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Live-in treatment quality standard: for the child and youth mental health, substance use health, and addictions sector

Knowledge Institute
on Child and Youth Mental Health and Addictions

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Executive summary

The quality standard presented in this document offers guiding principles for delivering, evaluating, and sustaining high-quality live-in treatment programs to support the mental health and substance use health of children and young people in Ontario. This quality standard is one component of the Ontario Intensive Treatment Pathway (OITP) initiative.

This standard is intended for agencies in the community-based child and youth mental health, substance use health, and addictions sector (the sector) that deliver live-in treatment. The standard can be tailored to an organization's specific needs and values. It was developed according to the standard development process[1] of the Knowledge Institute on Child and Youth Mental Health and Addictions (the Knowledge Institute) and draws on our expertise in research, performance measurement, evaluation, engagement, quality improvement, and implementation science.

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. Quality standards help reduce systemic inequities and improve service delivery, quality, and outcomes (Knowledge Institute, 2025a).

The standard presented in this document is:

- Focused on live-in treatment that serves children and young people with needs and concerns related to mental health, substance use health, and addictions.
- Intended to be applicable, relevant, and meaningful to all live-in treatment programs across Ontario.
- Intended to be used by system and organization leaders, as well as service providers delivering treatment in live-in treatment settings.
- Designed to be easily accessible and understandable; children, young people, and their caregivers are either receiving treatment or engaged in evaluating live-in treatment programs, so this standard is designed to be accessible to them.

1 For more information about our standard development process, please see our Standard development process brief.

Executive summary

Rather than proposing rigid definitions and rules, this quality standard offers clear and practical statements that describe practices, processes, and supports required to provide the highest quality care. They are not a reflection of what is currently happening, but of the ideal state.

This quality standard is based on a set of 10 core principles that fit into four themes (Table 1). These core principles are ambitious but achievable and are designed to support agencies in delivering and continually improving live-in treatment programs. Every community is in a different place in their journey, and what the core principles look like in action varies across communities. The standard is accompanied by a suite of resources for agencies implementing and measuring the quality standard.

The core principles are not listed in priority order and should be considered together.

Table 1: Core principles of high-quality live-in treatment

Foundations of treatment

- Live-in treatment is child- and youth-centred.
- Live-in treatment programs encourage and empower caregiver involvement.
- Live-in treatment is equitable, inclusive, and trauma-informed.
- Live-in treatment supports the unique needs of young people with concurrent disorders and complex needs.

Delivery of treatment

- Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.
- Live-in treatment programs purposefully integrate treatment and care.
- Live-in treatment is grounded in staff capacity, competencies, and well-being.

Pathways in and out of treatment

- Live-in treatment programs ensure a smooth and coordinated transition into treatment, where the right services are matched to a young person's needs and goals.
- Live-in treatment programs provide a smooth and coordinated transition out of treatment.

Sustaining high-quality treatment

- Live-in treatment programs commit to continuous quality improvement.

Language matters

Clear and respectful language is important for effective and safer communication. The glossary below defines key terms used throughout this quality standard. It is important to recognize that language evolves over time; definitions presented here reflect our current understanding of these key terms and may change as best practices evolve.

Care

"Care" encompasses a vast range of supports focused on enhancing the well-being of children, young people, and caregivers. It includes meeting the daily needs of children and young people while creating a stable and supportive environment grounded in consistent, trusting relationships. Care is inherently relational and responsive, emphasizing connection, co-regulation, cultural responsiveness, and active engagement of caregivers and support networks. It recognizes that well-being is supported through everyday interactions, relationships, and experiences. Care focuses on the milieu — the social environment, the people in it, and the quality of their interactions to support well-being. Care can be delivered through milieu therapy (see definition of milieu therapy).

Caregivers/caregiving system

Caregiver(s) refers to people who support and look out for an infant, child, or youth. The caregiving system is a group of people connected by the support, care, and supervision of an infant, child, or young person. Caregivers include individuals recognized by the child or young person as important for their well-being (Ontario Centre of Excellence for Child and Youth Mental Health, 2021a; 2021b). They can be connected through family, biology, emotions, culture, or legal ties. Caregivers include parents, as well as family members such as siblings, grandparents, aunts and uncles, and other supportive individuals, like partners, Aunties, Elders, mentors, peers, and legally appointed guardians.

Advocacy, consistency, and coordination throughout an infant, child, or young person's treatment journey is often led by, and relies on, a parent or primary caregiver. It is acknowledged that the term "caregiver" does not adequately represent the depth of connection and responsibility that is experienced and required of those most responsible for the young people in their care. The use of "caregiver" and "caregiving system" throughout this quality standard are meant to holistically represent these individuals and communities, and the pivotal role they play.

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; Infant and Early Years Mental Health Promotion, 2024).

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. These are funded by different Ministries — Ministry of Health, Ministry of Children, Community and Social Services, and others — all dedicated to delivering mental health, substance use health, and addictions 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 (Children's Mental Health Ontario [CMHO], n.d). There are 31 Lead Agencies that serve Ontario's 33 service areas. Under Ontario's *Child, Youth and Family Services Act*, Lead Agencies 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 Child and Youth Mental Health Lead Agency Consortium (LAC), to plan and provide leadership at the provincial level (LAC, 2019).

Complex needs

Some children or young people experience significant, multiple, rare, or persistent mental health challenges that can impact their functioning at home, at school, and in the community. These are considered complex needs and often require intensive services. Examples of complex mental health challenges include bipolar and related disorders, emerging personality disorders, dissociative disorders, schizophrenia and psychotic disorders, gender dysphoria, and sexual and paraphilic behaviours (Ontario Intensive Treatment Pathway [OITP], 2025). "Complex" also refers to the mental health needs of children and young people who have other conditions or challenges that impact the services they require. These might include medical needs, developmental and physical disabilities, autism spectrum disorder, or substance use disorder (Knowledge Institute, n.d.).

Concurrent disorders

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

Culturally safe

Culturally safe refers to an outcome of reflective and aware practice and policy, where providers and organizations address bias and barriers contributing to inequities. It is the recipient of care, and not the provider, who determines whether or not cultural safety is present.

Culturally specific care/treatment

Culturally specific care/treatment refers to the delivery of services 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 emphasize that care and treatment aligned with a client's culture are intentionally prioritized from the outset.

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, 2023a).

Live-in treatment

Live-in treatment is intensive out-of-home treatment for children and youth who are dealing with mental health challenges that impair their functioning at home, school and/or in the community, and who require an intensive level of intervention. Treatment is delivered within a 24-hour a day environment by an inter-professional, multi-disciplinary team, making therapeutic use of the daily living milieu (LAC, 2021; OITP, 2026). 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).

Mental health

Mental health is a multidimensional state of emotional, psychological, and social well-being that reflects how individuals feel and function in their daily lives. It exists on a continuum from languishing to flourishing, independent of the presence or absence of mental illness (Keyes, 2002; Westerhof & Keyes, 2009).

Milieu therapy

Milieu therapy is an approach that aims to create a structured, supportive, inclusive, and safe environment to promote well-being. It is one of the ways that care can be delivered. While treatment tends to focus on evidence-based interventions for specific mental health and substance use health conditions and symptoms, milieu therapy involves the intentional and consistent use of daily routines, activities, and relationships to develop and practice 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 improvement

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

Quality standard

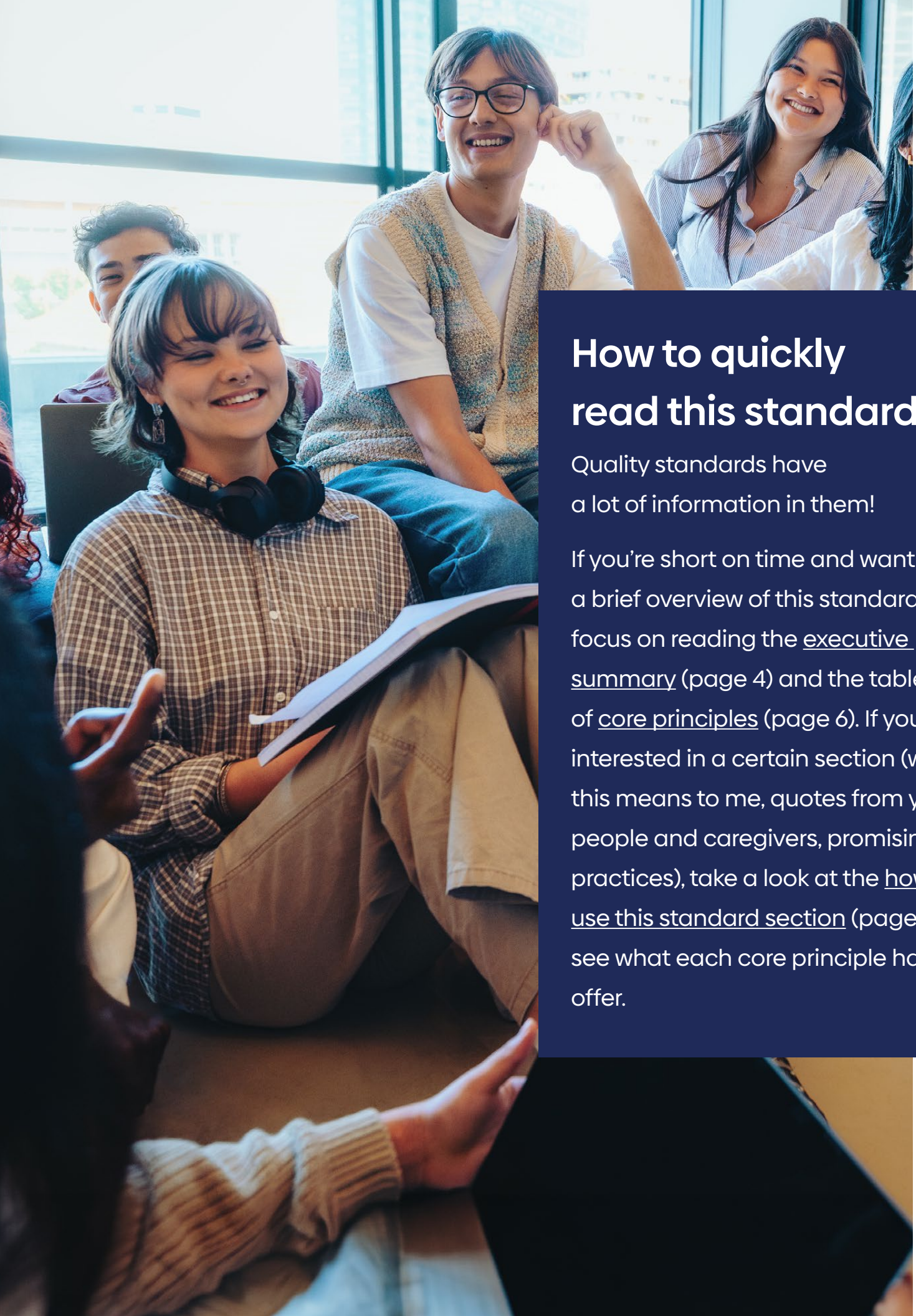
A quality standard is a resource that has clear, practical, and ambitious statements describing the practices, processes, and supports required to provide the highest quality care, based on the best available evidence. Standards are essential to a system that is driven by accountability and continuous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

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 (CAPSA, 2023). Addictions refer to behavioural or process addictions, such as gambling.

