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Topic brief: Live-in treatment in the child and youth mental health and addictions sector in Ontario

Knowledge Institute
Institut du savoir

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Introduction

This topic brief provides an overview of the approach to quality standard development undertaken by the Knowledge Institute on Child and Youth Mental Health and Addictions (the Knowledge Institute), along with the results of a comprehensive scoping search on child and youth live-in treatment. The purpose of these scoping activities is to propose the scope, timelines, target audiences, and core principles for a new quality standard for live-in treatment in the child and youth mental health, substance use health, and addictions sector (the sector) in Ontario.

It is important to note that the topic brief is not a quality standard; rather, it is a foundational document to support scoping and drive conversations about what the quality standard should look like. Specifically, this document:

1. Provides background information to the Quality Standard Advisory Committee (QSAC) members for discussions and decisions.
2. Identifies individuals and organizations to engage in developing and adopting the quality standards.

The information presented here will inevitably change as we continue scoping the literature, discussing with topic experts, and drafting the quality standard.

Background

The Knowledge Institute has invested in the development of provincial quality standards for the sector in Ontario. In 2018 and 2019, we developed our first quality standards and began to refine our processes. In 2021, our Strategic Advisory Council, along with the Child and Youth Mental Health Lead Agency Consortium (LAC) and representatives from Ontario Health and the Ministry of Health, unanimously agreed that the Knowledge Institute would continue to lead the development of quality standards to inform the delivery of care in our sector.

In 2022, we published our standard development process (SDP), which is continually refined as we develop standards over time (Knowledge Institute, 2022). This rigorous, four-phase process is grounded in the strengths of the Knowledge Institute: quality research and engagement; implementation science; knowledge mobilization; evaluation; and continuous quality improvement.

Our Levels of Care Quality Standard will be released in summer 2025. The topic for our next quality standard — live-in treatment — was uniquely decided on in conjunction with work on the Ontario Intensive Treatment Pathway (OITP). The process for developing the live-in treatment quality standard began with the scoping phase in September 2024.

To learn more about our quality standards work, please see the quality standards page on our website.

Ontario Intensive Treatment Pathway (OITP)

The Ontario government has invested resources to address system gaps and advance system transformation in intensive mental health treatment for children and young people in Ontario by establishing the OITP in 2024. The goal of the OITP is to create a provincially guided, regionally delivered model for treating children and young people with intensive mental health needs. Regional Hub organizations will co-ordinate up to six regional intensive treatment networks and apply provincial standards to their local contexts. Developing a quality standard is important to the success of the overall OITP work.

The OITP will initially focus on live-in treatment. This specific focus aligns with the government's commitment through *Roadmap to Wellness* (Ontario Ministry of Health, 2020) and the LAC's Provincial Priorities Report (LAC, 2021), which identified the need for a live-in treatment quality standard. Intensive services was also identified as a top five priority, short-listed for standard development throughout the Knowledge Institute's topic selection process (January 2023). The Knowledge Institute has been asked to lead various aspects of the OITP initiative, including development of the quality standard. As such, live-in treatment was selected as the topic for the Knowledge Institute's next quality standard (2024–2026).

Of particular interest for this standard's relationship with OITP is the plan for an Indigenous-led parallel process. From the outset, OITP has been supporting Indigenous-led services to develop a specific intensive treatment model that meets the needs of Indigenous children and young people. For this quality standard, we will emphasize equity, diversity, inclusion, access, and anti-racism (EDIA-R) and health equity considerations according to our SDP. As well, we will seek to collaborate with the Indigenous OITP partners and take their lead to incorporate culturally specific practices and enhance the broad and flexible applicability of the quality standard. This collaboration between the standards

team and Indigenous OITP partners incorporates EDIA-R and health equity practices and considerations throughout the SDP and includes ongoing partnerships and consultations with priority populations. We do not expect to develop a separate quality standard, but we will confirm through ongoing consultation that the quality standard is meaningful and relevant across all communities.

What are quality standards?

A quality standard is a resource that has clear, practical, and ambitious statements describing the practices, processes, and supports required to provide the highest quality care, based on the best available evidence. These statements come together to form a unified quality standard that includes best practices, along with indicators to demonstrate the progress and impact of each statement. Quality standards are essential to a system that is driven by accountability and continuous improvement.

There are important differences between quality standards and clinical or operational standards. Clinical and operational standards describe specific actions and processes that must be taken to meet minimum service provision requirements. Primarily, these standards give detailed, specific direction to service providers on how to deliver treatment. Quality standards are composed of quality statements grouped by core principles. They provide an adaptable foundation to understand, strive toward, and advocate for the highest quality treatment and care. Quality standards are applicable to and may be used by systems-level decision makers, organizational leaders, service providers, and service users. In addition to this quality standard, which is a deliverable of the OITP, clinical and operational standards will also be created to define specific details of the clinical practice models and operational standards for intensive treatment.

Given that our quality standards are principles-based, the individuals or communities implementing them must use their judgement to apply the principle to their context. Principles-based standards provide flexibility and allow for a person- or community-centred approach. Ontario's communities are diverse in strengths, needs, and challenges. A uniform approach is not appropriate or effective in bringing system-level initiatives to life and improving child and youth mental health, substance use health, and addictions treatment and care.

We recognize the importance of flexible quality standards that can be tailored across diverse communities. That is why we develop quality standards using principle-based statements with special

attention to implementation and evaluation considerations. This will ensure that communities can use the standard as a guidepost and tailor the quality statements to their specific community context, needs, and values.

Timelines

Phase	Activities
Scoping **September 2024 – April 2025**	• Establish the QSAC. • Prepare topic brief, case for improvement, indicator framework, implementation framework and needs assessment, and draft knowledge mobilization plan.
QSAC consultations **April 2025 – June 2026**	• QSAC members participate in meetings and contribute to deliberations and feedback related to key topic areas, quality statements and indicators, public feedback and modifications, implementation, and knowledge mobilization.
Drafting **April 2025 – August 2026**	• Draft the standard. • Solicit multiple rounds of feedback including public feedback. • Revise the standard through several iterations. • Validate the SDP. • Finalize the standard.
Mobilizing **September 2026**	• Publish the standard. • Mobilize the standard according to communications and knowledge mobilization plans. • Implement and sustain the standard.
Maintaining **September 2026 and onward**	• Review the standard for continued relevance and necessary updates.

Approach

To carry out the scoping phase of standard development, we created a scoping analytical framework (a comprehensive plan) to triangulate data from literature reviews, environmental scans, and expert consultations. Between September 2024 and February 2025, we reviewed published academic and grey literature (n = 67), scanned public information available on 51 live-in treatment programs for children and young people in Ontario, and hosted semi-structured consultations (n = 86) with 126 individuals. Consultations were held with young people, caregivers, researchers, clinician scientists, system leaders, agency leaders, service providers, and community representatives. These discussions helped our team learn from the individuals who are studying, using, implementing, and accessing live-in treatment. They provided information on the current state of live-in treatment and shared their perspectives on gaps, needs, and important considerations specific to the sector in Ontario.

