Community Adaptation of Youth Discharged from Residential Treatment: Case Study Results

Would Better Access to Mental Health Treatment Help?

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Acknowledgements

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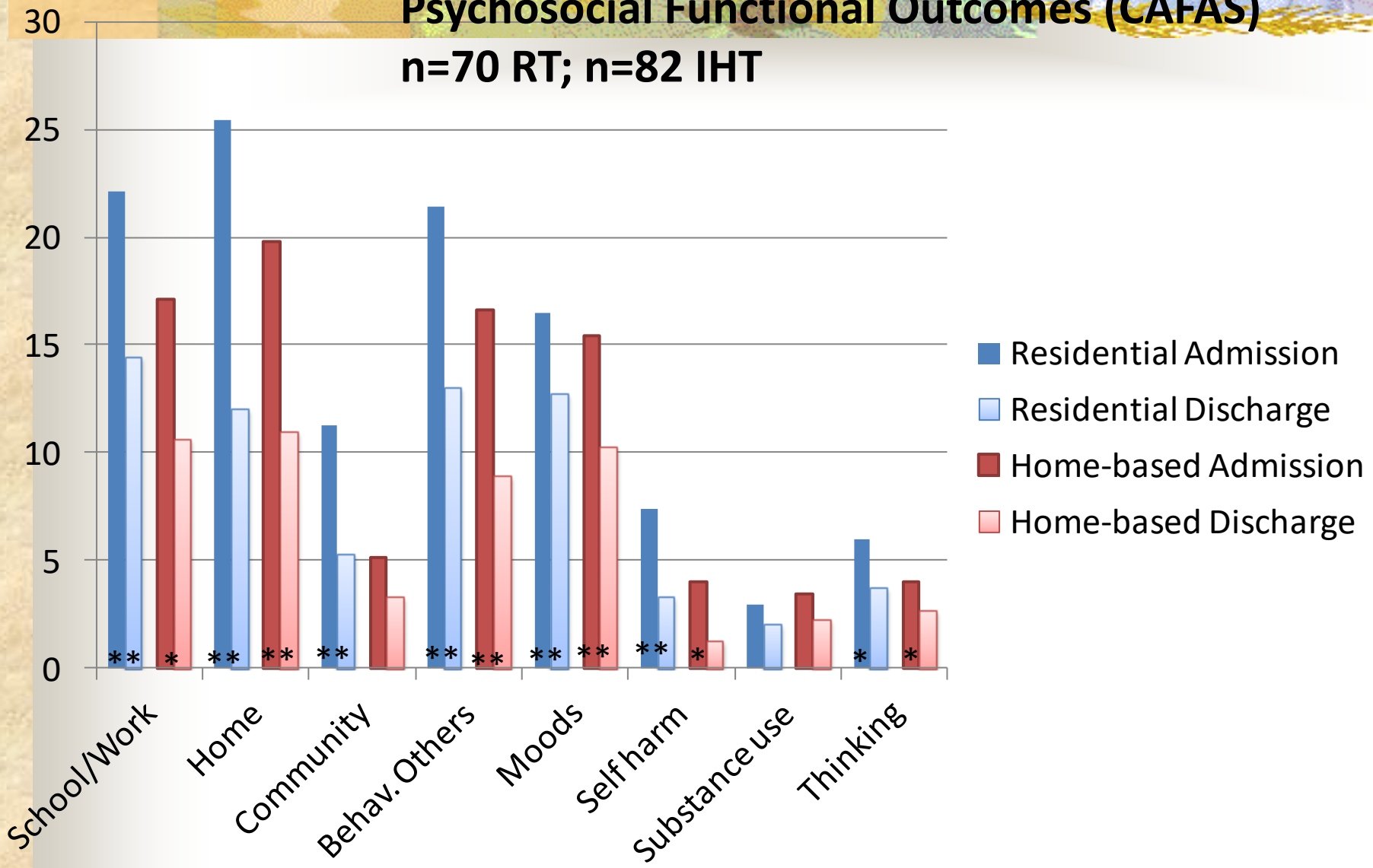
Residential Treatment Centres

- Partnered with 6 community-based mental health agencies offering secure RT, 24/7
- Provide care: professional parenting and child rearing are critically important
- Provide a range of treatments for emotional and behavioural disorders (EBD) such as Disruptive behaviour disorders
- In addition to EBD, child and family adversity, family history of mental illness or addiction, few social resources and other challenges
- This presentation will be focussed on the experiences of youth following discharge from RT