Treatment

Treatment refers to time-limited evidence-based interventions or modalities (Cognitive Behavioural Therapy [CBT] and Dialectical Behaviour Therapy [DBT], for example), that address specific mental health and substance use health conditions and symptoms such as substance use disorders, depression, or anxiety. Treatment is delivered by regulated health professionals — such as psychologists, psychiatrists, social workers, and registered psychotherapists — who have the required education, clinical training, and competencies to provide treatment safely, ethically, and effectively.



How to quickly read this standard

Quality standards have a lot of information in them!

If you're short on time and want a brief overview of this standard, focus on reading the executive summary (page 4) and the table of core principles (page 6). If you're interested in a certain section (what this means to me, quotes from young people and caregivers, promising practices), take a look at the how to use this standard section (page 24) to see what each core principle has to offer.

What are quality standards?

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. 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 standards provide a clear, evidence-based framework to guide policy, program design, and service delivery.

- **System level:** Standards inform policy development, promote consistency across regions, enhance accountability, bridge disparities in access to care, and provide mechanisms for monitoring service delivery to drive continuous improvement (Fishbein & Sloboda, 2023; McGorry et al., 2022; Pincus et al., 2016; Quinlan-Davidson et al., 2021).
- **Agency level:** Standards help optimize resources, ensure consistent implementation of evidence-based practices, improve service outcomes, foster integration and collaboration across sectors (education, healthcare, social services), and inform professional development needs for staff (Hoover & Bostic, 2021; Kilbourne et al., 2018; Patel et al., 2016; Sterling et al., 2010; Tremblay et al., 2020).
- **Service user level:** Standards guide prevention, early intervention, and tailored care that improves long-term outcomes, empowers children, young people, and families to advocate for themselves, and helps reduce stigma associated with mental health and substance use health services (Minkoff & Covell, 2022; National Mental Health and Substance Use Health Standardization Collaborative, 2024; Racine et al., 2021).

There are many points of alignment between this standard and other system-level initiatives taking place within the sector, including the Levels of care quality standard, Right time, right care, the OITP, care pathways for infant and early years, and continuous, improved engagement of young people and caregivers. Within each core principle, we highlight where and how this standard aligns with many other guidance documents across our sector and other sectors and show how the standard can be used at individual, organization, and systems levels.

What are quality standards?

Our standard includes promising practices that reinforce the importance of the Ministry of Health's legislation and its regulations, such as privacy, informed consent, and the rights of clients. This quality standard is an educational, informational resource only. It does not replace or have the force and effect of the law and does not provide clinical or legal advice. If there are any conflicts or differences between the standard and legislation, the law will take precedence.

This quality standard is principles-based, meaning it describes a set of core principles that are the foundation of high-quality care (International Organization for Standardization, 2015). It is up to the people or agencies who are implementing the quality standard to use their judgment when applying each core principle to their community. Used this way, principles-based standards can guide consistent and high-quality care that is specific to the context of each community (Mughal et al., 2022; 2025).

How was this standard developed?

This quality standard was developed using the Knowledge Institute's standard development process, which is outlined in our Standard development process brief. Our process strengthens principles-based standards through early considerations of measurement and implementation science, as well as our ongoing and meaningful engagement with our partners. The development process is collaborative and iterative, and we continuously adapt and improve it based on ongoing evaluation.

In developing this standard, we have consulted with the Quality Standards Advisory Committee (QSAC)[2], community partners, young people and caregivers, and the OITP. This wide-ranging collaboration has helped to ensure the standard is aligned with provincial frameworks, pathways, and initiatives related to intensive and live-in treatment services.

2 The QSAC is a topic-specific, expert committee convened by the Knowledge Institute that advises on and approves the quality standard.

What are quality standards?

Engagement with a wide spectrum of individuals and communities is essential to ensuring that standards are important, meaningful, and impactful to young people, caregivers, and key community partners, and that they do not perpetuate harm. At the core of our work is a commitment to equity, diversity, inclusion, and accessibility through a focus on meaningful engagement and health equity, and by striving to address geographic disparities and barriers to access. Our standard development process incorporates a health equity impact assessment and applies a health equity lens. It also closely follows the principles outlined in our Quality standard for youth engagement and Quality standard for family engagement.

Throughout the standard's development and mobilization, purposeful steps are taken to outline, adapt, and carry out engagement activities with key audiences. We are committed to continuing and strengthening these important reflections, conversations, activities, and partnerships, and to continuously improving the standard development process.

We consistently review our quality standards and take action to uphold, revise, or retire standards. This supports sound decision-making and alignment with current promising practices. We will continue to connect with groups and individuals to inform this work.

About this live-in treatment quality standard

What is live-in treatment?

Live-in treatment refers to intensive out-of-home treatment for children and youth who are dealing with mental health challenges that impair their functioning at home, school or in the community, and who require an intensive level of intervention. Treatment is delivered within a 24-hour a day environment by an inter-professional, multi-disciplinary team, making therapeutic use of the daily living milieu (LAC, 2021; OITP, 2026).

Ontario's core mental health, substance use health, and addictions 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 (Knowledge Institute, 2025a). These levels of care range from health promotion, prevention, and early identification to highly specialized, intensive care. Intensive treatment encompasses a suite of services, including community-based/day treatment, in-home services, and out-of-home services such as live-in treatment (Ontario Ministry of Health, 2024).

Live-in treatment is a voluntary treatment. It is 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).

Live-in treatment is 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;

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 program, while others continue to receive education at their regular school (Gutterswijk et al., 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 is usually compulsory and guided by legislation, with the goal of stabilizing individuals in a highly supervised environment before transitioning to less restrictive treatment settings (Schutte et al., 2022). Live-in treatment programs frequently play a key role in this transition, serving as a "step-down" option to continue treatment in a less restrictive environment (Johnson et al., 2015).

About this live-in treatment quality standard

The Ministry of Children, Community and Social Services (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).

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., 2020; Vogelsang et al., 2024).

Live-in treatment programs operate within a broader network of sectors, including hospitals, education, youth justice, child welfare, and young parent and infant services. Inpatient hospital settings provide short-term stabilization for children and young people in crisis, but ongoing support is often required to maintain long-term recovery. Live-in treatment programs serve as an important bridge, offering a less restrictive environment for continued care. Some hospitals 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).

Why is this quality standard needed?

Live-in treatment programs in Ontario vary widely in their approaches. This variation includes differences in admission criteria, intake and discharge processes, age groups served, lengths of stay, and clinical treatment modalities. Minimum program expectations for live-in treatment programs are outlined by the Ministry of Health and the MCCSS Quality Standards Framework (MCCSS, 2020), and specific approaches are determined by each agency. Despite these differences, however, common elements do exist across programs.

- Interdisciplinary teams deliver treatment and care to children, young people, and caregivers/the caregiving system.
- Transition planning begins early.
- 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.

Despite their critical role, live-in treatment programs face significant challenges, including:

About this live-in treatment quality standard

- **Workforce challenges,** including demanding work environments, lack of standardized training in treatment approaches, underutilization of staff skills, high turnover, and inadequate compensation.
- **Lack of clear and consistent eligibility criteria and standardized assessment tools,** making it difficult to determine the children and young people who would benefit most from live-in treatment and to match them to appropriate programs.
- **Misalignment between needs and placement,** where admission may depend on bed availability rather than best fit, or where appropriate placements are unavailable.
- **Challenges with caregiver involvement,** including geographic distance, strained relationships, and varying caregiver capacity.
- **Variation in clinical program models and limited use of evidence-based practices**, alongside a lack of standardized performance measurement and limited evidence of long-term outcomes.
- **Difficulties transitioning out of live-in treatment,** such as limited aftercare, fragmented services, and challenges sustaining progress after discharge. The challenge of transition is also significant when ongoing needs require movement across sectors including into the adult sector, where there are often considerable waitlists and lack of appropriate settings for young people.
- **System-level challenges,** including the high cost of care, one-size-fits-all licensing requirements, and geographic barriers that limit equitable access, particularly in rural, remote, and northern communities.

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.

Equity considerations

Equity is central to high-quality live-in treatment. Historical and ongoing inequities have shaped how children and young people experience mental health, substance use health, and addictions services, including live-in treatment. These inequities are rooted in systemic factors such as colonialism, racism, discrimination, and barriers related to language, disability, immigration status, socioeconomic barriers, and more. As a result, some groups have experienced harm, exclusion, or unmet needs within institutional and live-in care settings. A quality standard for live-in treatment must acknowledge these realities and support treatment that is culturally safe, inclusive, and responsive to the diverse identities, experiences, and needs of children, young people, and their caregivers.

In developing this standard, equity considerations were intentionally integrated throughout. Our approach included reviewing the historical and current contexts shaping care experiences for diverse groups of children, young people, and families, including those who are Indigenous, racialized, Francophone, newcomers, from remote communities, those with varying abilities or complex needs, 2SLGBTQIA+, and pregnant and parenting young people.

While each group has distinct experiences and needs, several common, system-level themes emerged that are reflected across the standard (see Appendix D). These considerations also highlighted that children, young people, and families may understand and approach mental health and substance use health in different ways, shaped by cultural, spiritual, familial, and community contexts. Live-in treatment programs should be responsive and adaptable to diverse perspectives and approaches to care.

The inequities and lived experiences across different population groups highlight the need for live-in treatment standards that are intentionally designed to address historical and ongoing harms across these populations (MCCSS, 2020; Mental Health Commission of Canada [MHCC], 2019; Ontario Human Rights Commission, n.d.).

Quality standards should promote treatment and care that is trauma-informed, culturally safe, anti-racist, inclusive, and accessible. This includes recognizing the potential for institutional environments to evoke mistrust or distress, particularly for children and young people with histories of systemic harm, and ensuring that care environments prioritize safety, dignity, and trust (Beaulieu et al., 2025; Ontario Health, 2025; Public Health Ontario, 2024). Standards should also recognize that dominant approaches to mental health treatment may not reflect the values, beliefs, or approaches to support all children, young people, and families. Environments that do not acknowledge these differences may contribute to feelings of disconnection or exclusion and can affect engagement in treatment.

Standards should embed equity into governance and service design, including advancing Indigenous self-determination and culturally grounded approaches to care, supporting workforce diversity and training, and ensuring that services are responsive to the cultural, linguistic, developmental, and social needs of children and young people (Beaulieu et al., 2025; MCCSS, 2020). This approach includes ensuring meaningful engagement of children, young people, families, and communities in the decision-making processes, particularly those impacted by racism, colonialism, and other forms of oppression and discrimination.

In addition, standards should promote coordinated and adaptable models of care that address intersecting needs, reduce barriers to access and engagement, and include mechanisms to identify, monitor, and address disparities in experiences and outcomes across populations (Kirmayer et al., 2011; Lunsky et al., 2018; MCCSS, 2020; Saunders et al., 2018; Yun et al., 2019).

Throughout the development of this resource, we worked toward these objectives by engaging with diverse individuals and organizations to deeply understand present gaps and needs that could be addressed through the quality standard.

What is the scope
of this quality standard?

What is the scope of this quality standard?

Topic: What is the standard about?

- Community-based live-in mental health and substance use health and addictions treatment.

Population: Who is receiving treatment?

- Children and young people up to age 25.

Setting: Where is the standard being implemented?

- Intended for Ontario's community-based child and youth mental health, substance use health, and addictions agencies.

Audience: Who is implementing this standard?

- Different audiences are impacted by the standard and will use it in their work. The main audience implementing this standard includes professionals such as clinicians, researchers, system and agency leaders, service providers, and policy makers. Children, young people, and caregivers may also be a part of implementation, and are a primary audience of this standard.