State of the literature

In our scoping analytical framework, we identified base search terms for live-in treatment, including "live-in care," "residential treatment," and "residential services", as well as “bed-based services,” which is frequently used in the substance use health and addictions literature. Through our review of the academic literature, we found a variety of other terms used to describe live-in treatment, such as "therapeutic residential care," "residential mental health care," "residential mental health treatment," "residential mental health facility," and "residential treatment center." Very few academic articles use the term "live-in treatment." In Ontario, there has been a recent shift away from using the term "residential treatment" in favor of "live-in treatment" to acknowledge the ongoing harms of the residential school system for Indigenous peoples (Burman et al., 2024; LAC, 2019; 2021; O’Leary et al., 2024). However, this shift is still new and not widely reflected in the academic literature. We conducted searches using all related terms and included “mental health,” “substance use health” and “addictions” in concert with these variations.

The populations discussed in the academic literature are also varied. Some articles specifically focus on children and young people in group care or foster care and define live-in treatment as a placement for children and young people in child welfare who need housing. Articles focusing solely on child welfare without addressing mental health, substance use health, or addictions treatment were excluded from our review. However, articles that covered both child welfare and children and young people

needing mental health, substance use health, and/or addictions treatment were included. This highlights the ongoing conversation about the distinction between care and treatment, and the way in which they are addressed by live-in treatment programs.[1]

In the grey literature, several reviews and reports over the past 10 years have called for improvements to live-in treatment and out-of-home care in Ontario:

- Strengthening children's mental health treatment through evidence and experience (Johnson et al., 2015).
- Residential treatment: Working towards a new system framework for children and youth with severe mental health needs (Children's Mental Health Ontario [CMHO], 2016).
- Because young people matter: Report of the residential services review panel (Ministry of Children and Youth Services [MCYS], 2016).
- Residential Treatment Working Group: Final report (Residential Treatment Working Group, 2017)
- Provincial Priorities Reports (LAC, 2019; 2021)
- Ministry of Children, Community, and Social Services (MCCSS) Quality Standards Framework (MCCSS, 2020).

Additionally, many agencies have conducted their own internal reviews and quality improvement initiatives for their live-in treatment programs. This body of work reflects significant foundational efforts to understand the current landscape, identify challenges, and shape a vision for improving live-in treatment in Ontario, which will help to inform the development of this quality standard. Findings from this academic and grey literature are incorporated in the sections below.

[1] Care and treatment are closely connected, and a quality standard focused on live-in treatment must consider how they are integrated. The language used to define care and treatment is evolving and will continue to change throughout the development of the standard.

Why is this quality standard needed?

What is live-in treatment?

Ontario's core mental health, substance use health, and addiction services are provided along a continuum that includes varied types and intensities of care to meet the needs, goals, and preferences of children, young people, and caregivers. These levels of care include (1) wellness, health promotion, prevention, and early identification at all levels for all children, young people, and caregivers in the community (targeted prevention, such as health literacy); (2) low-intensity care (self-guided resources, peer support, brief services); (3) moderate-intensity care (psychotherapy, group therapy, medication, family services); (4) moderate- to high-intensity care (specialized consultation, inpatient psychiatric hospital services, acute care); and (5) highly specialized, intensive care (inpatient hospitalization with inter-professional teams, intensive treatment services (Knowledge Institute, 2025; Ontario Ministry of Health, 2024). Intensive treatment encompasses a suite of services, including community-based/day treatment, in-home services, and out-of-home services (live-in treatment; Ontario Ministry of Health, 2024).

At present, live-in treatment can be defined as "treatment within a 24-hour a day out-of-home placement by an inter-professional, multi-disciplinary team making therapeutic use of the daily living milieu" (LAC, 2021). Live-in treatment is an important component of a comprehensive continuum of care, intended for children and young people who require a greater level of support than can be provided in a less restrictive setting (Harper et al., 2019; Herbell et al., 2024a; Herbell & Ault, 2021; Lanier et al., 2020; Liddle et al., 2018; Lynch et al., 2017; Roy et al., 2020; Theall et al., 2022; Vogelsang et al., 2024; Yeheskel et al., 2020). Children and young people who access live-in treatment have significant and complex mental health, substance use health, and/or addictions concerns, and often have a history of trauma that impacts their ability to function at home, in school, or in the community (Bryson et al., 2017; Coll et al., 2019; Evans et al., 2020; Frensch et al., 2022; Good & Mishna, 2021; Grosset et al., 2018; Herbell et al., 2024a; Herbell & Ault, 2021; Liddle et al., 2018; Matte-Landry & Collin-Vézina, 2022; O'Leary et al., 2024; Preyde et al., 2020; Roy et al., 2021; Vogelsang et al., 2024).

Live-in treatment is a voluntary treatment intended to help stabilize and de-escalate symptoms using evidence-based, clinical treatment modalities, while providing children and young people with

opportunities to develop and practice coping and living skills, with the goal of gradually transitioning to less intensive services (Grosset et al., 2018; Herbell et al., 2024a; Preyde et al., 2018; 2020; Theall et al., 2022; Vogelsang et al., 2024).

This quality standard is meant to be applicable, relevant, and meaningful to all live-in treatment programs across Ontario. We have included substance use health and addictions alongside our mention of mental health throughout this topic brief. This approach is to respond to the call to co-ordinate and integrate services for mental health and substance use health in the sector, and to include addictions services for children and young people in the new core services framework (Office of the Auditor General of Ontario, 2025). It is yet to be determined how this quality standard will apply to live-in treatment (or bed-based) programs specific to substance use health and addictions. We will explore this further throughout the standard development process.

What is the current state?

Through our scoping activities and synthesis of the data collected, we learned that live-in treatment programs in Ontario vary in their approaches, with different criteria for admission, intake and discharge processes, age groups served, lengths of stays, and clinical treatment modalities[2]. The Ministry of Health outlines minimum expectations of live-in treatment programs, but the specific approaches are up to each agency (Johnson et al., 2015; Ontario Ministry of Health, 2024). Despite these differences, there are common elements across programs.

- Interdisciplinary teams deliver treatment and care to children, young people, and caregivers/the caregiving system.
- Discharge planning begins as early as possible, often at the time of admission.
- Treatment includes a combination of individual and group therapy, family therapy and/or psychoeducation, and skill-building.
- Caregivers are strongly encouraged, and sometimes required, to be involved in treatment.

[2] The Provincial Intensive Landscape Report (Capitalize for Kids, 2025) provides a quantitative overview of live-in treatment in Ontario.

Related sectors

The current landscape of live-in treatment programs in Ontario involves a complex interaction with other sectors, including acute care, education, youth justice, and child welfare. Based on our consultations and literature review, it was clear that it is not possible to get a fulsome picture of live-in treatment without considering its interaction with these sectors.

Inpatient hospital settings provide short-term stabilization for children and young people who are in crisis. Once a young person's immediate mental health, substance use health, and addictions needs are addressed, they often require ongoing treatment to support their long-term recovery. Live-in treatment programs are an important bridge in this process, offering a less restrictive environment for continued treatment (CMHO, 2016; van Dorp et al., 2023; Woody et al., 2019). Some hospitals in Ontario use a "Step-up / Step-down" model, which allows children and young people to transition from acute hospital care to live-in treatment, and eventually back into the community (Capitalize for Kids, 2025).

Children and young people continue their education while in live-in treatment. Some participate in coursework under the leadership of a teacher embedded in the live-in program, while others continue to receive education at their regular school (Gutterswijk et al., 2020). It is important for live-in treatment providers to work closely and maintain open communication with district school boards, school authorities, education liaisons, and teachers. This collaboration ensures that children and young people get the educational support they need during treatment and helps plan for their transition back to school afterward (MCCSS, 2020).