Outcomes after RT for Youth in Care

- In our previous research, youth in care enter RT with severe symptoms in conduct and oppositional defiance disorder, and great difficulty managing moods and impulses
- Many youth made gains and maintained some of them 3 years post-RT, and some did not
- Highlighted the need for RT as part of a continuum of mental health treatment
- Many youth also reported appreciation for their connection with their care/service providers

Psychosocial Functional Outcomes (CAFAS)
n=70 RT; n=82 IHT

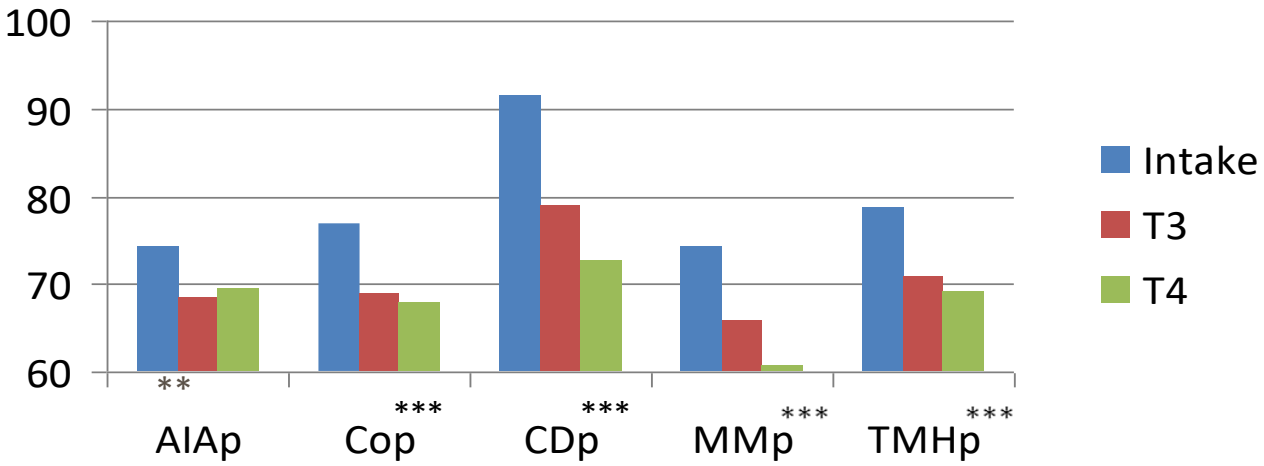


* Statistically significant improvement from admission to discharge at $p<0.05$

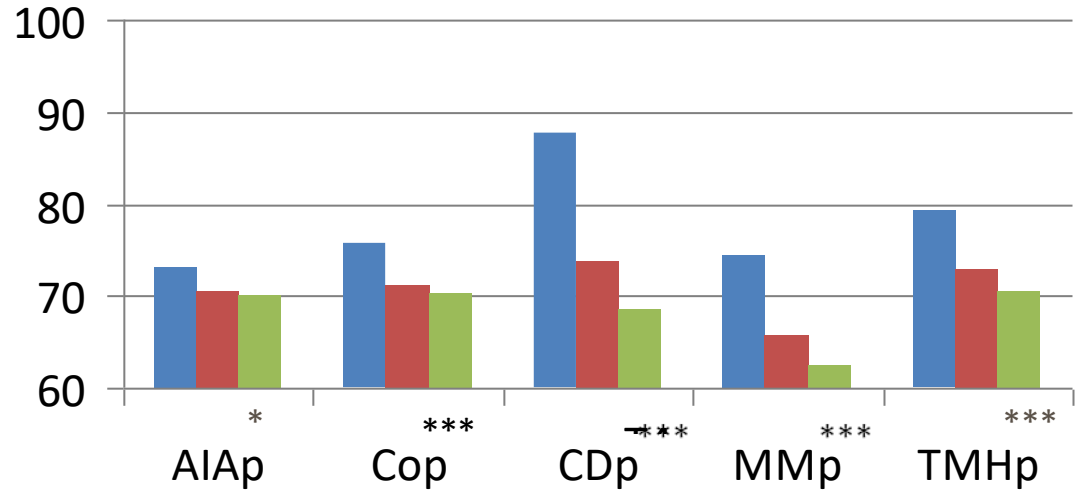
** Statistically significant at $p<0.001$

Symptom Severity Outcomes (BCFPI)