See Appendix B for more information on the scope of this quality standard.

What is the scope of this quality standard?

Related initiatives and resources

This live-in treatment standard is situated within a broader system of guidance supporting live-in treatment programs in Ontario, including the OITP. The OITP is a provincially guided initiative aimed at improving coordination, consistency, and equitable access to intensive services for children and youth with complex mental health needs. Within OITP, complementary initiatives include the Clinical Populations Report, which identifies groups of children and young people most likely to benefit from live-in treatment (OITP, 2025); and the Live-in Treatment Clinical and Operational Standards (OITP, 2026), which support a consistent, evidence-informed approach to service delivery across the province. In addition, live-in treatment programs are subject to licensing requirements established by the MCCSS in the Quality Standards Framework (MCCSS, 2020). This standard aligns with these related initiatives.

In Ontario, responsibility for live-in treatment programs for children and young people is shared across ministries. The Ministry of Health oversees live-in mental health treatment programs for children and young people, and MCCSS oversees licensed live-in settings, including treatment programs run by young parent and infant agencies.

How to use this standard

Overview of core principles

The quality standard consists of 10 core principles that fit into four themes (see Table 1) that are designed to support agencies in delivering and continually improving live-in treatment programs. These core principles are ambitious but achievable. They are not a reflection of what is currently happening, but of the ideal state. Every community is in a different place in their journey, and what the core principles look like in action varies across communities.

The core principles are not listed in priority order and should be considered together.

In this document, each core principle is explained in more detail using the following aspects:

- **Quality statements:** Describes the core principle and its defining characteristics using clear, practical, and ambitious statements.
- **Promising practices:** Outlines each quality statement in detail to describe what the core principle looks and feels like.
- **Practical examples:** Illustrates some relevant ways the core principle is being applied in the sector.
- **Quotes from young people and caregivers:** Reveals what the core principle means to them.
- **Descriptions for different audiences:** Provides the intended outcomes and uses of the core principle for (a) children, young people, and caregivers; (b) service providers and agency leaders; and (c) system decision makers (funders, policy makers, and government bodies).
- **Quality indicators:** Suggests ways agencies can measure how well the core principle is being implemented and how it is improving care in their community. For technical details to measure and calculate the indicators, please refer to our Measurement guide for quality standards.
- **Implementation considerations:** Describes some potential barriers to implementing the core principle and identifies any mitigating strategies.
- **Related standards and guiding documents:** Demonstrates alignment with other guidance documents, including national and provincial standards and guidelines.
- **Mapping to the clinical standard:** Lists the specific points of overlap and alignment between the core principle and the OITP Live-in Treatment Clinical and Operational Standards.

"Clinical standard" refers to the Ontario Intensive Treatment Pathway Clinical and Operational Standards.

Measurement, implementation, and knowledge mobilization

Using, mobilizing, and evaluating the quality standard is as important as the quality standard itself.

To move the vision of this document into practice, measurement and evaluation are key processes. For each core principle, we suggest a range of indicators that agencies can consider when evaluating how the core principle is being implemented and how it improves the quality of their live-in treatment program. Suggested indicators can be found in each section of the quality standard to illustrate which indicators may be mapped to each core principle.

For information on how to calculate and interpret the indicators, including methods for collecting data and examples of tools to use, please see our Measurement guide for quality standards and the standard-specific Indicator workbook.

The standard includes resources and knowledge mobilization supports that are rooted in implementation science and build on the strengths of existing efforts throughout the province. These resources can be used and adapted by anyone implementing the quality standard in their agency or community.

Core principles

Foundations of treatment

The practices and values that underpin and are present throughout all aspects of live-in treatment.

Core principle 1

Live-in treatment is child- and youth-centred.

Quality statement

Children and young people are at the centre of decision-making throughout live-in treatment, and their needs, goals, preferences, experiences, circumstances, and strengths are recognized and respected.

- Children and young people feel empowered to make informed decisions about all aspects of their treatment and care, including intake, treatment, and discharge.
- Shared decision-making is an ongoing process throughout the live-in treatment journey.
- Service providers collaborate with children and young people to share and understand information.
- Treatment plans are individualized and flexible.
- Young people are engaged at both the organizational and system levels to meaningfully co-design, implement, and co-monitor live-in treatment.

Core principle 1
Live-in treatment is child- and youth-centred.

Needs include a child's, young person's and/or caregiver's clinical, developmental, emotional, accessibility, and cultural needs.

Promising practices

Children and young people feel empowered to make informed decisions about all aspects of their treatment and care, including intake, treatment, and discharge.

Children and young people are experts in their own experiences. Their voices are at the forefront of all decision-making throughout live-in treatment, with all treatment and care decisions grounded in the child or young person's needs, goals, beliefs, preferences, and strengths. This child- and youth-centred approach fosters respectful, compassionate, safe, identity-affirming, and responsive treatment.

During the referral and intake process, children and young people are supported to fully understand the services and options available to them and to make informed decisions about the treatment they receive. They work in partnership with service providers and caregivers to co-develop individualized treatment and discharge plans and to create a safe treatment environment that meets their physical, emotional, spiritual, and cultural needs and preferences.

Shared decision-making is an ongoing process throughout the live-in treatment journey and will look different for all children and young people based on individual circumstances like readiness, age, maturity, capacity, existing barriers, and available supports. As these circumstances can change over time, service providers are flexible and work with children and young people in ways that are responsive to their needs. Engaging children and young people in shared decision-making can help restore a sense of control, build self-efficacy, agency, and trust, and increase commitment to treatment.

At each step, service providers continue to seek informed consent and support children and young people to make decisions about their treatment and care. In some cases, greater support from service providers and caregivers is beneficial or necessary for shared decision-making, such as age or when developmental and cognitive disorders are present.

Trust is the foundation of a child- and youth-centred approach, and service providers are responsible for building that trust by creating a safe, respectful environment where children and young people can participate in ways that reflect their needs and readiness at that time.

Core principle 1
Live-in treatment is child- and youth-centred.

Service providers collaborate with children and young people to share and understand information in a way that reflects and responds to their preferences and needs related to language, development, and accessibility. Clear communication and continuous collaboration are essential for informed consent and to empower children and young people to actively participate in treatment planning. Service providers work to build rapport and trust through communication with children and young people. They communicate with children and young people in ways they can fully understand and that meets their preferences, needs, and goals for treatment, and adapt their approach as those aspects evolve.

Children and young people feel safe and respected expressing their needs throughout live-in treatment, and service providers actively listen, understand, and respond without judgement.

Treatment plans are individualized and flexible.

A comprehensive assessment at program admission helps service providers identify the unique treatment needs of each child and young person. The child or young person is empowered with this information to collaborate with service providers and caregivers to co-develop an individualized treatment plan. This ensures that treatment plans are strength-based, developmentally appropriate, and tailored to individual needs and goals.

Ongoing assessments and regular updates to these plans help treatment evolve in response to the changing needs of the child or young person. Outcomes from ongoing assessments are shared with children, young people, and when appropriate, caregivers, to collaboratively understand how the outcomes are meaningful and relevant to the child or young person in treatment and how it informs their treatment plan. This supports shared decision-making.

Treatment plans are flexible, with the treatment intensity and frequency aligned with each child or young person's individual needs.

Core principle 1
Live-in treatment is child- and youth-centred.

Young people are engaged at both the organizational and system levels to meaningfully co-design, implement, and co-monitor live-in treatment.

Young people are engaged continually and over time. What meaningful and authentic engagement looks like is co-determined with young people, who are valued as key partners in decision-making. Evidence drives these collaborative conversations, and agencies share normative data and empirical evidence with young people in a way that is accessible to them to inform decision-making. Young people who are currently, have previously, or are trying to access live-in treatment are all included in engagement activities.

Practical examples

- Communication barriers that can impact engagement are identified and addressed. For example, interpreters, communication aids, braille, sign language, and/or pictures are used to ensure young people are empowered to participate in and provide feedback on their treatment.
- Service providers and agency-specific resources use standard naming conventions or acronyms to describe and explain services to bolster children's and young people's understanding of the services they receive.
- Youth peer support is a part of the intake process to share program information and expectations with young people who are admitted into live-in treatment.
- Off-hour inquiries are available through multiple channels (telephone, email, text, online). If a significant issue arises during a weekend visit at home, young people and caregivers can call a point person at the live-in treatment program for further support and suggestions.

Implementation considerations

Barriers

- Cultural stigma around mental health, substance use health, and addictions can prevent young people from accessing services or pursuing assessment for a diagnosis.
- There may be a lack of trust between service providers and children or young people, especially for those with intersecting identities.
- Misunderstandings between young people, service providers, and caregivers about care needs and goals can lead to placements in overly intensive environments and treatments that are not designed to meet the young person's needs, goals, or desired outcomes.
- Service providers may feel that the policies and mandates of agencies conflict with the principles of child- and youth-centered care or a desired course of treatment.

Normative data refers to a set of standardized reference values derived from a large, representative population, used to establish typical ranges or distributions against which individual or group results can be compared (O'Connor, 1990).

- High staff turnover can interrupt the therapeutic alliance and makes it difficult to achieve timely, seamless, and individualized care planning that meaningfully embeds child and youth voice in care decisions.

Mitigating Strategies

- Develop case management and treatment plans using shared decision-making and co-development strategies. Ongoing checks, such as co-developing plans and using written or verbal reflections, can help to confirm a young person's understanding of services and options available to them.
- Involve young people in program design and governance and have multiple mechanisms and opportunities for providing anonymous feedback.
- Listen to the needs and desires of children and young people and strive to respect their needs in decisions about their care.
- Provide information about live-in treatment in ways that children and young people can understand. This includes explaining treatment models, treatment plans, and treatment options, how these components support the young person's needs and goals, and who provides various components of treatment, as well as how and when they are provided.

What young people and caregivers told us

"When I see child- and youth-centred care, I feel heard and seen. As a result, I feel hopeful and acknowledged. There's hope that people will listen, understand, and I will be able to get the treatment and care that I need."
- Young person

"For me, child- and youth-centred really is involving the child and youth in their treatment plan. I think the successes will be better when they are involved."
- Caregiver

What this means for our audiences

To children, young people, and caregivers

You feel empowered to actively participate in decisions about your treatment in ways that reflect your individual circumstances, including your readiness, preferences, goals, and needs. Your voice is at the centre of all decisions, and what you say is respected throughout your journey — from intake to treatment and discharge. You feel safe and supported in expressing your concerns and you are listened to without judgment.

Core principle 1
Live-in treatment is child- and youth-centred.

Your treatment continues to reflect what matters most to you over time. You work in partnership with service providers and caregivers to understand your options and make informed decisions. You are provided with information in ways that are clear, accessible, and tailored to your language, developmental stage, and communication preferences.

Programs are flexible and meet you where you are. Your goals and preferences guide decisions about if and how your caregiver is involved in your treatment, and who is a part of your support system.

To service providers and agency leaders

As service providers, you continuously centre child and youth engagement in decision-making by building rapport and trust through genuine partnership. You are responsive to and prioritize their preferences, goals, and needs. Information about services and options are communicated in ways that are clear, accessible, and tailored to their language, developmental stage, and accessibility needs.

You co-develop individualized treatment and discharge plans with each child or young person that reflect their physical, spiritual, and cultural contexts. You conduct ongoing check-ins to ensure alignment of goals and that treatment continues to meet their needs.