Children and young people with mental health concerns, who have caused or attempted to cause bodily harm to themselves or others, can receive treatment through secure treatment programs. Admission to these programs occurs when children and young people have serious mental health concerns, they display behaviors that put themselves or others at significant risk, and their behaviors cannot be safely managed by alternative services in their current living situation or other out-of-home placements (Schutte et al., 2022). Secure treatment programs are governed by legislation and require a court order for admission, with admission usually being compulsory (Schutte et al., 2022). They aim to stabilize children and young people in a highly supervised environment, with the goal of allowing them to make enough progress to eventually transition to less restrictive treatment options. Live-in treatment

programs often play a critical role in this transition, serving as a "step-down" program where children and young people can continue their treatment in a less restrictive setting (Johnson et al., 2015).

MCCSS oversees programs run by Children's Aid Societies, including foster care and group care. These settings provide a safe living environment for children and young people who cannot remain with their families and focus on providing basic care needs rather than treatment. Some children and young people in the care of child welfare have significant mental health, substance use health, and addictions concerns and may require live-in treatment (LAC, 2019).

What are the challenges with live-in treatment?

Through the literature and in our consultations, we found notable gaps and challenges in live-in treatment programs, including:

- Workforce challenges
- Lack of clear and consistent eligibility criteria
- Challenges with involving caregivers
- Varying clinical program models and evidence-based practices
- Difficulties transitioning out of live-in treatment

Workforce challenges

One of the most significant challenges identified in consultations and the literature are those involving the workforce. Live-in treatment environments are among the most demanding settings within the sector. Staff work in a 24/7, shift-based environment with children and young people who have some of the most complex needs (LAC, 2019).

Given the complexity of need among children and young people who access live-in treatment, and the 24-hour, out-of-home nature of the services, live-in treatment programs typically consist of interdisciplinary teams with different educational backgrounds and scopes of practice, such as child and youth workers, psychologists, psychiatrists, and social workers. However, in-house staff training for live-in treatment is not regulated in Ontario (MCYS, 2016; O'Leary et al., 2024). Certain topics such as crisis intervention require annual training, but there is no standardized or mandatory specialized training for all staff in treatment approaches (MCYS, 2016; O'Leary et al., 2024). For example, child and youth workers — who spend more time with children and young people than other service providers, often

observing them in the milieu and during moments of crisis — typically receive limited training in specific treatment modalities (LAC, 2019; O'Leary et al., 2024). Post-secondary programs in child and youth care provide broad training but offer limited focus on psychological theories and mental health, substance use health, and addictions treatment. This contrasts with the more specialized education received by clinical staff such as social workers and psychologists. The lack of consistent, baseline training for all staff ultimately affects the standard of care that children and young people receive (MCYS, 2016; O'Leary et al., 2024). It also means that child and youth workers' skills are often underutilized, leading to missed opportunities for purposeful integration of clinical treatment and milieu therapy, including the incorporation of treatment support in the milieu.

Live-in treatment work is emotionally demanding. Without proper training, supervision, and support, direct service providers may struggle to meet the demands of such intensive environments, often leading to burnout (Geoffrion et al., 2021; Kor et al., 2021). Despite the challenging nature of the work, direct service staff are often underpaid, leading many to seek better-paying opportunities elsewhere. Live-in treatment is often described as a "stepping stone" to other careers, contributing to high turnover rates and exacerbating the staffing crisis (MCYS, 2016). The high turnover rate further complicates the issue by placing strain on training resources. Organizations are faced with the logistical challenge of providing ongoing training while ensuring that shifts are covered (MCYS, 2016; O'Leary et al., 2024). The combination of insufficient training, inadequate compensation, and high turnover creates a cyclical and complex challenge.

Lack of clear and consistent eligibility criteria

There are currently no consistent diagnostic criteria or clinical indicators to determine eligibility and suitability for live-in treatment. Without a well-defined and up to date clinical profile, it becomes difficult to determine which children and young people require and will benefit from live-in treatment, what the best treatment approach is for them, and their compatibility with others in the program (Evans et al., 2020; Johnson et al., 2015; LAC, 2019; Optimus SBR, 2025; Theall et al., 2022).

There are no common assessment tools or guidelines in place to help identify when live-in treatment is the best option and which live-in treatment program is the best option (Johnson et al., 2015, LAC, 2019). Live-in treatment is intended for children and young people facing the most complex and severe mental health, substance use health, and addictions concerns, and so the clinical profiles are diverse. This raises the question of how to accurately identify those who would benefit most from and meet the criteria for this level of treatment.

Without standardized assessment tools, criteria to match needs with the best fit clinical program models, or criteria to define who is eligible for live-in treatment, it is difficult to ensure that live-in treatment is truly the best option for the children and young people accessing it (Johnson et al., 2015; LAC, 2019). Focusing solely on the clinical presentations of children and young people who are currently in live-in treatment does not provide insight into the clinical profiles of those not accessing live-in treatment, who might also benefit from it (LAC, 2021). Without clear clinical profiles, it is challenging to determine which children and young people would benefit most from live-in treatment as opposed to other intensive services. The OITP is currently supporting work to determine the clinical population of live-in treatment (Optimus SBR, 2025). Clear clinical profiles and standardized assessment would ensure that needs are matched to the appropriate intensity and modality of treatment.

Another challenge is that admission to live-in treatment programs is often based on bed availability rather than on aligning the child or young person's needs with a program's characteristics (the clinical program model). This can result in a situation where a bed is occupied by a client whose needs are not the best fit for the program, which not only delays access for others who might benefit more but also leaves the current client's needs unmet (CMHO, 2016; Evans et al., 2020; Johnson et al., 2015; LAC, 2021; MCYS, 2016; Optimus SBR, 2025; Yeheskel et al., 2020). Alternatively, some programs may deny admission if they cannot effectively meet the child or young person's needs. The result is that beds remain unoccupied, with no alternative programs available to refer the child or young person to that would better meet their needs (Johnson et al., 2015). This challenge is rooted in the absence of a variety of defined clinical program models and aligned tiers of live-in treatment throughout the province.[3]

Compatibility is also a key consideration in the admission process. Programs must carefully consider how a child or young person will interact with other clients in the program to prevent negative group dynamics and to minimize the risk of impeding treatment progress (Gutterswijk et al., 2020; Johnson et al., 2015; Kor et al., 2021).

At times, a child or young person may require a safe place to stay and support for mental health, substance use health, or addictions, without needing the level of intensive treatment that live-in

[3] Several reports have described the need for a tiered model of live-in treatment in Ontario (CMHO, 2015; 2016; Johnson et al., 2015; LAC, 2021; Residential Treatment Working Group, 2017).

treatment programs provide. Due to a shortage of safe and supportive housing options and pathways to appropriate levels of care, a live-in treatment bed may be sought even though the placement does not align with the child or young person's needs. This placement challenge often stems from a lack of clarity around live-in treatment program criteria and expectations. Conversely, there are instances where children and young people in the care of child welfare require intensive mental health treatment but are not able to access a bed in live-in treatment (LAC, 2019). In both cases, there is a misalignment between the child or young person's needs and the placement provided.

Challenges with involving caregivers

The literature emphasizes the importance of active caregiver involvement as a key factor for the success of children and young people in live-in treatment. Nevertheless, caregivers can differ in their capacity to be involved for several reasons.