Residential
n=53



Home-Based
n=60



*Statistically significant improvement at p<0.05

** Statistically significant improvement at p<0.01

*** Statistically significant improvement at p<0.001

As Emerging Adults

- ~ 80% identified service provider as important adults in their lives (e.g., from RT and Children's Aid Society)
- "… I don't like people…" (female, age 19) "My old foster mom…We call each other,…just the workers at the Children's Aid… she was supervising my visits when I first went into care…grade 5…I talk to her about a lot of stuff…they've always been there for me and they care about me, and I know they do…Best thing that's probably happened to me...being in Children's Aid"

Recent Research Project: Multiple Perspectives Case Study

Timelines of Interviews

Participant	Time 1*	Time 2**	Time 3***
Youth	√	√	√
Caregiver (Parent or CAS Provider)	√		√
Mental Health Provider	√		

* interview scheduled within about one month of discharge from RT

** about six months post discharge

*** about one year post discharge

Multiple perspectives over a year following RT (n=25 youth)

- 12 youth identified as female, 12 youth identified as male, and one youth identified as transgender
- Mean age: 15.8 years
- 13 youth discharged into care of family (10 into families as guardians and 3 into alternate settings); one unplanned discharge due to destructive behaviour
  - 4 youth were transferred to other homes/settings during the study
- 12 youth discharged into care of CAS; 8 had unplanned discharge due to poor behaviours, problems with engagement
  - 6 youth were placed in group homes, three in specialized foster care, two informal arrangements (eg with friend/family), one in semi-independent living
  - by T2 (~6 months later) 3 youth were homeless; two were trying assisted living
  - No change from T2 to T3 in living arrangements

Accommodation Relationships of Youth discharged into CAS care

- 5 youth maintained good relationships during the year following discharge
- One youth returned to his former foster family:
- “I was really happy… I had to regain their trust… everything is going good” and his CAS provider concurred “…he’s very happy and feels secure..”

Accommodation Relationships of Youth discharged to family

- All but 2 youth reported improvement in relationships in initial transition period
- One youth reported that before RT she "…didn't talk to anyone in this house. Not even my brother, I ignored my mom…they all hated me" but after discharge "we came a long way from like where I was a year and a half before I went [to RT]" (10AT2).
- 7 cases were able to maintain good relationships
- 2 youth reported no change: "my family tends to fight a lot…they're fighting a lot less…they're making an effort" (13AT1) but by T3, the youth revealed how she dealt with the on-going conflict: "My family argues a lot. And so I try to distance myself from it."
- In three cases, the relationships deteriorated in the year following discharge: "we were doing pretty well… and I lost it and I slap him…and um he just fight me…" (2BT2).

Accommodation of youth discharged into CAS care

- 5 youth experienced deteriorating relationships characterized by conflict; relocated: to “youth jail”, shelter and unknown
- One youth reconnected with his mother where he experienced a downward spiral into video gaming; his CAS provider stated “I think the problem came when he just discovered that he didn’t have to leave his mom’s house and could game all that he wanted to”
- One youth moved 11 times in this year, including being homeless, living with boyfriend; CAS provider stated: “she does not have the capacity to sustain relationships...”

Main challenges after discharge

- On-going difficulty managing:
- Mental health disorders and the symptoms:
  - Aggressive behaviours
  - Depression/anxiety/emotion regulation
  - Addictive video gaming/Internet behaviours (and aggression)
  - Self-harm/suicide ideation
- Interpersonal difficulties and asocial behaviours
  - “I don’t find anybody a close friend”
- Difficulty developing life skills

Challenges after RT

- “I’m still like recovering and I’m still like getting used to the idea of like continuing on instead of like trying to end things” (Youth T3).
- “we had another conversation with regards to his gaming; expressed concerns that it was becoming an addiction and that it was interfering with his day to day life. He struggled…he…he said it was an addiction but he struggled to see that it was a bad addiction. He said umm…it’s not like crack cocaine, you’re never going to find me in the ER because I’ve overdosed on gaming” (CAS provider T3)
- “…he was getting violent… So I had to call Children’s Aid…they got him in the car,…so he’s no longer with us… he got so angry…he broke everything…” (Caregiver T3)

Living contexts

- “I think I’m just finally seeing it. I thought I was like a lot more normal until I spent time with a little more normal families and started functioning in society in normal … Like my girlfriend, I just at least I got to see a little more of like normal like family dynamics and stuff. And how…it’s supposed to work, not how my stuff was going” (Youth T3)

- “I’m not sure what normal is” (Caregiver T3).