As agency leaders, you foster a culture where the voices of children and young people shape treatment and decision-making by ensuring service providers are supported through organizational policies and procedures for meaningful engagement. You prioritize and contribute to the creation of inclusive, respectful, and culturally responsive environments where children and young people feel safe, heard, and valued.

To system decision makers

As decision makers, you establish structures and commitments to meaningfully engage children and young people in collaborative decision-making at the system level. You ensure young people are engaged as key partners in co-designing system models and treatment frameworks, in communicating approaches, and in implementing and monitoring all aspects of live-in treatment services.

Core principle 1
Live-in treatment is child- and youth-centred.

Quality indicators

- Percentage (%) of children and young people who report they were involved in decisions about all aspects of their treatment and care.
- Percentage (%) of children and young people who report that their informed consent was sought throughout their live-in treatment journey.
- Percentage (%) of clients who report that they received clear information in a way that reflects and responds to their language and accessibility needs.
- Percentage (%) of children and young people who report that they co-developed their treatment plan.
- The program has a youth advisory committee that ensures young people's expertise informs key decisions about live-in treatment (Yes/No).
- Percentage (%) of young people who report that they were meaningfully engaged in the design, implementation, and/or evaluation of live-in treatment.

Related standards and guiding documents

- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standards Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- HealthCareCAN & Mental Health Commission of Canada. (2021). The quality mental health care framework.
- Mental Health Commission of Canada. (2016). Guidelines for recovery oriented practice.
- Ministry of Children, Community and Social Services. (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- Ontario Centre of Excellence for Child and Youth Mental Health. (2021). Quality standard for youth engagement.
- Persi, J., & Greenham, S. (2020). Ontario Network of Child & Adolescent Inpatient Psychiatry Services: Service guide, standards, benchmarks, & literature review: Standard 2. Psychological safety, dignity, rights, inclusion & participation. December 3, 2020 Update.
- The Knowledge Institute on Child and Youth Mental Health and Addictions. (2025a). Levels of care quality standard: Matching the right care to needs and goals.

Core principle 1
Live-in treatment is child- and youth-centred.

Mapping to the clinical standard

This core principle maps to Topics 1.2, 10.2, and 13.1 of the clinical standard, as well as the following criteria: 1.1.2, 2.1.2, 3.1.1, 4.1.4, 4.1.7, 5.1.3, 5.3.4, 6.1.3, 6.1.6, 6.1.10, 7.2.2, 7.2.3, 8.4.5, 9.1.2, 9.2.1, 9.2.2, 9.2.3, 9.3.4, 10.1.4, 10.1.6, 12.1.15, 13.2.4, 14.1.6, 19.1.1, 19.1.10, 19.2.3, 20.1.2, 20.1.4, 21.1.6, 21.1.8 and 22.1.5.

OITP Clinical and Operational Standards.

Sources

CMHO, 2015; 2016; Johnson et al., 2015; Knowledge Institute, 2025a; Kvamme et al., 2024; Live-in Treatment Quality Standard Consultations (LIT QS Consultations), 2024-2026; MCCSS, 2020; MHCC, 2025; Ministry of Children and Youth Services (MCYS), 2016; Ninan et al., 2014; O'Leary et al., 2024; Residential Treatment Working Group, 2017; Strides Toronto, 2022; Theall et al., 2022; Woody et al., 2019; Yeheskel et al., 2020.

Core principle 2

Live-in treatment programs encourage and empower caregiver involvement.

Quality statement

The caregiving system is meaningfully engaged throughout all aspects of live-in treatment and is supported alongside children and young people.

- Service providers work with children and young people in ways that are appropriate to their age, developmental needs, and capacity to determine how to best involve caregivers in treatment.
- Caregiver involvement is a foundational component of live-in treatment, and there is a defined and consistent approach to involving caregivers in all aspects of the program, from intake, throughout treatment, and at discharge.
- Caregivers are supported alongside children and young people to promote the well-being of the caregiving system and the home environment, and to strengthen relationships.
- Service providers share and understand information collaboratively with caregivers to enhance communication and amplify the importance of caregivers' roles.
- Caregivers are engaged at both the organizational and system levels to meaningfully co-design, implement, and co-monitor live-in treatment.

Promising practices

Service providers work with children and young people in ways that are appropriate to their age, developmental needs, and capacity to determine how to best involve caregivers in treatment.

Engaging caregivers requires an individualized approach and considers the preferences, developmental needs, and home environment of each child or young person, as well as the caregivers' capacity to be involved. Caregiver involvement prioritizes the safety of the child or young person and is guided by their autonomy and consent.

At intake, service providers collaborate with children and young people to identify who they consider to be caregivers and who they would like to be involved and not involved in their treatment, recognizing that caregivers

Core principle 2
Live-in treatment programs encourage and empower caregiver involvement.

can be anyone identified as important for well-being. Service providers collaboratively explore options with children and young people on how caregivers could best support their well-being and care throughout live-in treatment, including identifying ways for caregivers to be involved that align with the child or young person's preferences and consent. This is achieved with informed consent and in consultation with caregivers, if it is safe and appropriate to do so.

Children and young people are not denied access to live-in treatment if they do not identify a caregiver they wish to involve. Instead, service providers help children and young people establish trusted supports and are flexible to revisit opportunities throughout treatment to involve a caregiver.

At each step, service providers continue to seek informed consent and support children and young people to make decisions about their treatment and care. Informed consent is revisited over time to continue determining the caregivers who are involved and how to best involve them in treatment.

Caregiver involvement is a foundational component of live-in treatment, and there is a defined and consistent approach to involving caregivers in all aspects of the program, from intake, throughout treatment, and at discharge.

Service providers share information with caregivers about what they can expect during treatment, the goals that children and young people will work towards, and how caregivers will be involved. The absence of caregiver involvement in live-in treatment is not assumed to reflect a lack of care or responsibility. Instead, the different ways caregivers provide support, based on their strengths and circumstances, are recognized. Barriers to caregiver involvement (transportation to and from live-in treatment, childcare, technology access) are identified and mitigated in collaboration with children, young people, and caregivers.

Caregiver voices are valued, respected, and considered throughout treatment planning and decision-making. Caregivers work with service providers and the child or young person to co-develop treatment and discharge plans, ensuring that treatment is tailored to the needs of the child, young person, and caregiving system. Disagreements in service planning between caregivers and children and young people are acknowledged and addressed collaboratively.

Core principle 2
Live-in treatment programs encourage and empower caregiver involvement.

Caregivers are supported alongside children and young people to promote the well-being of the caregiving system and the home environment, and to strengthen relationships.

For a child or young person to maintain the progress made in treatment, their home environment must evolve along with them. Improved functioning of the caregiving system creates a more supportive home environment so that young people can maintain and apply skills learned in live-in treatment after they are discharged.

Service providers and clients discuss the needs of caregivers in the context of the young person's own needs and goals. Service providers reinforce caregivers' ability to support children and young people throughout and following live-in treatment. Caregivers are provided with the support and resources they need to develop skills and knowledge to enhance caregiving and support the child or young person. These supports and resources are provided either through the live-in treatment program or through a referral along the continuum of care. This could include information and education on mental health, substance use health, and addictions, and participation in individual and/or family therapy.

Agencies support caregivers by coordinating access to adult mental health and substance use health and addictions services, support for non-healthcare and practical needs (childcare, education, housing, finances, and employment), and by providing caregiver peer support throughout live-in treatment, from intake to aftercare. In cases where caregivers would like to be involved but children and young people do not give their consent, caregivers are supported in their own care journey.

Children, young people, and caregivers have opportunities to practice skills at home during treatment to help prepare for sustained progress after discharge.

Service providers share and understand information collaboratively with caregivers to enhance communication and amplify the importance of caregivers' roles in nurturing the well-being and addressing the needs of children and young people. Communication with caregivers is maintained consistently throughout treatment to keep them informed and engaged. Service providers share information with caregivers collaboratively about what they can expect and how to best support the child or young person's journey through live-in treatment. There are mechanisms for caregivers to share information with service providers throughout intake, treatment, and discharge.

Core principle 2
Live-in treatment programs encourage and empower caregiver involvement.

Service providers work to build rapport and trust through communication that respects the privacy and confidentiality of the child or young person in treatment. The information shared by service providers is responsive to the caregivers' linguistic, cultural, and accessibility needs and preferences. This information is shared continually and over time, while respecting confidentiality and privacy of the child or young person.

Caregivers are engaged at both the organizational and system levels to meaningfully co-design, implement, and co-monitor live-in treatment.

Caregivers are engaged continually and over time. What meaningful and authentic engagement looks like is co-determined with caregivers, who are valued as key partners in decision-making. Evidence drives these collaborations, and agencies share normative data and empirical evidence with caregivers in a way that is accessible to them to inform decision-making. Caregivers who currently, previously, or have not yet been able to access live-in treatment for their child are all included in engagement activities.

Practical examples

- Caregivers are offered a pre-admission orientation to meet the full interdisciplinary team, ask questions, and build familiarity with the live-in treatment program.
- Waitlist support services are available for caregivers, including caregiver peer support groups as well as caregiver-specific webinars, resource materials, and regular check-ins to provide updates and maintain engagement.
- When appropriate and informed consent has been obtained, case conferences are held regularly with the young person in treatment and their caregiver(s) to collaboratively discuss treatment plans.
- Regardless of their level of involvement in a child or young person's treatment, caregivers have access to a range of support conducted in person, virtually, or by telephone throughout the live-in treatment program, including family support groups and peer support services.
- Agencies have a formal commitment to collaborate with caregivers in the design and planning of organizational policies and strategic planning, hiring committees, and boards of directors.

Core principle 2
Live-in treatment programs encourage and empower caregiver involvement.

Implementation considerations

Barriers

- Strained caregiver relationships (with other caregivers or with the child or young person in treatment) can make caregiver involvement in live-in treatment challenging.
- Taking part in live-in treatment programming is difficult for caregivers living far away and without cars or accessible transit options. Even when facilities are relatively nearby, a lack of public transit or transportation support makes access difficult.
- Caregivers and other siblings may struggle with their own mental health, substance use health, and addictions concerns, impacting caregivers' ability to engage.
- A caregiver and young person may have conflicting goals, like caregivers wanting to be involved in care but the child or young person not granting consent. Staff may not have the skills to help resolve this conflict.
- When families are undergoing custody or decision-making rights through a court system, it can be difficult and complex to involve caregivers in treatment and can impede the provision of services.

Mitigating Strategies

- Ask young people early and often who they consider to be a part of their caregiving systems. Trusted individual(s) could be an Elder, a representative chosen by the young person or their bands and First Nations, Inuit, and Métis communities, local community-based provider, educator, coach, or extended family member.
- Establish caregiver engagement guidelines within agencies to guide service providers on how to support and involve caregivers throughout live-in treatment, including when caregivers would like to be involved but children and young people do not give their consent. Consider how to support caregivers, involve the young person in deciding what to share with their caregiver, and educate caregivers on the importance of confidentiality.
- Provide staff with ongoing mentoring and clinical supervision that is specific to engaging caregivers. Support staff with conflict resolution protocols and provide training — with the input from a trained caregiver peer support worker — on how to engage with caregivers in care and treatment planning. This can also include trauma-informed communication and mediation to address discrepancies between the treatment goals of young people and of caregivers.
- Establish clear communication strategies for all stages of live-in treatment programming, so caregivers know what to expect throughout and how their involvement contributes to improving live-in treatment programs.

Core principle 2
Live-in treatment programs encourage and empower caregiver involvement.