- Children and young people may attend live-in treatment programs that are located far from home, which can make it challenging for caregivers to be physically present and can limit opportunities for communication and home visits due to the distance.
- Relationships may be strained between children, young people, and caregivers, and those involved might need time for respite.
- Caregivers may also be navigating their own mental health, substance use health, or addiction concerns, which can affect their capacity to participate.
- Children and young people involved with child welfare and child protection services may have limited contact with their caregivers.

Some programs require caregivers to be involved in treatment, while others strongly encourage and expect caregiver participation but do not require it. This emphasis on caregiver involvement is based on the evidence that live-in treatment is most effective when caregivers are actively engaged in all aspects of the program (CMHO, 2016; Coll et al., 2019; Herbell et al., 2024a; 2024b; James, 2017; Johnson et al., 2015; Ninan et al., 2014; Patel et al., 2019; Residential Treatment Working Group, 2017; Whittaker et al., 2016; Woody et al., 2019). For a child or young person to maintain the progress made in treatment, their home environment must evolve along with them (Herbell et al., 2024a; 2024b; Johnson et al., 2015). To achieve this, caregivers need to receive support alongside children and young people (Knowledge Institute, 2025).

Varying clinical program models and evidence-based practices

In Ontario, live-in treatment programs vary widely in their treatment approaches, as there is no standard calling for the implementation of clinical program models rooted in treatment modalities that are best

practice for live-in treatment. There is no standardized treatment modality across programs, and this flexibility is important because it allows for different clinical approaches to meet the diverse needs of children and young people. Agencies typically design and develop programs based on their expertise, philosophies, and priorities (LAC, 2019). Challenges arise because some programs do not follow a specific clinical model and instead rely solely on milieu therapy. While some consider milieu therapy a form of treatment, effective treatment should be guided by an evidence-based clinical model, with the milieu serving as a supportive environment for treatment. It is essential that live-in treatment programs implement evidence-based models with fidelity and demonstrate that their approach leads to meaningful clinical outcomes.

Additionally, the sector faces challenges in evaluating program effectiveness. There is no standardized performance measurement system to assess live-in treatment outcomes, nor a reliable method for tracking long-term outcomes (Johnson et al., 2015; MCYS, 2016; Theall et al., 2022). Data collection mechanisms and approaches vary greatly from program to program. The diversity of program models also makes it difficult to draw conclusions from existing research about which interventions are most effective. Despite their intensive nature and high cost, live-in treatment programs often struggle to provide evidence of positive, lasting outcomes for children and young people beyond discharge (Grosset et al., 2018; LAC, 2019; Theall et al., 2022).

Difficulties transitioning out of live-in treatment

Many children and young people who access live-in treatment show improvements at discharge but often struggle to maintain these gains over the long term (CMHO, 2016; Frensch et al., 2022; Givetash et al., 2017; Johnson et al., 2015; MCYS, 2016; Optimus SBR, 2025; Preyde et al., 2018; 2020; Tran et al., 2017; Vogelsang et al., 2024). A key challenge is the transition back to their home environments, which may have contributed to their initial mental health, substance use health, or addictions concerns. Live-in treatment provides a structured and therapeutic space to receive treatment and develop skills, but sustaining progress can be difficult if caregivers have not been actively involved in the treatment process or received support themselves (Johnson et al., 2015; Preyde et al., 2020).

Further complicating this transition is that live-in treatment programs in Ontario vary in their capacity to provide post-discharge support, as transitional services and aftercare are generally not funded (Johnson et al., 2015). In addition, live-in treatment has historically operated in isolation from other community services. While child and youth mental health, substance use health, and addictions services exist along a continuum, live-in treatment is often seen as a last resort rather than as a

component of a comprehensive treatment plan. This fragmented approach creates challenges at discharge, when strong collaboration with community partners is crucial for a smooth transition. Without coordinated efforts across services and sectors, continuity of care is often lacking, making it harder for children, young people, and caregivers to sustain the progress they made in treatment (LAC, 2019; MCYS, 2016; Patel et al., 2019; Preyde et al., 2018; Vogelsang et al., 2024).

Other challenges

Other challenges mentioned in the literature and consultations include:

- Live-in treatment is one of the most **resource-intensive** services in the sector, requiring substantial financial investment (Coll et al., 2019; Herbell et al., 2024a; Theall et al., 2022). However, rising inflation, increasing operational and staffing costs, and the growing complexity of needs outpace existing funding models (CMHO, 2016; Johnson et al., 2015; LAC, 2019).
- **One-size-fits-all licensing requirements** create significant challenges for live-in treatment. Current licensing approaches do not differentiate between licensed care and licensed mental health treatment where evidence-based treatment is required. Although some licensing standards apply across all out-of-home settings, there must be specific considerations for the unique context of out-of-home mental health, substance use health, and addictions treatment, and the unique characteristics and needs of specific treatments and program models (CMHO, 2016; Johnson et al., 2015; LAC, 2019)
- Ontario's **geography creates barriers to equitable access** to live-in treatment. Children and young people living in rural, remote, and northern communities often need to leave these areas to receive treatment, which results in separation from their caregiving system who are unable to be closely involved in their treatment. When they return, their communities may not have the resources to support ongoing treatment (CMHO, 2016; LAC, 2019; MCYS, 2016).

Beyond these challenges, there is sometimes a broader sense of scrutiny surrounding live-in treatment. Some agencies have decided to close their live-in treatment programs and reallocate funding to other intensive services. Concerns often centre around the impact of removing children and young people — especially those in their early and middle years — from their homes, as well as the significant costs of these programs without consistently demonstrating clear clinical outcomes (Gutterswijk et al., 2020; James, 2017; Liddle et al., 2018; Lynch et al., 2017; Strickler et al., 2016; Whittaker et al., 2016; Woody et al., 2019). Despite the challenges and critiques, live-in treatment remains an essential component of a comprehensive continuum of care.

What is an ideal vision for live-in treatment?

Many children and young people can receive intensive mental health treatment while staying with their caregivers (day treatment, in-home treatment). However, some will have severe and complex needs

that require intensive, around-the-clock care. In some cases, live-in treatment placements are necessary due to challenging home environments that cannot support intensive mental health treatment (Johnson et al., 2015; LAC, 2019). A comprehensive, community-based child and youth mental health, substance use health, and addictions system provides a full continuum of services — ranging from brief services to intensive treatment — and is designed to support the small percentage of children and young people who would benefit from live-in treatment. Insights from consultations and the literature have helped shape the following ideal vision for live-in treatment.

Admission to live-in treatment begins with a clear understanding of which children and young people will benefit most from this type of treatment. To support this vision, OITP is currently supporting work to define the clinical population for live-in treatment in Ontario (Optimus SBR, 2025), and this report will be shared with the Knowledge Institute to inform future discussions. Standardized assessments are conducted to align the best treatment with children and young people's needs and goals. If live-in treatment is determined to be the right option, the specific program that can best support the child or young person's mental health, substance use health, and addictions needs is matched to them.