- “He—and he flat out said he didn’t understand being part of a family because he had never had one..” (Foster parent/Caregiver T3)

Alone and unproductive

- One youth was asked “What does your average day look like when you come home from school?” and he replied:
- “In my room. Eat dinner…go back to my room… [to play] my video games” (17AT2).

Social interactions

- Most youth and their caregivers did not spend time together in engaging or positive interactions even with ordinary daily activities
- Many youth spent too much time alone and too much time in unproductive activities such as video gaming.
- Very few youth had daily interactions with people such as caregivers who showed them by example, healthy ways of interacting.

Interpretation

- RT can help decrease the intensity/severity of mental health symptoms AND may help some youth who may also have developmental needs
- After leaving RT, youth continue to need formal mental health intervention:
- After RT, youth should have intensive home-based treatment provided by clinician/therapist from RT (continuity)
- Involving a consistent, knowledgeable and caring mental health team may help youth maintain gains made during RT
- Find ways to engage these hard-to-engage youth

Overview of disruptive, impulse-control and conduct disorders (DSM 5)

- Repetitive patterns of problems in self-control of emotions and behaviours, characterized by behaviours such as violating the rights of others (e.g. aggression) and/ or engaging in behaviours that are in conflict with societal norms (e.g. lying, stealing)
- Differentiate from typical behaviours in frequency, persistence, pervasiveness across situation, and impairment
- High comorbidity with other disorders including anxiety and depressive disorders
- Requires treatment

Some key characteristics of these disorders

- Low self-esteem, lack of friends and constructive pastimes
- Deficits in language-based verbal skills, social cognition, executive functioning
- Youth with conduct disorder elicit negative reactions from others
- Heterogeneous presentation thus thorough assessment
- Can persist into adulthood ⇒ antisocial personality disorder
- Health as adult compromised (medical illnesses, earlier death than norm)

May also have Neurodevelopmental disorder

- Characterized by developmental deficits that can impair academic, educational, personal and social functioning
- Includes ADHD, ASD, Communication disorders, intellectual disability, learning disorder and motor disorder

- CD has high co-morbidity with ADHD

May also have a Substance-related and/or addictive disorder

- All drugs taken in excess activate the brain reward system, affects behaviours and memory
- Those with low self-control may be predisposed
- And/or nonsubstance-related disorder (e.g., gambling disorder) (research not yet developed to include behavioural addiction in DSM)

RT

- It has been documented that the care of youth in RT is very good, though availability of quality treatment is variable
- Engagement of youth is highly variable
- Engagement affects youths' exposure to treatment, the understanding of their needs and development of plans
- Youth may think they do not have a problem
- We may improve motivation and engagement by exploring youths' personal goals, help foster understanding of social consequences of emotional expressions and behaviours

Engagement

- Increase efforts to connect youth with mentor, mentor the mentors
- Ungar:
  - Informal support, emphasize empathy, enforce few rules – only necessary rules that youth understand are in their best interest (Warmth)
  - Reasonable expectations, structure/consistency but flexible/negotiable (Responsiveness)
- Positive Interactions
  - Eye contact, a smile that says I care about you
  - Mundane encounters critical eg help youth process events, develop perspective, self-awareness, hangout/laugh/socialize – time away from problems

Child development and daily positive interactions: foundation

MH treatment post-RT

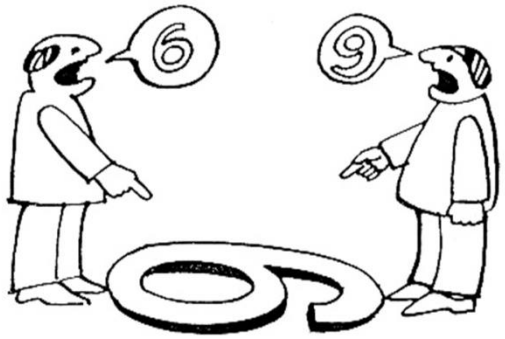
- For most youth leaving RT their treatment is by no means complete, and a consistent, knowledgeable and caring mental health team is very much needed to help them continue with the gains they have made in RT and use the skills they developed
- Evidence from well-designed meta-analyses (= highest level of evidence to inform practice), clinical practice guidelines, and professional and patient (participant) experience inform post-RT intervention options
- Robust evidence for prevention in young children targeting parents; however, our sample comprised adolescents with no or minimal family contact – are there effective interventions?
- Focus on youth-targeted components (most interventions also have caregiver component eg parent training)