What young people and caregivers told us

"I think people really need to understand that caregiver involvement can mean many different folks, including friends and siblings. All those voices that don't always feel heard are the strongest support for the person going through the program. Recognize that it's not always a parent in that role."
- Young person

"What this core principle means to me, as a caregiver and primary worker, is that helping young people isn't just one-on-one care; it's about building a strong support system (parents, caregiver, peers, etc.) around them so they feel understood, supported and not alone."
- Caregiver

What this means for our audiences

To children and young people

Your caregiver is involved throughout your treatment journey in ways that feel meaningful to you, and you can change your mind about their involvement as your needs evolve over time. You are supported to make informed decisions about caregiver involvement, including understanding consent and confidentiality, which are revisited regularly to ensure the right people are involved in ways that respect your preferences. Care is taken to ensure caregiver involvement does not cause harm. Your caregiver is also supported to strengthen their ability to support you during and after treatment. This may include access to information and education, peer support, and therapeutic interventions.

To caregivers

Your voice is valued, and you are heard. You are acknowledged, supported, and kept informed throughout your child's (the child in your care's) treatment and care, and you are treated with dignity and respect. Engagement is tailored to you, with your needs, preferences, and capacity recognized and respected. Your health and well-being are also acknowledged as important. You are offered resources, therapeutic supports, and education alongside your child to help you navigate the treatment process. You remain meaningfully connected to the treatment team and to your child. Coordinated supports and community connections are in place to reduce isolation. You are supported to build confidence and knowledge to advocate for your child and for yourself.

Core principle 2
Live-in treatment programs encourage and empower caregiver involvement.

You understand that consent may evolve throughout your child's live-in treatment journey, with decisions guided by your child's best interests. Communication from service providers is clear and easy to understand, using formats and language that meet your needs.

To service providers and agency leaders

As service providers, you revisit informed consent with children and young people over time to determine who should be involved and how caregivers can best participate throughout their live-in treatment journey. You communicate with caregivers when there are changes to consent and ensure they understand what to expect. This is done using formats, styles, and language that are clear, accessible, and responsive to caregivers' needs. You acknowledge and validate caregivers' preferences and capacity, recognizing their strengths as well as the circumstances that may shape their ability to engage. You support caregivers' health and well-being within the context of the child or young person's needs and goals by offering resources, therapeutic supports, and education.

As agency leaders, you ensure that flexible infrastructure and policies are in place to support meaningful caregiver engagement, including peer support, accommodations, virtual participation options, and community-based supports.

To system decision makers

As decision makers, you work to reduce structural, geographic, and socioeconomic barriers to caregiver involvement. You invest in the conditions that support sustained, meaningful caregiver involvement throughout children's and young people's treatment journeys. You prioritize equitable approaches to engagement and ensure resources are allocated in ways that respond to the diverse needs and realities of caregivers across different contexts.

Quality indicators

- Percentage (%) of children and young people who collaborated with service providers to determine how to best involve caregivers in their treatment.
- Percentage (%) of caregivers who report being involved in key aspects of live-in treatment.
- Percentage (%) of caregivers who were referred to or offered support throughout live-in treatment.

Core principle 2
Live-in treatment programs encourage and empower caregiver involvement.

- Percentage (%) of caregivers who report access to support groups and/or mentorship programs for caregivers throughout live-in treatment.
- Percentage (%) of caregivers who report feeling valued as a member of the care team.
- The program has a family advisory committee that ensures caregivers' expertise informs key decisions about live-in treatment (Yes/No).
- Percentage (%) of caregivers who report that they were meaningfully engaged in the design, implementation, and/or evaluation of live-in treatment.

Related standards and guiding documents

- Mental Health Commission of Canada. (2016). Guidelines for recovery-oriented practice.
- Ministry of Children, Community and Social Services. (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- Ontario Centre of Excellence for Child and Youth Mental Health. (2021). Quality standard for family engagement.
- Persi, J., & Greenham, S. (2020). Ontario Network of Child & Adolescent Inpatient Psychiatry Services: Service guide, standards, benchmarks, & literature review: Standard 2. Psychological safety, dignity, rights, inclusion & participation. December 3, 2020 Update.
- The Knowledge Institute on Child and Youth Mental Health and Addictions. (2025a). Levels of care quality standard: Matching the right care to needs and goals.

OITP Clinical and Operational Standards.

Mapping to the clinical standard

This core principle maps to Topics 11.1, 11.2, and 11.3 of the clinical standard, as well as the following criteria: 1.2.1, 1.2.2, 2.1.2, 3.1.4, 4.1.4, 4.1.7, 5.1.3, 5.1.4, 5.1.5, 5.3.4, 5.3.5, 6.1.7, 6.1.10, 7.1.3, 8.2.8, 9.2.2, 9.2.4, 9.3.1, 9.3.5, 19.1.3, 21.1.2, 21.1.6, and 21.1.8.

Sources

CMHO, 2015; 2016; Coll et al., 2019; Frensch et al., 2022; Furtado et al., 2016; Grosset et al., 2018; Gutterswijk et al., 2020; Herbell et al., 2024a; 2024b; Johnson et al., 2015; Knowledge Institute, 2025a; LIT QS Consultations, 2024-2026; MCCSS, 2020; MCYS, 2016; MHCC, 2025; Ninan et al., 2014; Patel et al., 2019; Preyde et al., 2020; Residential Treatment Working Group, 2017; Strides Toronto, 2022; Whittaker et al., 2016; Yeheskel et al., 2020.

Core principle 3

Live-in treatment is equitable, inclusive, and trauma-informed.

Quality statement

Live-in treatment programs respect and affirm the diverse identities of young people and their caregivers. Equity, diversity, inclusion, and accessibility are embedded into all aspects of live-in treatment — including intake, assessment, treatment planning, discharge planning, and staff training and competencies.

- All aspects of live-in treatment are culturally safe, identity affirming, and accessible.
- Trauma-informed care is a foundational component of live-in treatment programs.
- Live-in treatment programs support staff in ongoing learning to develop cultural humility and deliver treatment that is anti-oppressive, anti-racist, trauma-informed, and culturally safe.
- Pathways to culturally specific and linguistically relevant care are made available through organizational policies and meaningful partnerships and collaboration.

Equity considerations are described further in Appendix D.

Promising practices

All aspects of live-in treatment are culturally safe, identity affirming, and accessible.

Children and young people can explore and embrace their identities in a safe, inclusive, and affirming environment. Service providers create space for open dialogue without assumptions or biases, encouraging children and young people to share how their identities can be acknowledged and supported throughout their treatment. This approach helps children and young people feel safe, accepted, and empowered to engage in ongoing conversations about their treatment needs.

Culturally safe refers to an outcome of reflective and aware practice and policy, where providers and organizations address bias and barriers contributing to inequities. It is the recipient of care, and not the provider, who determines whether or not cultural safety is present.

Core principle 3
Live-in treatment is equitable, inclusive, and trauma-informed.

Diverse communities often approach and understand mental health through a spiritual, communal, or family lens. Live-in treatment programs are flexible to recognize and accommodate this to meet the diverse needs of those they serve. Programs apply an equity lens to policies, procedures, and treatment to help remove barriers to access and to ensure all aspects of services are adaptable and responsive to the values and needs of different communities. This includes ongoing considerations and adaptations to improve physical accessibility. Interpretation and translation services are provided to support engagement in treatment, and interpreters understand the cultural ways mental health and substance use health are conceptualized and communicated within a child's or young person's culture and language.

Treatment also takes cultural context into consideration and includes access to culturally specific approaches and perspectives through collaboration and partnerships. Agencies align organizational values and policies with anti-oppressive and anti-racist efforts. They sustain this commitment through transparency, accountability, and ongoing investment in resources, training, and partnerships.

Feedback on experiences of cultural safety and identity-affirming treatment is continuously collected and informs improvements. By supporting each child and young person's unique identities, live-in treatment programs help foster a sense of belonging and build self-esteem, which are essential to overall well-being and success in treatment.

Trauma-informed care is a foundational component of live-in treatment programs.

A trauma-informed framework provides the foundation for all therapeutic interventions. Treatment is trauma-aware and trauma-informed, is attachment-informed, and emphasizes safety and trustworthiness. Trauma-informed treatment encourages ongoing self-reflection and awareness of bias. Staff are trained to understand and recognize signs of trauma and to interpret behaviours through a trauma-informed lens so they can respond in ways that reduce the risk of re-traumatization and pathologizing trauma responses.

Core principle 3
Live-in treatment is equitable, inclusive, and trauma-informed.

Live-in treatment programs support staff in ongoing learning to develop cultural humility and deliver treatment that is anti-oppressive, anti-racist, trauma-informed, and culturally safe.

All staff in live-in treatment programs are equipped to support the diverse cultural, identity, and linguistic needs of children, young people, and caregivers. To facilitate this, staff receive ongoing training to build the knowledge, skills, and humility necessary to provide inclusive and culturally specific treatment, and staff feel supported in navigating cultural, identity, linguistic, and trauma-related considerations. Organizational policies, procedures, pathways, and partnerships are also in place to support access to cultural and linguistic resources, and staff are responsible for leveraging these pathways to meet the needs of children, young people, and caregivers. Additionally, the diversity of program staff reflects the communities they serve, which can foster stronger trust and a greater sense of comfort for children, young people, and caregivers.

Pathways to culturally specific and linguistically relevant care are made available through organizational policies and meaningful partnerships and collaboration.

Live-in treatment programs develop and maintain their awareness of cultural organizations and resources within the community — community organizations, culturally specific resource centres, newcomer navigation programs, and faith-based organizations, for example — so they can develop partnerships and facilitate timely, culturally specific supports to children, young people, and caregivers. Based on the preference of the child or young person, these community partners are engaged in the planning and delivery of treatment so that children and young people are connected to culturally specific supports while in live-in treatment. Staying connected to the community helps maintain cultural ties and relationships and facilitates transitions.

Core principle 3
Live-in treatment is equitable, inclusive, and trauma-informed.

Practical examples

- Service providers support young people in identifying services provided or recommended by partners closely linked to that young person's culture, heritage, and traditions. An introductory meeting with the young person and the identified Indigenous community-based provider or Nation representative takes place to explain the available services, supports, and community connections.
- Accommodations are made to ensure children and young people with learning disabilities and neurodivergence can fully participate.
- Agencies assess trauma-informed organizational practices using validated tools, like the National Child Traumatic Stress Network's Trauma-Informed Organizational Assessment.
- A trauma-informed organizational framework, like the Attachment, Regulation, and Competency (ARC) framework, provides the foundation for live-in treatment programs.
- Programs offer community passes to children and young people so they can attend events in their community that are important to them, such as a pride parade, local community centre event, religious holiday, or ceremony.
- Programs prioritize ongoing access to gender-affirming resources (binders, make-up, print and virtual resources, peer support) and access to gender-affirming healthcare providers and specialists. These resources are complemented by guidelines that address the safety and preferences of trans and gender non-confirming young people across sleeping arrangements, as well as bathing and washroom access, within the physical environment.
- An agency incorporates Traditional First Nations, Inuit, and Métis models of care and healings (naming ceremonies, smudging, pow wows). This could include offering land-based healing and identity-centred supports in ways that honour their specific creed, spirituality, culture, and language during live-in treatment.
- Agencies provide free interpretation services to Ontario residents and community agencies like Tele-Mental Health Service.
- Agencies hold and maintain French Language Services designations and deliver French language services in accordance with applicable laws. There is engagement with French language communities and an active offer of French language services. System partners with expertise in planning and delivering French-language services can advise about best practices.
- Programs incorporate visible signals of allyship within the physical environment (bulletin boards highlighting Black History Month, progress flags) and recognize significant dates (Orange Shirt Day, Pride Month, Mental Health Week).