When children and young people are admitted, live-in treatment programs:

- Support the caregiving system alongside children and young people, ensuring they are actively and meaningfully engaged throughout every stage of the program (CMHO, 2016; Coll et al., 2019; Frensch et al., 2022; Herbell et al., 2024a; 2024b; James, 2017; Johnson et al., 2015; Ninan et al., 2014; Patel et al., 2019; Preyde et al., 2020; Residential Treatment Working Group, 2017; Whittaker et al., 2016; Woody et al., 2019).
- Include an interdisciplinary team of professionals who receive ongoing support, training, and clinical supervision to support the clinical program model (Coll et al., 2019; Johnson et al., 2015; O'Leary et al., 2024).
- Thoughtfully and purposefully integrate appropriately matched evidence-based treatment (dialectical behavioural therapy [DBT], cognitive behavioural therapy [CBT], and others) with milieu therapy and activities like physical activity, recreation, and skill-building to provide holistic care (Coll et al., 2019; Frensch et al., 2022; Johnson et al., 2015).
- Prepare children, young people, and caregivers for discharge early in the process (Johnson et al., 2015; Woody et al., 2019).
- Routinely measure progress and outcomes to inform individualized treatment plans and to ensure that children and young people are making progress toward their goals (measurement-based care; Theall et al., 2022; Yeheskel et al., 2020).
- Provide specialized support for children and young people with complex and concurrent needs, either through their interdisciplinary team or in collaboration with other services (Woody et al., 2019).

When children and young people are ready for discharge, they are connected to after-care supports to maintain the progress made during treatment. This includes coordinated collaboration among community-based mental health, substance use health, and addictions agencies and other sectors to ensure a smooth transition to lower levels of care and reintegration into the community (CMHO, 2016; Coll et al., 2019; MCYS, 2016; Woody et al., 2019).

Throughout all aspects of this process, from intake to discharge:

- Clients are always at the centre of decision-making, with their needs, goals, experiences, and capacity for care recognized and respected (Ninan et al., 2014; Woody et al., 2019).
- Treatment and care are culturally specific, identity-affirming, and safe (Johnson et al., 2015, Residential Treatment Working Group, 2017).
- Ongoing case management ensures continuity of care and helps match children and young people to the right level of care and live-in treatment that aligns with their needs and goals (CMHO, 2016; Herbell et al., 2024a; Johnson et al., 2015).

Case for improvement

Significant foundational work has been carried out to identify challenges and develop a vision for improving live-in treatment in Ontario. Although there is a shared commitment to delivering high-quality live-in treatment, implementation of evidence-based live-in treatment across the province is inconsistent. Implementing a quality standard for live-in treatment is important to the success of the provincial initiatives to provide equitable access to evidence-based intensive treatment across the province, to improve consistency of services and treatment outcomes, and to establish clear treatment pathways. A quality standard will build on the sector's strengths and work to improve the quality of intensive mental health, substance use health, and addictions treatment by addressing inconsistencies, improving clarity and reliability, and establishing a core set of evidence-based principles that encourage accountability, evaluation, and continuous improvement.

Core principles

We recognize that a one-size-fits-all approach does not work to meet the diverse needs of Ontario's communities. The quality standard will identify specific core principles (or themes) that represent the most important considerations for live-in treatment. In the quality standard, each core principle is accompanied by specific quality statements. These ambitious-but-realistic statements, which are based on the best available evidence, describe optimal, highest-quality live-in treatment.

Core principles and quality statements are defined in consultation with the QSAC. To begin this process, we have identified preliminary themes for consideration, based on our literature reviews and consultations.

Please note, at this point in the process, the themes below are meant only to inform conversations on core principles for the quality standard. Some themes will include repeated and overlapping concepts. They might also include concepts or details that should be foregrounded as a core principle. Please read through the themes to consider what details you believe are most important, meaningful, and relevant for a quality standard on live-in treatment.

Individualized and client-centred

- A standardized assessment identifies the unique treatment needs of each child and young person, ensuring that treatment plans are strength-based and tailored to individual needs (CMHO, 2016; Johnson et al., 2015). Ongoing assessments and regular updates to these plans help treatment evolve in response to the changing needs of the child or young person (measurement-based care; CMHO, 2016; Theall et al., 2022; Yeheskel et al., 2020).
- Children and young people are at the forefront of decision-making and collaborate with service providers to make decisions about their treatment and care (MCCSS, 2020; MCYS, 2016; Ninan et al., 2014; Woody et al., 2019).
- Ongoing case management helps identify and match children, young people, and caregivers to the right level(s) of care that aligns with their needs, preferences, and goals, and supports navigation and continuity of care (CMHO, 2016; Herbell et al., 2024a; Johnson et al., 2015; Kanter, 1989).

Caregiver involvement

- Caregivers are empowered to be actively engaged in all aspects of the program, including at intake, treatment planning, during treatment, and discharge (CMHO, 2016; Coll et al., 2019; Herbell et al., 2024a; 2024b; James, 2017; Johnson et al., 2015; MCYS, 2016; Ninan et al., 2014; Patel et al., 2019; Residential Treatment Working Group, 2017; Whittaker et al., 2016; Woody et al., 2019).

- The caregiving system receives support alongside children and young people, including opportunities for collaborative communication, information and education, peer support, and participating in individual and/or family therapy where possible (Coll et al., 2019; Frensch et al., 2022; Herbell et al., 2024a; 2024b; Johnson et al., 2015; Ninan et al., 2014; Preyde et al., 2020; Residential Treatment Working Group, 2017).
- Programs help children, young people, and caregivers strengthen family relationships and create a more supportive home environment (Furtado et al., 2016; Grosset et al., 2018; Johnson et al., 2015; Optimus SBR, 2025; Patel et al., 2019; Whittaker et al., 2016).
- Barriers to caregiver involvement (location, for example) are identified and mitigated whenever possible (CMHO, 2016; Herbell et al., 2024a; 2024b; Johnson et al., 2015; Ninan et al., 2014).

Equity, diversity, inclusion, access, and anti-racism (EDIA-R)

- Considerations for EDIA-R are embedded into all aspects of live-in treatment, including intake, assessment, treatment planning, and discharge planning, as well as staff training and competencies. This ensures that treatment takes cultural context into consideration and includes access to culturally specific approaches and perspectives (CMHO, 2015; Johnson et al., 2015; MCYS, 2016).
- Pathways to culturally specific and linguistically relevant care are made available through meaningful partnerships and culturally diverse staffing (Johnson et al., 2015; MCCSS, 2020).
- Staff engage in ongoing capacity building to increase their knowledge and competence in delivering anti-oppressive, anti-racist, trauma-informed, and culturally specific care (Johnson et al., 2015).
- Performance measurement includes diversity metrics to assess equity and outcomes among cultural groups (Johnson et al., 2015; MCYS, 2016; Residential Treatment Working Group, 2017).

Matching to the right services

- Live-in treatment is an important part of the continuum of care for children and young people with complex needs. Treatment is initially provided in the least restrictive environment, with live-in treatment offered to children and young people when their needs require a higher level of support than what can be provided in a less intensive setting (Gutterswijk et al., 2020; James, 2017; Johnson et al., 2015; Liddle et al., 2018; Lynch et al., 2017; Whittaker et al., 2016; Woody et al., 2019).
- A comprehensive, standardized assessment is completed to ensure that children and young people are matched to the right level of care and a live-in treatment program that meets their needs (CMHO, 2016; Coll et al., 2019; Johnson et al., 2015; Stewart et al., 2023; Theall et al., 2022).

Concurrent disorders and complex needs

- Children and young people with complex mental health needs, including concurrent disorders (co-occurring mental health and substance use health or addiction concerns) and dual diagnoses (co-occurring mental health concerns and developmental disabilities), receive integrated, specialized care (Woody et al., 2019).
- Partnerships and pathways are established with services that can provide specialized support.