Systematic Reviews: CBT, and Multi-systemic, multi-dimensional treatment

- CBT- teach coping skills, cognitive restructuring and social skills training – modeling, behavioural rehearsal, conflict resolution, appropriate expression of feelings
- Multi-systemic (Henggeler); use positive language, reframing negative thoughts and beliefs; positive reinforcement for appropriate behaviours and discipline, problem-solving, see barriers as challenges
- Multi-dimensional (Chamberlain); individual therapy, social perspective taking, teach and reinforce avoidance of social-relational problems, recognize feelings, coping strategies

Intervention

- Multi – focussed: interventions target many systems including CAS providers, home (caregivers, foster parents), school (teachers, youth workers), relationships, peer groups AND youth cognitions and perceptions
- Target strengthening youth positive cognitions and perceptions, prosocial behaviours and perspective taking
- Increase self-esteem



Clinical Practice Guidelines

- Heterogeneous presentation ⇒ individualize treatment
- Psychoeducation (youth and caregivers) about the disorders
- Target caregiver skills, 'family' functioning, child interpersonal skills, difficulties at school, peer group influences
- Caregiver: build on youth's strengths; provide consistent and calm consequences for unwanted behaviour
- Youth: CBT for anger management and interpersonal skills
  - Decrease impulsivity and angry responding
  - Therapist: Model, role play, feedback/prompts, praise
- Place youth with CD in group of youth who are functioning well (coaching)

Intervention Efforts

- For youth with severe disorder, efforts to improve cognitive or internal mechanisms may not work until influences of abusive, chaotic or problematic contexts are improved
- Efforts to use social support systems may not work until youth has developed positive social interactional skills
- Treatment needs to target youths' functioning in all systems*
- Frequent (daily/weekly) and Long term
- Insufficient resources so must select targets based on each youth's individual needs

Wellness: positive social experiences

- Often problematic social or interpersonal interactions involved in the onset of EBD but healthy positive interactions are an important part of the treatment and long-term well-being
- EBD may be held in place by contagion (Joiner & Katz, 1999)
- Happiness from collective activity (eg people laugh more often in presence of others https://doi.org/10.1111/j.1439-0310.1989.tb00536.x)
- Collective effervescence (Durkheim, 1912)
- Hugs release hormone, Oxytocin, that fosters happiness, reduces stress and anxiety, increases trust, sociability (Jurek & Neumann, 2018) and regulation of behaviours and reduced aggression (Berends et al., 2019) and improves social memory processes ….. in healthy people

Many of us didn't touch during the pandemic: Is it safe to hug again?
Alia E. Dastagir
USA TODAY

- Oxytocin is a hormone released in response to love (e.g., hugs when the relationship is perceived as positive) and plays a role in social bonding (e.g., secure attachment)
- When social cues in the environment are interpreted as “safe” oxytocin may promote prosocial behaviours
- A well-regulated oxytocin system has been linked to resilience and reduced chance of developing mental illness or substance dependence.
- Adverse environments (e.g., poor parental care, parental substance use, maltreatment) can adversely affect the oxytocin system and increase susceptibility to stress, anxiety, mental illness and addictions.

Can oxytocin or hugs help our youth in RT?

- It is proposed that interventions designed to target the oxytocin system during or soon after exposure to adversity may prove protective (Johnson & Buisman-Pijlman, 2016).
- However, research suggests that such an intervention will depend heavily on the context; e.g., administering oxytocin when the youth is in a competitive or tense environment may provoke aggression instead of feelings of calm, warmth and positive social bonding (Olff et al 2013).
- When the social cues are interpreted as “unsafe” oxytocin may promote “anti-social” emotions and behaviors especially in people who view the social milieu in negative or uncertain terms such as those with severe attachment anxiety and/or childhood maltreatment, borderline personality disorder.
- In other words, there is no easy fix