Core principle 3
Live-in treatment is equitable, inclusive, and trauma-informed.

Implementation considerations

Barriers

- Children and young people are unable to access live-in treatment due to its complete absence in their region, service boundaries, and challenging and complex referral processes to treatment options in other areas of the province.
- There is a lack of culturally specific assessment tools or population-specific resources.
- Specific and purposeful gender-affirming care is lacking in some live-in treatment programs, impacting the safety and relevance of the program and leaving some young people feeling isolated and unsupported.
- There are few organizations representing communities impacted by racism, colonialism, and other forms of oppression and discrimination for sector agencies to connect with, leading to limited access to culturally responsive and specific care. These organizations are often overloaded with meeting the needs and goals of the communities they serve.

Mitigating Strategies

- Organizations allocate a percentage of their budget to provide staff with training on trauma-informed approaches to cultural- and identity-affirming care in live-in treatment settings. Training can ensure the treatment approach does not unintentionally retraumatize young people and their caregivers. For instance, trainings could include the impacts of intergenerational trauma related to residential schools, the Sixties Scoop, the Millennial Scoop, adverse childhood experiences, racial profiling, and stereotypes.
- Establish pathways to culturally relevant supports and services in the community (Iman, Elders, support groups for families with trans youth, community agencies for newcomers) that can serve as cultural brokers, mediators, or mentors for the child or young person.
- Collaborate with other services — for example, early learning and childcare services, education services, housing services, community services, faith-based organizations and faith/spiritual leaders, legal aid, and social service agencies.
- Consider service delivery, assessment, and treatment impacts on supporting children, young people, and caregivers with and seeking refugee protection (see Mental health care for children with and seeking refugee protection).
- Develop a protocol to support decision-making in reported instances of discrimination and harm, including actions to support safety and accountability.

Core principle 3
Live-in treatment is equitable, inclusive, and trauma-informed.

What young people and caregivers told us

"In terms of equity and inclusivity, it's definitely something that resonates in terms of finding care that's malleable to my needs, particularly when it pertains to my lived experience and my identity, both as a queer person, and as a racialized person from a rural space, and how those factors integrate into the way that I'd be receiving care, the way that I'd be treated within care, and the reasons that led me to it in the first place."
- Young person

"Accountability — making sure folks are being equitable, inclusive, and trauma-informed — is necessary. To see that in writing is really important because it speaks to how unique each person's journey is. We need to really care about [equity and inclusion] and approach each person differently."
- Young person

What this means for our audiences

To children, young people, and caregivers

You are empowered to embrace and celebrate your identity and culture throughout your live-in treatment journey. From intake to discharge planning, your needs are approached in ways that are individualized and affirming of your intersecting identities, cultural context, and lived experiences. You are supported to express who you are in ways that feel safe and meaningful to you. The live-in treatment environment is safe, inclusive, and free from stigma. It recognizes the impact of trauma and fosters a strong sense of belonging.

Your cultural, spiritual, and community connections are acknowledged and integrated into your treatment. Clear information is provided about the program's commitments to equity, inclusion, anti-racism and anti-discrimination (policies, protocols, action plans, statements of commitment), including how the organization, leaders, and staff will prioritize your safety and well-being and raise and respond to any experiences of discrimination, violence, or harm.

To service providers and agency leaders

As service providers, you recognize historical, systemic, and ongoing racism, colonialism, and other forms of oppression and discrimination. You prioritize equity, inclusion, and cultural safety in all aspects of

Core principle 3
Live-in treatment is equitable, inclusive, and trauma-informed.

treatment. You approach treatment through a trauma-informed lens, recognizing the impact of trauma and responding in ways that prioritize safety and trust-building while avoiding practices that could re-traumatize. You adapt your approaches to be responsive to each child's or young person's intersecting identities and cultural context.

As agency leaders, you establish meaningful partnerships that support culturally safe and inclusive care. You engage community agencies and partners across planning, implementation, and delivery to ensure services reflect the needs of diverse populations. You establish clear processes and commitments (policies, procedures, protocols) to uphold safety, accountability, and well-being across the live-in treatment program. You acknowledge and respond to experiences of discrimination, violence, or harm according to these processes, and welcome feedback to continually improve your approach. You ensure staff have access to ongoing training, learning, and reflection in areas such as cultural safety, anti-racist and anti-oppressive practices, and trauma-informed care. You strive to build and retain a diverse, confident, and competent workforce.

To system decision makers

As decision makers, you make actionable commitments to advance equity and identity-affirming care by improving system-level policies and service pathways. You allocate resources and build structures that support equitable access, reduce systemic barriers, and enable meaningful collaboration with community partners, while addressing barriers faced by rural, remote, and underserved communities.

Quality indicators

- The program has a written policy or practice framework that embeds cultural safety, identity-affirming practice, and equity considerations across all aspects of live-in treatment (Yes/No).
- Percentage (%) of children, young people, and caregivers who report that live-in treatment was culturally safe and identity affirming.
- Percentage (%) of adapted service offerings (culturally adapted, identity affirming, multi-lingual).
- Percentage (%) of staff trained in trauma-informed approaches.

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Live-in treatment is equitable, inclusive, and trauma-informed.

- The program implements a trauma-informed framework that guides treatment approaches across live-in treatment (Yes/No).
- Percentage (%) of service providers trained to provide care that is anti-oppressive, anti-racist, culturally safe, and identity-affirming.
- Percentage (%) of children and young people whose care included active involvement of community partners in planning and delivering culturally specific supports.
- The program provides access to linguistically appropriate services (interpretation, translation, French Language Services where applicable) (Yes/No).

Related standards and guiding documents

- Children's Mental Health Ontario. (2025). Growing together: Advancing health equity in Ontario's community child and youth mental health system.
- First Nations Health Authority and Health Standards Organization. (2022). HSO 75000:2022 British Columbia cultural safety and humility standard.
- Health Quality Ontario. (2018). Northern Ontario health equity strategy.
- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standard Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- HealthCareCAN & Mental Health Commission of Canada. (2021). The quality mental health care framework.
- Mental Health Commission of Canada. (2016). Guidelines for recovery-oriented practice.
- Ministry of Children, Community and Social Services. (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- Persi, J., & Greenham, S. (2020). Ontario Network of Child & Adolescent Inpatient Psychiatry Services: Service Guide, Standards, Benchmarks, & Literature Review: Standard 2. Psychological Safety, Dignity, Rights, Inclusion & Participation. December 3, 2020 Update.

Core principle 3
Live-in treatment is equitable, inclusive, and trauma-informed.

- Thunderbird Partnership Foundation, Indigenous Services Canada, & Health Canada. (2011). Honouring our strengths: A renewed framework to address substance use issues among First Nations people in Canada.

Mapping to the clinical standard

This core principle maps to Topics 2.1 and 5.2 of the clinical standard, as well as the following criteria: 3.1.1, 4.1.1, 4.1.4, 4.1.5, 4.1.7, 6.1.2, 6.1.8, 6.1.9, 6.1.10, 8.1.3, 8.1.5, 8.2.1, 8.2.7, 9.2.1, 9.3.4, 10.1.7, 10.2.3, 10.2.4, 10.2.6, 11.1.1, 11.1.3, 11.2.4, 11.3.8, 12.1.6, 12.1.10, 12.1.11, 12.2.2, 13.2.14, 13.2.16, 15.1.2, 18.1.2, 18.1.3, 19.1.1, 19.1.5, 19.1.7, 19.1.15, 19.1.16, 20.2.1, and 22.1.5.

OITP Clinical and Operational Standards.

Sources

Ali et al., 2023; Bryson et al., 2017; Burman et al., 2024; CMHO, 2015; Coll et al., 2019; Goldman et al., 2019; James, 2017; Johnson et al., 2015; Knowledge Institute, 2025a; 2025b; Kor et al., 2021; LIT QS Consultations, 2024-2026; MCCSS, 2020; MCYS, 2016; Ninan et al., 2014; Optimus SBR, 2025; Preyde et al., 2018; SickKids, 2025; Stewart et al., 2023; Stokes et al., 2024.

Core principle 4
Live-in treatment supports the unique needs of young people with concurrent disorders and complex needs.

Core principle 4

Live-in treatment programs support the unique needs of young people with concurrent disorders and complex needs.

Quality statement

Children and young people with concurrent disorders and complex needs receive integrated, specialized treatment from trained staff or through strong partnerships and collaboration between agencies and across sectors.

- Children and young people with concurrent disorders and complex needs receive integrated, specialized treatment.
- Live-in treatment programs build capacity to support children and young people with concurrent disorders and complex needs.
- Collaboration, partnerships, and pathways help provide specialized support.

Promising practices

Children and young people with concurrent disorders and complex needs receive integrated, specialized treatment.

Admission to a live-in treatment program is based on inclusion guidelines and a comprehensive validated, individualized screening that is trauma-informed. Inclusion guidelines for live-in treatment are clearly defined and transparently aligned with the clinical profiles of the children and young people the program is designed to support. This ensures that each program is matched as closely as possible to the needs and goals of the young person seeking treatment. Assessments recognize that children and young people may have emerging or evolving conditions that do not yet meet formal diagnostic criteria; inclusion is based on clinical presentation and functional impact and not on diagnosis alone. Inclusion decisions are individualized and regard co-occurring issues as an indication, not a barrier. Programs consider staff specializations and expertise, additional resources and capacity, formal collaborations and partnerships, and integrated services, including other programs at the agency, when identifying the best treatment options. There are also safety considerations with clear pathways for stabilization through acute or hospital-based services. If a live-in treatment program cannot meet a child or young person's needs, agencies facilitate a referral to another program that is a better fit.

Concurrent disorders
When someone is experiencing a mental health and substance use health concern at the same time, we call it a concurrent disorder. An example of this would be an individual with schizophrenia who has a cannabis use disorder (Knowledge Institute, 2023b; 2024a).

Core principle 4

Live-in treatment supports the unique needs of young people with concurrent disorders and complex needs.

Complex needs

Some children or young people experience significant, multiple, rare, or persistent mental health challenges that can impact their functioning at home, at school, and in the community. These are considered complex needs and often require intensive services. (Knowledge Institute, n.d.).

Live-in treatment programs build capacity to support children and young people with concurrent disorders and complex needs.

Programs are adaptable, holistic, and flexible, with individualized treatment plans that address each child or young person's unique needs while leveraging collaboration and partnerships to bridge gaps in expertise. All staff have core clinical competencies in concurrent disorders and substance use health, as well as in behavioural and developmental challenges. When additional support is required to fully meet children and young people's needs, service providers collaborate with system partners, children and young people, and caregivers to explore referral options. Throughout this process, the referring agency remains actively involved to ensure continuity of care and shared responsibility until a best-fit program is identified.

Collaboration, partnerships, and pathways help provide specialized support.

Children and young people with concurrent disorders and complex needs often require a range of specialized services, both within the community-based child and youth mental health, substance use health and addictions sector, and across other sectors. Each live-in treatment program establishes close collaborations, referral pathways, and integrated in-house care through partnerships, to ensure that children and young people receive coordinated support that addresses the full scope of their needs.