Evidence-based clinical program models and treatment modalities

- Treatment takes an interdisciplinary approach to meet the complex needs of children and young people and provide holistic care (O'Leary et al., 2024; Ninan et al., 2014). Treatment is

individualized and flexible and rooted in a biopsychosocial understanding to support the unique needs of children, young people, and caregivers (Kvamme et al., 2024; Ninan et al., 2014).

- Evidence-based treatment models (DBT, CBT) are used to define clinical program models (James, 2017; O'Leary et al., 2024; Ninan et al., 2014) and to inform individualized treatment plans, such as the types and frequency of interactions with clinicians (O'Leary et al., 2024)
- Treatment is trauma-aware and trauma-informed (Bryson et al., 2017; Burman et al., 2024; Coll et al., 2019; James, 2017; Johnson et al., 2015; Kor et al., 2021; MCCSS, 2020; Ninan et al., 2014; Optimus SBR, 2025; Stewart et al., 2023), attachment-informed (Ninan et al., 2014; Preyde et al., 2018), and emphasizes safety and trustworthiness (Burman et al., 2024).
- Live-in treatment provides ongoing opportunities for client choice, collaboration, and connection, and prioritizes strengths-based approaches and complementary skill building (Burman et al., 2024).
- Live-in treatment programs use measurement-based care, with routine assessments at key timepoints (intake, discharge) to inform individualized treatment planning, to determine if children and young people are making progress towards their treatment goals, and to evaluate the effectiveness of the treatment modality (Theall et al., 2022; Yeheskel et al., 2020).

Purposeful integration of treatment and care

- Care and treatment are closely connected (see "Important Considerations" section, below). Children and young people have better outcomes when care and treatment work together and are purposefully integrated. For example, combining CBT with milieu therapy or training staff to use CBT techniques in their daily interactions makes the approach more holistic, purposefully blending the therapeutic environment with effective treatments (Creed et al., 2021).
- Live-in treatment extends beyond delivering evidence-based treatment; it emphasizes the importance of the therapeutic milieu, where the physical setting, relationships, and daily interactions encourage growth and healing (Gharabaghi, 2024). Evidence-based treatment (CBT, DBT) is thoughtfully integrated with complementary activities such as recreation, life skills development, and non-Western therapeutic approaches to provide holistic support (Coll et al., 2019; Frensch et al., 2022; Johnson et al., 2015).

Treatment environment

- Live-in treatment provides a warm and responsive environment. This type of environment is foundational for establishing a sense of safety and resilience where children and young people learn to trust the environment as a safer space that promotes growth and healing (Frensch et al., 2022; Gharabaghi, 2024; MCCSS, 2020).
- Staff build therapeutic alliances and relationships with children and young people. These connections are key to achieving improved mental health outcomes during live-in treatment (Frensch et al., 2022; Gharabaghi, 2024; Johnson et al., 2015; MCCSS, 2020; Vogelsang et al., 2024).
- Live-in treatment settings have a physical space that is welcoming and home-like, with access to nature and greenspace when possible.
- *This topic area may be able to be combined with purposeful integration of treatment and care.*

Staff capacity, competencies, well-being and retention

- Interdisciplinary teams collaborate to provide treatment and care, including but not limited to child and youth workers, psychologists, psychiatrists, social workers, nurses, and physicians

(CMHO, 2016; Johnson et al., 2015; O'Leary et al., 2024; Ninan et al., 2014; Residential Treatment Working Group, 2017; Woody et al., 2019).

- All staff are given ongoing training on the program's treatment modality (O'Leary et al., 2024) and trauma-informed care (Coll et al., 2019; Stewart et al., 2023). All staff are supported in delivering treatment and care by engaging in clinical supervision (Coll et al., 2019; Johnson et al., 2015; MCYS, 2016; O'Leary et al., 2024).
- Agencies support staff well-being through fair compensation, comprehensive training, regular supervision, and a positive team climate (Geoffrion et al., 2021; James, 2017; Kor et al., 2021). Prioritizing staff well-being improves workplace satisfaction and strengthens retention.

Transitions out of treatment

- Discharge planning begins as soon as the child or young person enters treatment (Johnson et al., 2015; Woody et al., 2019).
- After-care support individualized to the needs of children and young people is important for maintaining gains made in live-in treatment and successful reintegration into lower levels of care (CMHO, 2016; Coll et al., 2019; Woody et al., 2019). There is coordination and collaboration with community-based mental health agencies and across sectors including education, youth justice, child welfare, primary care, adult mental health, substance use health, and addictions (Johnson et al., 2015; MCYS, 2016; Patel et al., 2019).
- The caregiving system plays a vital role in ensuring a smooth transition for children and young people leaving live-in treatment and in sustaining progress. Transition plans incorporate support for caregivers, including in-home support (Herbell et al., 2024b; Preyde et al., 2020), and help strengthen relationships, rebuild trust, and create a supportive home environment (Patel et al., 2019; Preyde et al., 2018).

Collaboration and partnerships

- Live-in treatment is part of a complete continuum of care and is integrated with community-based mental health services (Johnson et al., 2015; Whittaker et al., 2016).
- Strong partnerships and collaboration between agencies and across sectors (education, youth justice, child welfare, primary care, adult mental health, substance use health, and addictions) and community organizations provide integrated, holistic, and culturally specific care to address complex needs (CMHO, 2015; 2016; Johnson et al., 2015; Ninan et al., 2014; Residential Treatment Working Group, 2017; Woody et al., 2019).
- These relationships support continuity of care and facilitate transitions in and out of live-in treatment (CMHO, 2015; 2016; Kor et al., 2021; MCYS, 2016).

Continuous quality improvement

- Live-in treatment programs are continuously evaluated to identify gaps and challenges and leverage strengths and opportunities for improvement (CMHO, 2016; Johnson et al., 2015; MCYS, 2016; Residential Treatment Working Group, 2017).
- Indicators are established to measure progress, and there are mechanisms to collect, evaluate, and report data (CMHO, 2016; Johnson et al., 2015; MCYS, 2016; Residential Treatment Working Group, 2017).

Proposed scope and target audience

One quality standard — on live-in treatment in the community-based child and youth mental health, substance use health, and addictions sector in Ontario — will be developed. This quality standard will focus on children and young people up to 25 years old. The Knowledge Institute recognizes the unique needs of children and young people across all stages of child and youth development, from the early years (under age 6) to the transition years (ages 18–25). Supporting caregivers in fostering children's social and emotional development early in life helps establish a foundation for lifelong well-being, and ongoing access to services beyond age 18 is important for maintaining well-being into adulthood. This quality standard will emphasize the cross-sectoral collaboration needed to support children and young people across their development.

The primary audience for this standard is system- and agency-leaders and service providers. This standard should also be accessible and relevant to children, young people, and caregivers. Although mental health and substance use health and addictions services should be inclusive of other settings (education and primary care, for example), the target setting for this standard is community-based child and youth mental health, substance use health, and addictions agencies. This standard is not explicitly developed for use by those in allied sectors, but it can support community-based agencies to foster partnerships with agencies in related sectors.