Context matters tremendously

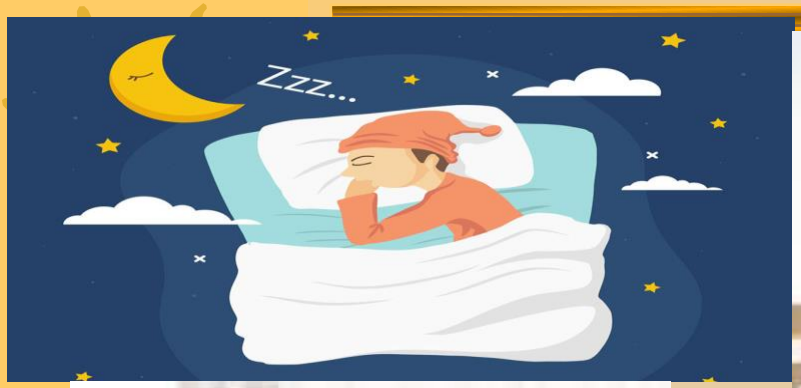
- Several different lines of research indicate that the context in which youth with EBD live, work or play matters considerably
- Studies on building resilience (eg Ungar) and the oxytocin system (eg Olff et al., 2013) suggest that ensuring a healthy context/environment should be a major target for treatment for EBD during and after RT

- Creating culture where youth engage in productive tasks, engage in exercise (fun activities) via positive social interactions that may lead to well-being (Ford et al)

Clinical experience and clinical research

- (Already doing) Foster longitudinal contact with any family member and service providers, understand that families and youth often have history of adversity or trauma
- If good therapeutic relationship created with therapist in RT, youth contact with this therapist should be maintained during and after discharge rather than switching to a different system post-discharge: RT ⇒ Intensive home-based intervention
- Note true triggers in natural environments, identify and treat comorbid conditions
- Comprehensive assessment and treatment requires thorough history from key people, good clinical recordkeeping
- Attend to healthy lifestyle: sleep is key, positive social connections, wholesome food, adequate exercise and activity