Practical examples

- Live-in treatment programs implement interim one-to-one staffing models to support young people who have significant behavioural needs.
- An integrated care team provides access to crucial, specialized supports within and across agencies such as with addictions medicine nurses/specialists, case coordinators, occupational therapists, educators, social workers, support workers, life skills specialists, behavioural therapists, recreational and art therapists, housing supports, and speech and language pathologists.
- Agencies provide tailored support for young people accessing live-in treatment services who are pregnant or are new parents, including providing childcare, infant mental health and parent-child attachment interventions, financial support, reliable transportation, group-based programming, and peer support groups.
- Agencies design a program's physical environment to meet complex needs (by including sensory rooms, for example) and adhere to standards outlined in the Accessibility for Ontarians with Disabilities Act (AODA).

Core principle 4

Live-in treatment supports the unique needs of young people with concurrent disorders and complex needs.

Implementation considerations

Barriers

- Agencies can find it difficult to recruit staff with the necessary expertise in concurrent disorders and complex needs, and to secure time and resources for training in these areas.
- Live-in treatment programs are unable to effectively support withdrawal management, resulting in the exclusion of young people with significant substance use health needs, leaving them to rely only on withdrawal management, often without robust complementary supports.
- Due to resourcing limitations, some agencies must reduce intake numbers in order to adequately support young people with multiple diagnoses and/or complex needs.
- The growing and rapidly evolving complexity of needs across live-in treatment programs can make it difficult to align timely and individualized treatment with existing funding models. Funding models and complexity of needs often evolve on different timelines.

Mitigating Strategies

- Establish clear referral pathways and defined roles between agencies to support integrated care.
- Convene multi-sector community partners for joint case conferencing to coordinate treatment plans to support young people with complex needs who require additional treatment considerations and services across multiple systems.
- Where stability at admission is required, put in place safety considerations with clear pathways for stabilization through acute or hospital-based services and subsequent transitions to live-in treatment programs. Throughout this process, the referring agency remains actively involved to ensure continuity of care and shared responsibility.
- Ensure that interdisciplinary teams across live-in treatment programs receive training and mentorship through provincial collaborative platforms (Project ECHO, for example) to promote knowledge exchange and strengthen collective practice in supporting young people with complex needs.

Core principle 4

Live-in treatment supports the unique needs of young people with concurrent disorders and complex needs.

What we heard from young people and caregivers

"I have had such harmful experiences where [support for concurrent disorders and complex needs] wasn't the case. To see this as a core principle is really exciting because I think even if someone has one diagnosis, it's still complex. Recognize how complex some folks' journeys can be and how programs need to be adaptable and flexible. Understand that it's not black and white."

- Young person

"I really, really appreciate the adding of the concurrent disorders and complex needs, because it's been very siloed in the past, and that needs to end."

- Caregiver

"What strikes me about this one is that I think about the families who are actually turned away because they're told their child is too complex. I feel like this is the section that should identify that children won't be turned away and that treatment will be found where possible. That's what families want to hear, that something will be done."

- Caregiver

What this means for our audiences

To children, young people, and caregivers

Your treatment is individualized to reflect your unique needs, including concurrent and complex needs — physical, intellectual, or developmental — and your treatment team has the capacity and expertise to provide appropriate support. You are given clear information to support your decision-making, including about your treatment and the specific complementary services available to support your needs. You have access to a range of appropriate options, and admission to programs is guided by your needs rather than availability alone. Your treatment is coordinated across services to ensure continuity and consistency. Efforts are made to ensure you are not excluded from treatment due to gaps in service availability or provider expertise. Timely connections are made to appropriate, integrated, concurrent, or collaborative care.

To service providers and agency leaders

As service providers, you prioritize admission based on inclusion rather than restrictive eligibility criteria. Treatment is individualized to reflect the unique and complex needs of each child and young person. You collaborate with organizations across sectors to provide comprehensive and coordinated support, including across mental health, substance use health, and other relevant services.

Core principle 4
Live-in treatment supports the unique needs of young people with concurrent disorders and complex needs.

As agency leaders, you support the development and maintenance of clear pathways and partnerships that enable timely access to appropriate, coordinated services. You ensure appropriate staffing complements and invest in ongoing training to build staff capacity.

To system decision makers

As decision makers, you allocate funding and resources to improve access to treatment for children and young people with concurrent disorders and complex needs. You promote collaboration and communication across sectors to reduce silos and fragmentation to ensure policies, mandates, and services are connected and complementary. You support integrated service models that respond to complex and diverse health needs.

Quality indicators

- Percentage (%) of children and young people with concurrent disorders and complex needs who receive coordinated, specialized treatment from two or more interdisciplinary team members.
- Percentage (%) of staff who report that they consistently apply the treatment model(s) as intended in their practice.
- Percentage (%) of staff with training/competencies in concurrent disorders and complex needs.
- Percentage (%) of children and young people with complex needs who access specialized services through established partnerships or pathways.

Related standards and guiding documents

- Health Quality Ontario. (2020). Problematic alcohol use and alcohol use disorder: Care for people 15 years of age and older.
- Health Quality Ontario. (2018). Opioid use disorder (opioid addiction): Care for people 16 years of age and older.
- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standard Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- Hernandez-Basurto, M. A., Bate, E., & Taha, S. (2024). Substance use health competencies for all prescribers. Canadian Centre on Substance Use and Addiction.

Core principle 4
Live-in treatment supports the unique needs of young people with concurrent disorders and complex needs.

- Ministry of Children, Community and Social Services. (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- Newfoundland Labrador Department of Health and Community Services, Health Canada, & Rush, B. (2015). Concurrent disorders guidelines.
- School and Community System of Care Collaborative. (2022). Right time, right care: Strengthening Ontario's mental health and addictions system of care for children and young people.
- Standards Council of Canada. (2022). The mental health and substance use health standardization roadmap.
- Thunderbird Partnership Foundation, Indigenous Services Canada, & Health Canada. (2011). Honouring our strengths: A renewed framework to address substance use issues among First Nations People in Canada.
- Canadian Centre on Substance Use and Addiction. (2023). Behavioural competencies for Canada's substance use and mental health workforce.
- Canadian Centre on Substance Use and Addiction. (2023). Technical competencies for Canada's substance use and mental health workforce.

Mapping to the clinical standard

OITP Clinical and Operational Standards.

This core principle maps to Topics 8.1, 8.2, 10.1, 12.1, and 15.1 of the clinical standard, as well as the following criteria: 4.1.3, 4.1.8, 6.1.5, 6.1.6, 6.3.2, 9.1.2, 9.1.3, 9.1.4, 12.2.1, 12.2.2, 12.2.3, 12.2.5, 12.2.8, 13.2.3, 13.2.4, 13.2.14, 13.2.16, 17.1.2, 17.1.3, 17.1.9, 19.1.1, 19.1.4, 19.1.14, and 20.2.1.

Sources

Ali et al., 2023; Burman et al., 2024; Canadian Centre on Substance Use and Addiction, 2023; CMHO, 2015; 2016; Government of Ontario, 2016; Johnson et al., 2015; LAC, 2021; LIT QS Consultations, 2024-2026; O'Leary et al., 2024; Pumariega et al., 2003.

Delivery of treatment

The practices and processes that support the delivery of high-quality treatment.

Core principle 5

Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.

Quality statement

Evidence informs the design of clinical program models and the development of individualized treatment plans. Routine assessments at key timepoints — such as intake and discharge — are used to monitor each child or young person's progress toward their treatment goals and evaluate the effectiveness of the treatment modality.

- Treatment is individualized and flexible, and rooted in a biopsychosocial understanding, to support the unique needs of children, young people, and caregivers.
- Live-in treatment programs are guided by defined, evidence-informed treatment models.
- Measurement-based care guides treatment decisions.

Core principle 5

Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.

Biopsychosocial approach

A biopsychosocial approach recognizes that health and well-being are shaped by the dynamic interaction of biological, psychological, and social influences, and that understanding and supporting an individual requires attention to all three domains rather than any single aspect in isolation (Engel, 1977; Vögele, 2015).

Promising practices

Treatment is individualized and flexible, and rooted in a biopsychosocial understanding, to support the unique needs of children, young people, and caregivers.

A comprehensive assessment at intake is used to help identify each child or young person's strengths, challenges, and treatment requirements to ensure treatment is tailored to their individual needs. Where appropriate, these comprehensive assessments also consider caregiver strengths and challenges, so treatment may be tailored to best support the caregiving system. Assessments are trauma-informed and strengths-based and take a culturally responsive approach to understanding protective factors and healing approaches. When needed, agencies can access specialized consultation, assessment, and support for children and young people with complex needs through pathways and partnerships.

Treatment is guided by a holistic understanding of children's and young people's well-being, recognizing the biological, psychological, and social factors, along with the multiple interconnected systems – such as caregivers, community, and culture – that influence their experiences, needs, and capacity to engage in treatment. This guides the development of individualized treatment plans in collaboration with children, young people, and caregivers. Treatment plans use an integrated approach to address all life domains, including mental health, substance use health, physical health, developmental and behaviour needs, caregiver needs, social functioning, safety needs, spiritual/cultural needs and preferences, educational goals, and financial needs. Treatment plans are systematically revisited over time to reflect progress and evolving needs.

Treatment takes an interdisciplinary approach, drawing on the expertise of diverse professionals to meet the complex needs of children, young people, and caregivers, and to provide holistic care. This also includes collaborating with existing service providers and resources when developing treatment plans and maintaining communication with them throughout treatment.

To deliver effective evidence-based treatment, service providers build trust by establishing therapeutic alliances and creating a warm and responsive environment that is physically, emotionally, spiritually, and culturally safe, and where children and young people can participate in ways that reflect their needs and readiness.

Core principle 5
Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.

Measurement-based care
Measurement-based care is the systematic and ongoing collection of standardized data on an individual's symptoms, functioning, and experiences throughout care. The data is used to monitor progress and inform clinical decision-making.

Evidence is information used to inform decision-making processes and practices. In this standard, "evidence" refers to information from academic and grey literature, lived and living expertise, service provider experiences, and traditional knowledge and wise practices.

Treatment
Treatment refers to time-limited evidence-based interventions or modalities (CBT and DBT, for example), that address specific mental health and substance use health conditions and symptoms such as substance use disorders, depression, or anxiety.

Live-in treatment programs are guided by defined, evidence-informed treatment models.

A trauma-informed framework (such as the Attachment, Regulation, and Competency [ARC] framework) provides the foundation for all therapeutic interventions. Live-in treatment programs establish their clinical program models using evidence-based treatment modalities (Cognitive Behavioural Therapy [CBT], Dialectical Behaviour Therapy [DBT], and Collaborative Problem-Solving [CPS], for example). The clinical program models and chosen treatment modalities are based on the specific clinical profiles and needs of the children and young people the program serves. Evidence-based treatment modalities do not always account for diverse populations and culturally specific approaches, so they are applied flexibly and adapted to the needs of children, young people, and caregivers. The clinical program model forms the foundation for individualized treatment planning, informing but not prescribing, the types, intensity, and frequency of therapeutic interventions. It establishes a minimum standard of treatment while allowing treatment plans to be individualized to each child or young person's unique needs.

Peer support for children, young people, and caregivers is incorporated as a core component of live-in treatment, and children and young people can access culturally based interventions. When needed, collaboration and partnerships bridge gaps in expertise.

Staff apply the principles and strategies of the treatment model in the milieu to create a consistent, structured, and supportive environment that reinforces therapeutic goals throughout all aspects of care. In the therapeutic milieu, staff use daily routines and interactions, experiences, and relationships as therapeutic opportunities that complement and reinforce the evidence-based interventions led by treatment providers. To support this integrated approach, all staff receive training on the clinical model, as well as clinical supervision, to ensure treatment is delivered consistently, effectively, and with fidelity, with supervisory sign-off on key decisions. Agencies also monitor and adapt to changes in treatment modalities and novel treatment models as part of their continuous quality improvement process.