Table 2. Proposed inclusion and exclusion of the quality standard

	Proposed inclusion	Proposed exclusion
Criteria	• **Topic:** Community-based live-in mental health and substance use health and addictions treatment. • **Age:** Children and young people up to age 25. • **Setting:** Ontario's community-based child and youth mental health, substance use health, addictions agencies. • **Audience**	• Settings outside of Ontario's community-based child and youth mental health, substance use health, and addictions agencies.

- Professionals including clinicians, researchers, system- and agency-leaders, service providers and policymakers.
- Children, young people, and their caregivers.

Important considerations

The literature and our consultations highlighted groups and communities of children and young people who face additional barriers to receiving live-in treatment services that can meet their unique needs. For example:

- Although participation in live-in treatment is voluntary, some children and young people may attempt to run away (Preyde et al., 2020). These incidents place considerable strain on community resources, such as emergency services.
- The literature and anecdotal evidence from consultations note that some children and young people in live-in treatment have experienced human trafficking (MCCSS, 2020; MCYS, 2016).
- Children and young people with the most complex needs may engage in behaviours that require physical interventions like restraints. However, this practice should be minimized as much as possible and be used only in situations where less restrictive interventions were not successful to promote safety (Braun et al., 2020; Johnson et al., 2015; Mathieu & Geoffrion, 2023; Matte-Landry & Collin-Vézina, 2022; Ninan et al., 2014).The use of restraints can result in adverse outcomes for children, young people, and staff (Braun et al., 2020; Geoffrion et al., 2021; 2022; Johnson et al., 2015; Mathieu & Geoffrion, 2023; Matte-Landry & Collin-Vézina, 2022; Roy et al., 2020).

These challenges further emphasize the need for a trauma-informed approach to live-in treatment. Additional areas are presented here for your consideration.

Children under 12

Some live-in treatment programs serve children aged 6–12, often referred to as “latency years programs.” These programs place a strong emphasis on family involvement. However, perspectives shared during our consultations varied. Some participants expressed concerns about removing young children from their homes, while others anecdotally noted that children in this age group tend to have better outcomes in live-in treatment compared to young people in their teen years (Optimus SBR, 2025). To provide the best support for any young person, and particularly for children under 12,

programs must tailor their treatment approaches to align with the developmental stage, addressing distinct cognitive, social, and emotional needs.

Transition-aged young people

Live-in treatment programs typically serve young people up to age 18, creating challenges in the transition years (ages 18–25). When young people turn 18, they often are no longer able to access youth services. Navigating the transition to the adult system can be complex due to gaps in communication and collaboration between services. Additionally, adult programs are not always designed to meet the unique needs of transition-aged young people. To address these gaps, live-in treatment programs can ensure that young people turning 18 are given the support they need to transition to the adult system, including access to education or employment support or supportive or transitional housing when necessary (CMHO, 2016).

Pregnant and parenting young people

Experiencing pregnancy and parenting at a young age can have a significant impact on the development of both the birthing parent and their child(ren). Over the past decade, the number of young people under 25 experiencing mental health concerns during pregnancy has almost doubled (Burman et al., 2024). Young people who are pregnant or parenting and experiencing mental health challenges require specialized support (CMHO, 2015; 2016). A recent review of live-in treatment programs for pregnant and parenting youth in Ontario identified several areas for improvement: (1) improving staff retention and providing specialized training in strengths-based and trauma-informed approaches to working with pregnant and parenting youth; (2) adapting eligibility criteria to better support young people before their needs escalate into crises and connecting them with other services as their age requires them to transition out of programs; and (3) shifting away from institutional-style live-in programs to supportive, in-community, and transitional housing models with wraparound services or hub-like models (Burman et al., 2024).

Complex and concurrent needs

Anecdotal evidence from consultations shows that many children and young people seeking live-in treatment have complex and concurrent needs, such as substance use health concerns, physical health concerns, eating disorders, and developmental disorders (for example, Fetal Alcohol Spectrum Disorders and Autism Spectrum Disorders. This will be confirmed through the OITP clinical profile work). However, many programs are not equipped to support these complex needs. Agencies do not

have the capacity to support children and young people with substance use health concerns who require medical support for withdrawal management. When substance use health is the primary concern, it often becomes an exclusionary factor, although programs may consider each case individually. A recent performance audit of the sector in Ontario found that about 70% of agencies that responded reported their services do not meet the needs of children and young people with concurrent concerns (Office of the Auditor General of Ontario, 2025).

Similarly, most programs cannot accept clients with eating disorders as their main concern, as they lack the resources to provide medical support. Additionally, many children and young people with dual diagnoses are placed in live-in treatment programs that focus on providing mental health treatment rather than the behavioural support they need. Agencies frequently note that they "cannot be everything to everyone," underscoring the importance of comprehensive assessments to ensure children and young people are matched with programs best suited to their needs.

Equity, diversity, inclusion, access, and anti-racism

Live-in treatment programs that embed anti-racist, anti-colonial, and anti-oppressive approaches can ensure culturally and linguistically specific care that respects and affirms the diverse identities of young people and their caregivers (MCCSS, 2020). This approach can create meaningful opportunities for young people to connect with their family and caregiver history, heritage, culture, race, religion, and language (MCCSS, 2020). EDIA-R considerations can be applied to assessment, placement decisions, treatment planning, and discharge planning to ensure that services are responsive to the needs and culture of young people and caregivers (Johnson et al., 2015; MCCSS, 2020; MCYS, 2016). Establishing partnerships with culturally and ethnically specific community groups can help connect young people and caregivers to supports during treatment and at discharge (Johnson et al., 2015). Employing staff who reflect the identities and cultural diversity of young people (Johnson et al., 2015; MCCSS, 2020) — as well as offering anti-racism and anti-oppression training, supervision, mentorship, and coaching — can improve the ability of live-in treatment programs to affirm and better serve clients with diverse backgrounds (Johnson et al., 2015).

Performance measurement should also include diversity metrics to assess equity and outcomes among different cultural groups (Johnson et al., 2015; MCYS, 2016). Young people and caregivers with lived and living expertise can be meaningfully engaged at both the organizational and system levels in the design, implementation, and evaluation of live-in treatment, and their feedback can be used to drive

improvements (Knowledge Institute, 2025; Ontario Centre of Excellence for Child and Youth Mental Health, 2021a; 2021b).

Integration of treatment and care

There is an important distinction between the terms "treatment" and “care," particularly when discussing live-in treatment. The term “care” can encompass a vast range of services focused on supporting the well-being of children, young people, and caregivers by ensuring that the daily needs of children and young people are met while creating a stable and supportive environment. The word **“**treatment**”** refers explicitly to evidence-based interventions (for example CBT, DBT), that address specific mental health and substance use health conditions and symptoms (substance use disorders, depression, anxiety).

In a live-in treatment, bed-based care, or in-patient setting, care and treatment are closely connected. Care focuses on the milieu: the environment, the people in it, and their interactions, and is often delivered through milieu therapy. Literature points to better outcomes when care and treatment work together (Creed et al., 2021). Delivering high-quality care is the foundation for creating an environment that supports high-quality mental health treatment. Therefore, a quality standard focused on live-in treatment must consider purposeful integration of care and treatment.

There is an existing standards framework specific to residential care in Ontario: The Ministry of Children, Community and Social Services’ (MCCSS, 2020) *Quality Standards Framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings*. This standards framework is a document focused on residential *care:* the common care services provided across *all* licensed residential settings across *all* sectors. It is a foundational standard for all out-of-home care settings, including foster and group care, secure treatment, and live-in treatment. The MCCSS Quality Standards Framework indicates that developing standards for other services and supports delivered in licensed live-in settings, including mental health treatment, is outside the scope of the standard (MCCSS, 2020). Our quality standard will complement the Quality Standards Framework by focusing specifically on mental health treatment provided in live-in treatment settings.