Overall Health Related to Well-being



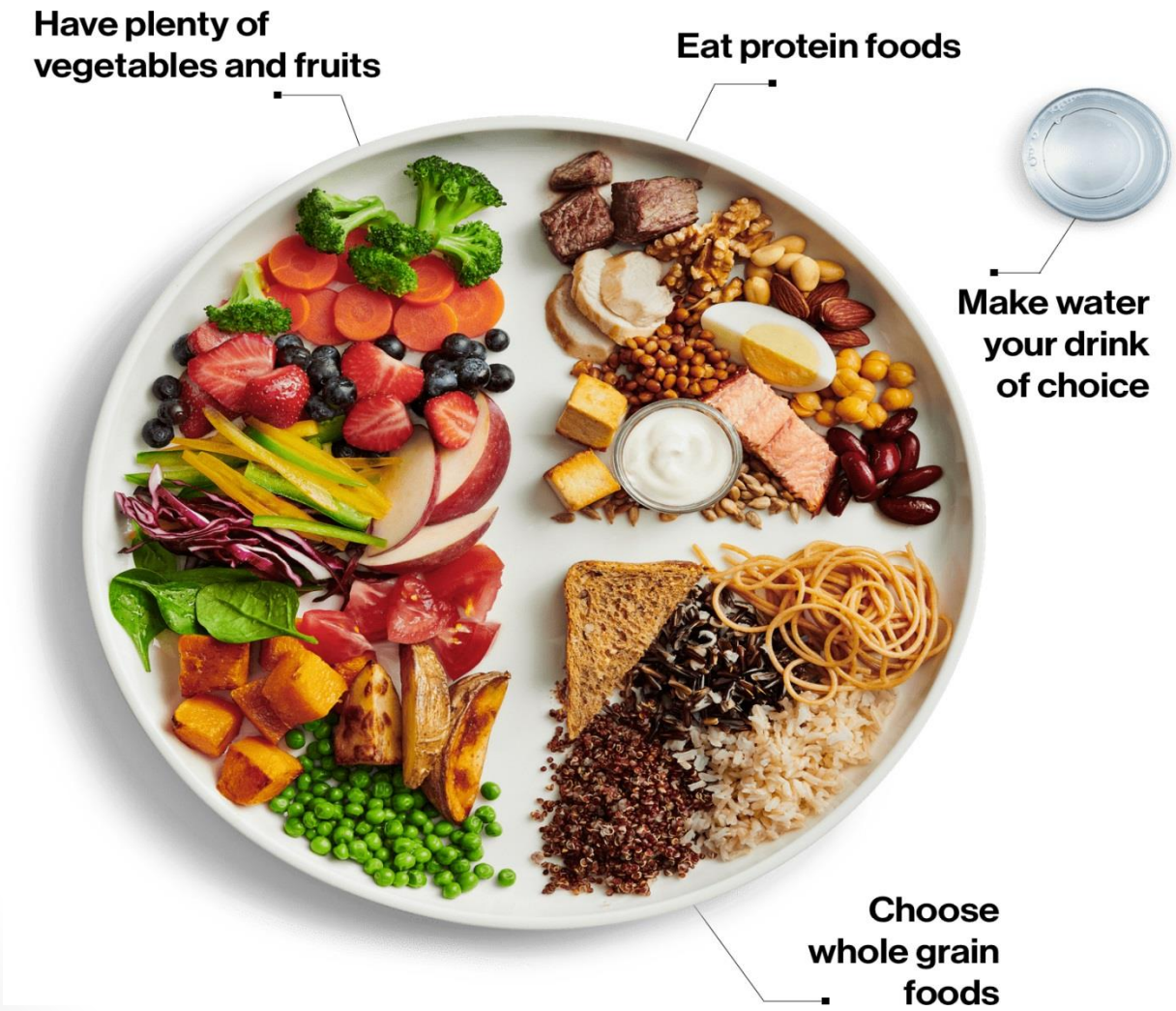
Reality

- 30-50% of kids met recommended amount of sleep
- 18% met the recommended amount of exercise
- 37% met screen time limit (less than 2 hours/day)
- 30% met fruit & vegetable intake – Stats Canada
- All associated with cognition and ability to self-regulate

- Most youth with severe MHD have poor health behaviours

Walsh et al 2018 The Lancet Child and Adolescent Health
Preyde et al. The Health and Well-being of Children and Adolescents Accessing In-Patient Psychiatry

Canada Food Guide 2019



Canada Food Guide

- Good diet associated with:
- Physical health (cardiac etc.)
- Positive Mood
- Good Memory
- Sleep
- Mediterranean diet (plants, olive oil, fish, beans, grains…) associated with decreased risk for depression

Physical Activity

Canadian Pediatric Society

- Children (5-11 yrs) and youth (12-17 yrs) should accumulate at least 60 min of moderate-to-vigorous-intensity physical activity daily, including:
- Vigorous-intensity activities at least 3 days/week.
- Activities that strengthen muscle and bone at least 3 days/week.

Reduce Sedentary Behaviour

- Limit sedentary (motorized) transport, extended sitting time, and time spent indoors throughout the day.
- Limit recreational screen time to no more than 2 h/day
- Screens should be monitored, watched jointly with caregiver

Screen time

- Reduced screen time and increased physical activity associated with improved:
- Cognitive abilities:
- Language abilities
- Executive functioning
- Attention
- Memory

Aerobic Physical Activity

- Improves overall health (cardiovascular, weight, etc.)
- Associated with positive self-concept, well-being, and reduced **anxiety and depression**
- **Movement associated with Cognition**

Sleep

- Children (5 to 13 years old) need 10 to 12 hours (9-11 hours)
- Youth (14 to 18 years old) need 8 to 10 hours

Benefits of Sleep

- Improves:
- Academic Performance
- Learning
- Brain function
- Physical health
- Emotional well-being
- Decisions – nutrition, interpersonal issues…
- Daytime performance (activity)

Promote Sleep

- Set bedtime, routines
- Try same schedule even on weekends
- Avoid stimulation 1 hr before bedtime
- Spend time outside every day in activity
- Keep bedroom cool and dark
- Use relaxation techniques before bedtime
- **No cell phone in bedroom overnight


lifestyle management
time
sleep
exercise
work
rest
stress
food
water

Tip to guide youth: Strive for SAVE

- S – sleep at night
- A – adaptability in social context, pleasant attitude
- V – vegetables instead of unhealthy snacks
- E – exercise of any kind

- Adequate sleep is key since it facilitates adherence to the other behaviours including prosocial ones

Mental health disorder: stigma and resources

- When children and youth have a physical illness or injury, caregivers seek professional help and work to get them the medical attention they need. When children and youth have symptoms of a mental illness, youth need their caregivers to respond in the same way.
- Stigma and scarce resources impact availability of treatment
- EG – compare to backlash from parents of children with autism "Ontario to modify reforms to autism program after backlash from parents"
- For youth with EBD, there are few, in any, resources or energy available for advocacy for funding for treatment or prevention (like ACRC efforts eg TELL CONGRESS TO FIX THE QRTP-IMD ISSUE)

