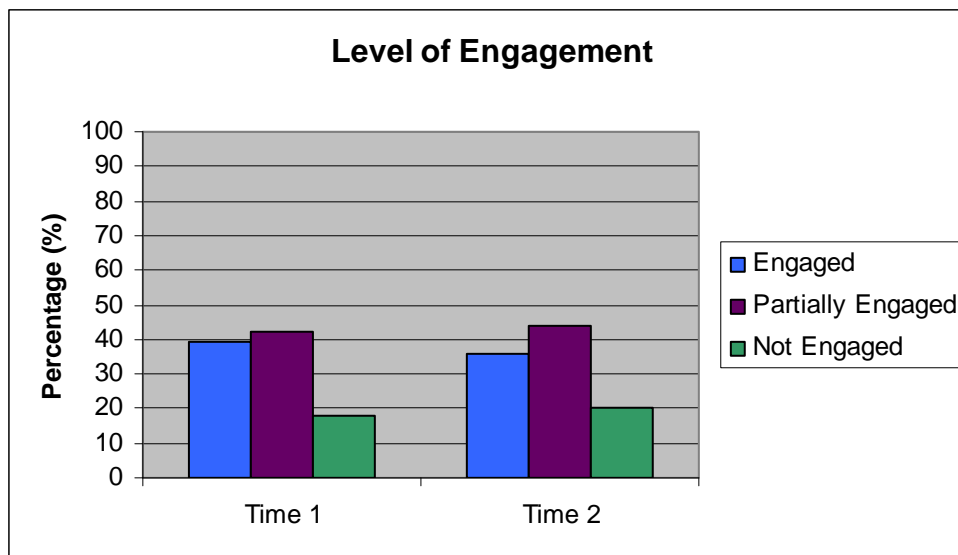


In terms of the Time 1 (entry) and Time 2 (approximately 6 months) mid overall CAFAS scores within the Residential programs, there was only a slight increase in the overall score in all three programs from 105 to 108 at D'Arcy, 112 to 118 at Ellesmere, and 90 to 102 at Megan. There is indication that the treatment and assessment process identifies new information, creating an increase in CAFAS scoring from the time of admittance into the programs. It is important to note that clients tend to score themselves lower at time of initial CAFAS scoring, as research shows that clients tend to minimize behaviors and events at time of admission. This elevation of the CAFAS scores during the second scoring phase is indicative of disclosures and observations from the multi-disciplinary team over the assessment and treatment process.

Goal attainment was an additional area that was measured this year to capture some of the gains made by clients. As the following table shows, there was an increase in goal attainment from Time 1 to Time 2 with commensurate decreases in numbers for not meeting goals.



Levels of engagement was another area measured this year. This refers to attendance in and engagement in therapy sessions as well as treatment planning. The following chart indicates the level of engagement of clients in all three Residential programs over a period of six months. It is important to note that overall clients are engaged in treatment, at the point of admission; however, levels of engagement can fluctuate over the duration of treatment depending on what challenges or successes clients are facing at point of evaluation. The increase of clients not engaged is reflective of clients who entered the program and were not interested in aspects of treatment, such as therapy. One of the challenges that the residential programs have faced is the referral of clients who are in need of residential treatment, but not engaged in counseling. It is also important to note that 66 per cent of client's families in the Residential programs were engaged in the treatment process. This is outstanding considering that 60 per cent of clients are Child Welfare clients, where parents are no longer the guardian.



Future Directions

As we move forward, there are several areas that the residential teams will be focusing on. The first is to continue with the implementation of DBT at D'Arcy with a view to expanding this practice into our 2 other homes. We also plan to work more closely with our service partners to ensure accurate and current information to best serve our clients. This will involve initiating more meetings with our service partners, particularly in reviewing the client files collaboratively to ensure clarity and accuracy. Further, we plan to increase communication/consultation between all clinical and front-line staff to routinely discuss treatment planning and discharge. Lastly, and despite increased caseloads, the supervisory staff plan to put more measures in place to provide front-line staff with more time for report writing and administrative requirements.