Proposed composition of QSAC

The QSAC acts as a topic-specific advisory committee to provide input and feedback on the Knowledge Institute's quality standard on live-in treatment throughout one cycle of the SDP (Knowledge Institute, 2022).

The primary objective of this QSAC is to provide input and feedback on the Knowledge Institute's live-in treatment quality standard. The committee also provides feedback on accompanying quality domains and indicators, implementation supports, and knowledge mobilization efforts. QSAC members will act as champions of the final standard in their communities and promote its uptake and implementation.

The committee for the live-in treatment quality standard is made of 39 members, including two co-chairs, who are experts in their fields and represent diverse perspectives, as well as 11 ex-officio members. Committee members represent a spectrum of professions that study, implement, plan, provide services in, and receive care in live-in treatment programs. This includes clinician scientists, researchers, system and agency-leaders, service providers, and young people and caregivers with lived or living expertise. A specific engagement process based on our Quality Standard for Youth Engagement and Quality Standard for Family Engagement and a standard-specific Equity Impact Assessment will be carried out throughout the development of this standard.

We strive to create a QSAC that is representative of Ontario's diversity, including across geographic regions (Central, Western, Eastern and Northern Ontario, as well as Toronto); racial identities; and sexual orientations and gender identities.

Proposed deliverables

- Live-In Treatment quality standard
- Indicator framework and workbook
- Implementation resources
- Knowledge mobilization plan
- Evaluation resources

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Appendix A: Glossary of terms

Care

"Care" can encompass a vast range of services focused on supporting the well-being of children, young people, and caregivers by ensuring that the daily needs of children and young people are met while creating a stable and supportive environment. **"Treatment"** refers explicitly to evidence-based interventions (CBT, DBT), that address specific mental health and substance use health conditions and symptoms (substance use disorders, depression, anxiety). Care focuses on the milieu—the environment, the people in it, and their interactions, and is often delivered through milieu therapy.

Caregivers

Caregivers include people who support and look out for one another. They can be connected through family, biology, emotions, culture, or legal ties. The term also includes individuals recognized by the client as important for their well-being (Ontario Centre of Excellence for Child and Youth Mental Health, 2021a; 2021b). Examples of caregivers include family members such as parents, siblings, grandparents, aunts and uncles, as well as other supportive individuals, like partners, Elders, mentors, peers, and legally appointed guardians. A group of people connected by the support, care, and supervision of an individual is referred to as a "caregiving system."

Children and young people

Children and young people encompass birth to age 25 and include infants, children, adolescents, and transition-aged youth. We use the term "children" to refer to ages 12 and under and "young people" and "youth" to refer to ages 13 to 25. When applicable, we are specific about infant and early years (0 to 6 years old).

Community-based child and youth mental health, substance use health, and addictions agencies

Navigating Ontario's system for child and youth mental health, substance use health, and addictions involves many providers and organizations across different sectors, all dedicated to delivering mental health, substance use health, and addiction services to children, young people, and caregivers. Ontario's community-based child and youth mental health and addictions agencies are publicly funded and operate across 33 service areas in 5 regions (CMHO, n.d). There are 31 Lead Agencies that serve Ontario's 33 service areas to improve care in their service area through local planning efforts alongside

the more than 190 Core Service Provider agencies that also provide care across Ontario. The Lead Agencies work together as a group, known as the LAC, to plan and provide leadership at the provincial level (LAC, 2019).

Concurrent disorders

When someone is experiencing mental health and substance use health concerns at the same time, we call it a concurrent disorder. For example, an individual with schizophrenia who has a cannabis use disorder (Knowledge Institute, 2024a).

Culturally specific care/treatment

Culturally specific care/treatment refers to healthcare that integrates and honours the beliefs, values, and practices of the group and is tailored to meet the unique needs of a particular cultural group from the outset. Other terms that are often used to describe similar approaches to care and treatment include “culturally affirming,” “culturally relevant,” and “culturally responsive”. In this document, we use the term “culturally specific” to highlight that care and treatment aligned with a client’s culture is not an afterthought, but an imbedded priority from the start.

Equity

Equity can be defined as both a process and an outcome. Advancing equity requires acknowledging, naming, and dismantling oppressive systems and barriers reinforcing historical and existing inequities that limit access to opportunities such as mental health, substance use health, and addictions care. As a process, equity can be advanced in many ways, such as co-developing with communities the policies and practices that impact their lives or applying an equity lens or framework to programs and services. As an outcome, equity is the absence of differential outcomes based on social, economic, demographic, or geographic characteristics. It is important to note that equity is not the same as equality (University of British Columbia, n.d.).

Implement, implementation, implementing

“Implement” means putting a plan, thing, or idea into action (Knowledge Institute, 2024b).

Key performance indicators

Key performance indicators are measurable and objective metrics that help assess how well a program, organization, or system is doing. They let us see progress toward a goal in a clear and quantifiable way.

Knowledge mobilization

Knowledge mobilization focuses on ensuring that evidence is meaningful, understandable, and practical for those who need it. Knowledge mobilization supports organizations by offering access to the best available evidence to guide their work. It also involves actively engaging partners to close the gap between new research and its application in practice (Knowledge Institute, 2023).

Live-in treatment

“Treatment within a 24-hour a day out-of-home placement by an inter-professional, multi-disciplinary team making therapeutic use of the daily living milieu" (LAC, 2021). *Note: this is a working definition that will be revised for the quality standard.* In Ontario, there has been a recent shift away from using the term "residential treatment" in favor of "live-in treatment" to acknowledge the ongoing harms of the residential school system for Indigenous peoples (Burman et al., 2024; LAC, 2019; 2021; O’Leary et al., 2024).

Milieu therapy

Milieu therapy is an approach that aims to create a structured, supportive, and safe environment to promote well-being. It leverages daily routines, activities, and interactions as opportunities for children and young people develop and practice their coping and living skills (Huefner & Ainsworth, 2021).

Performance measurement

Performance measurement involves regularly gathering information to monitor the progress of a policy, program, or initiative at any given time. It helps track the achievement of planned outcomes and observe performance trends over time (Ontario Centre of Excellence for Child and Youth Mental Health, n.d.).

Quality standard

A quality standard is a resource that has clear, practical, and ambitious statements describing the practices, processes, and supports required to provide the highest quality care, based on the best available evidence. Standards are essential to a system that is driven by accountability and continuous improvement. They help reduce systemic inequities and improve service quality and outcomes for children, young people, and caregivers.

Quality improvement

Quality improvement involves taking steps to increase the efficiency and effectiveness of processes and activities within your organization. It is a continuous effort aimed at consistently enhancing programs to achieve improved results for all partners (Knowledge Institute, 2024c).

Substance use health and addictions

Substance use health is the continuum of substance use and people's experiences with substances, including no use of substances on one end and substance use disorder on the other. Substance use health recognizes that along the continuum there are health effects, risks, and benefits associated with substance use, and that stigma can be experienced at any point along the continuum (Community Addictions Peer Support Association [CAPSA], 2023). Addictions refers to behavioural or process addictions such as gambling.