Conclusion: key messages

- Creating and protecting a healthy environment is key
- Evidence from high quality research supports the use of psychosocial intervention (CBT and multi-system)
- Youth need continued intervention after RT, ideally home-based intervention from same therapist
- Youth engagement in treatment, therapeutic alliance key
- Attend to the overall health of the youth (SAVE)
- Limited resources means the foci for each youth will have to be selected
- Advocate for mental health treatment for youth before, during and after RT

Main References

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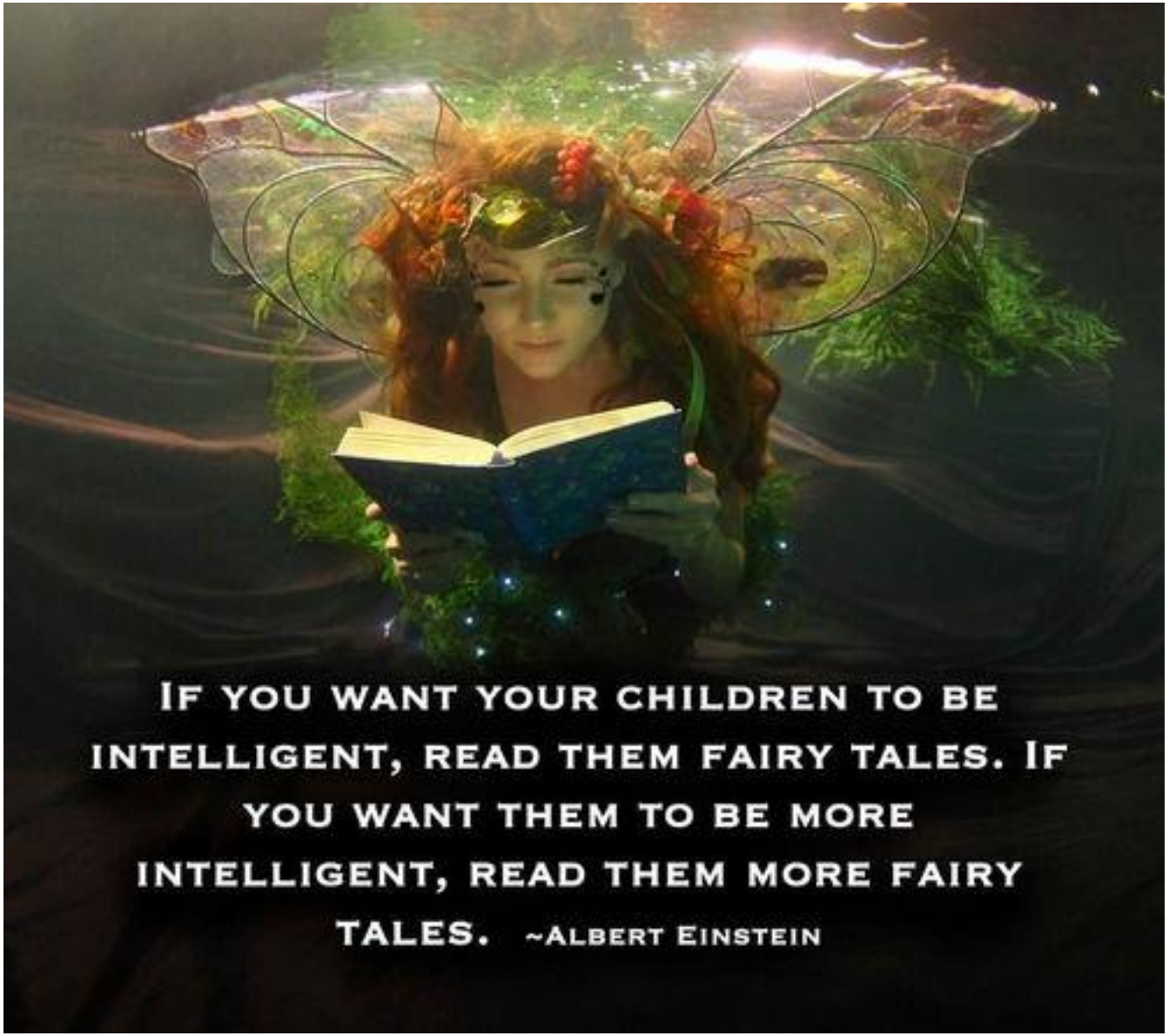
IF YOU WANT YOUR CHILDREN TO BE INTELLIGENT, READ THEM FAIRY TALES. IF YOU WANT THEM TO BE MORE INTELLIGENT, READ THEM MORE FAIRY TALES. ~ALBERT EINSTEIN