Core principle 5

Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.

Measurement-based care guides treatment decisions.

Live-in treatment programs use measurement-based care, combining evidence-informed tools with the lived expertise of young people and caregivers, to inform iterative and individualized treatment planning. Routine assessments at key timepoints (intake, throughout treatment, discharge) help determine if children, young people — and where appropriate, caregivers — are making progress toward the treatment goals and outcomes they identified, to evaluate the effectiveness of the treatment modality, and to inform readiness for transitions in treatment. Ongoing assessments help treatment plans evolve in response to the changing needs of the child, young person, and caregiver(s).

Outcomes from assessments are shared back with children, young people, and caregivers in a way that is easy to understand and developmentally appropriate to help inform collaborative decision-making. As part of the collaborative process, children, young people, and caregivers are informed of and aware of what assessments and re-assessments look like: the tools that are used, the information that is collected, and how it will support them in their journey through live-in treatment. This process respects data privacy, security, and sovereignty. Assessments work to counter the stigma around mental health, substance use health, and addictions, and include conversations on personal stigma, social stigma, and structural stigma.

Practical examples

- Agencies define a clinical model rooted in both CBT and Acceptance and Commitment Therapy (ACT).
- All staff are invited to join an interdisciplinary consultation team to ensure they have opportunities to consult and support one another to maintain competency and adherence to the treatment model.
- Agencies are informed by findings from the OITP's Clinical Populations Final Report (2025) to understand the clinical profiles best served through their live-in treatment program.
- Agencies use measurement-based care, like the CALOCUS-CASII at intake, mid-point, and transitions to inform clinical decision-making and to monitor progress.

Core principle 5
Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.

Implementation considerations

Barriers

- There is limited valid and reliable evidence on long-term treatment outcomes, appropriate length of stay, and performance measurement indicators for live-in mental health treatment.
- Rapidly evolving and complex clinical profiles in live-in treatment require robust and ongoing research synthesis to better understand which children and young people are most likely to benefit from live-in treatment. Relying solely on the clinical profiles of those currently in treatment does not provide insight into the clinical profiles of those not receiving live-in treatment but who might benefit from it.
- One-size-fits-all licensing requirements create significant challenges for live-in treatment providers. For instance, current licensing approaches do not differentiate between licensed care and licensed mental health treatment where evidence-based treatment is required.

Mitigating Strategies

- Partner with research and intermediary organizations to increase capacity for involvement in research and evaluation, and to further the evidence base surrounding live-in treatment programming and the efficacy of various treatment modalities.
- Adopt clinical and operational standards (such as those produced by the OITP) to support the creation, definition, and operation of clinical program models for live-in treatment.
- Offer training on the clinical program model and treatment modalities to all direct-service staff, ensuring consistent understanding and delivery across professional roles.
- Use implementation supports and processes to identify and leverage complementary components of licensing, clinical, and quality standards, and to harmonize efforts in program design and measurement.

What we heard from young people and caregivers

"Many different cultures and religions recognize other treatment modalities beyond CBT and DBT that would be considered evidence-based in their culture... I mean, for me, some of the treatment modalities that I've experienced that I felt were super effective were not CBT and DBT. It was things like horticulture therapy and animal therapy."

- Young person

Core principle 5
Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.

"Part of it is clearly outlining what evidence is going to be used, and includ[ing] evidence from the family, as well. Be really clear about the needs of the family too. I remember at one point in a clinical setting where they were talking about our son, and they spoke about progress and meeting all kinds of markers of progress, but he was still really violent, and it wasn't safe for his siblings."

- Caregiver

What this means for our audiences

To children, young people, and caregivers

You are informed about what your treatment plan includes and the evidence that supports it, with clear explanations to help you understand. Your treatment plan is individualized, reflecting your preferences and your social, cultural, and spiritual context. It takes a holistic approach, addressing different aspects of your well-being, and evolves over time as your needs and circumstances change. Routine assessments help identify areas where support is needed, guiding how your treatment is planned and adjusted throughout your live-in treatment journey. Assessments are presented and completed in a way that feels meaningful and helpful to your treatment journey. You are aware of and fully understand the tools that are used and the information that is collected, and it is clear how the information will support your treatment goals.

To service providers and agency leaders

As service providers, you ensure treatment plans are individualized and flexible to meet the unique needs of children and young people. You understand the many aspects and systems that shape a young person's experience, and you ground treatment in a biopsychosocial approach. You deliver treatment using evidence-based and evidence-informed models and remain aware of and transparent about any gaps in your knowledge, training, or confidence. Where appropriate, you integrate culturally safe approaches to ensure treatment is responsive to diverse identities.

As agency leaders, you promote the consistent use of evidence-based, trauma-informed, and culturally safe approaches, and support ongoing evaluation and learning to ensure approaches remain relevant and aligned with best practices.

Core principle 5

Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.

To system decision makers

As decision makers, you support ongoing research, iterative policy development, and commensurate resourcing to identify and implement a range of evidence-based approaches that respond to the varying levels of complexity and diverse populations taking part in live-in treatment. This includes culturally safe approaches, where appropriate. You promote alignment across the system in how clinical models are understood and applied, while enabling flexibility to ensure they remain relevant and responsive to the needs of children and young people over time.

Quality indicators

- Percentage (%) of children and young people who receive a comprehensive assessment to inform their treatment plan.
- Percentage (%) of children and young people who report that the treatment approach was individualized to match their needs, preferences, and goals.
- The program has evidence-based treatment model(s) to guide individualized treatment planning and daily therapeutic interventions (Yes/No).
- The program has structured training and clinical supervision processes in place, including supervisory sign-off on key decisions and documentation, to support the consistent application of evidence-based treatment models (Yes/No).
- Percentage (%) of staff who report feeling confident to apply the principles and strategies of the treatment model(s) in the milieu.
- The program has documented time points to monitor children's and young people's progress, reassess their needs, and measure treatment outcomes (Yes/No).
- Percentage (%) of children and young people who, at defined intervals, are supported to review and understand their progress data (through visual tools, summaries or discussion, for example).

Core principle 5
Live-in treatment is rooted in evidence-based clinical program models and treatment modalities.

Related standards and guiding documents

- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standards Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- HealthCareCAN & Mental Health Commission of Canada. (2021). The quality mental health care framework.
- Ministry of Children, Community and Social Services. (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- Newfoundland Labrador Department of Health and Community Services, Health Canada, & Rush, B. (2015). Concurrent disorders guidelines.

OITP Clinical and Operational Standards.

Mapping to the clinical standard

This core principle maps to Topics 6.1, 6.2, 6.3, 8.1, 8.2, 8.4, 10.1, 12.1, and 15.1 of the clinical standard, as well as the following criteria: 11.3.7, 14.2.3, 14.2.5, 20.2.2, 20.2.3, 20.2.4, 20.2.5, 20.2.6, and 20.2.7.

Sources

CMHO, 2015, 2016; Creed et al., 2021; Evans et al., 2020; Gharabaghi, 2024; Government of Canada, 2024; James, 2017; Johnson et al., 2015; Kanter, 1989; Knowledge Institute, 2025a; Kvamme et al., 2024; LAC; 2021; Lanier et al., 2020; LIT QS Consultations, 2024-2026; MCYS, 2016; Ninan et al., 2014; O'Leary et al., 2024; Theall et al., 2022; Yeheskel et al., 2020.

Core principle 6

Live-in treatment programs purposefully integrate treatment and care.

Quality statement

Live-in treatment programs provide a warm and responsive environment, where evidence-based treatment is thoughtfully integrated with milieu therapy and activities such as recreation, life skills development, and other specialized, adapted, or alternative therapeutic approaches to provide holistic support.

- Treatment and care are purposefully integrated.
- A holistic approach to treatment is adopted to support children and young people's mental, physical, emotional, and spiritual well-being and to promote skill development.
- Live-in treatment provides a warm and responsive environment that is physically, emotionally, spiritually, and culturally safe.

Promising practices

Treatment and care are purposefully integrated.

Live-in treatment consists of two interconnected components: evidence-based treatment (CBT, DBT, CPS, for example) and the therapeutic milieu. Evidence-based treatment is integrated with milieu therapy, where the care environment functions as a therapeutic intervention. The therapeutic milieu extends support beyond evidence-based treatment, where daily routines and interactions, experiences, and relationships are leveraged as opportunities for skill-building. Clinical program models guide these day-to-day interactions in the therapeutic milieu. In this way, milieu-based interventions and clinical treatment work together to create a cohesive and holistic approach to treatment. This integration is guided by formal documentation, such as an agency-specific framework for integrated programming, and is supported by staff training to ensure it is implemented consistently and effectively.

A holistic approach to treatment is adopted to support children and young people's mental, physical, emotional, and spiritual well-being and to promote skill development.

Core principle 6
Live-in treatment programs purposefully integrate treatment and care.

To complement evidence-based treatment, live-in treatment programs offer opportunities for children and young people to engage in a variety of activities including physical activity, accessing outdoor spaces, recreational and community activities, and other therapeutic approaches like art therapy and music therapy. Daily activities are individualized, developmentally appropriate, culturally responsive, and child- and youth-directed, balancing treatment with experiences that promote skill building (life skills, relationships with staff and peers, coping skills). Programs provide a range of activities and approaches that are responsive to children and young people's needs and preferences, and children and young people choose the activities and approaches that are meaningful for them. Programming is accessible across abilities, with assistive technologies and adaptive equipment, sensory accommodations, mobility supports, and cognitive adaptations available as needed.

Health promotion, such as sexual health education and substance use health education, is embedded throughout daily routines. This holistic approach to treatment promotes mental, physical, emotional, and spiritual well-being and provides children and young people with opportunities to build skills. Children and young people also receive support for non-healthcare and practical needs (childcare, education, housing, finances, and employment). These considerations support the sustainability of mental health, substance use health, and addictions treatment after discharge. Referrals to, and coordination with, other health and non-health-related supports are made as needed.

Equity considerations are described further in Appendix D.

Live-in treatment provides a warm and responsive environment that is physically, emotionally, spiritually, and culturally safe.

The live-in treatment environment provides the foundation for safety and resilience, offering children and young people a structured, safe, and supportive space to grow. The environment is accessible, inclusive, and meets individual needs to acknowledge and respect the unique ways children and young people experience physical, emotional, spiritual, and cultural safety. This warm and responsive care setting supports high-quality treatment. The physical environment is accessible, welcoming, and comfortable, with access to nature and green spaces. The environment is set up to balance comfort and safety while maintaining privacy.

Core principle 6
Live-in treatment programs purposefully integrate treatment and care.

Equally important are the therapeutic relationships and positive attachments within live-in treatment. Programs prioritize respectful, responsive, and safe connections between staff and young people, which are essential to positive mental health. Clients' voices, including their goals, needs, and preferences, are respected and included in the decision-making processes for all aspects of live-in treatment programming, so there is consistency and continuity between treatment, care, and complementary activities. Cultural context and identity are thoughtfully integrated into all aspects of treatment, as well as how they are brought together to meet the needs of the client. Together, these elements contribute collectively to a safe, inclusive, and healing environment that supports the effective delivery of treatment plans.

Practical examples

- There are protocols describing how child and youth workers and clinical treatment staff share information and collaborate to ensure symbiotic approaches to support the young person in treatment.
- Agencies maintain safe and appropriate work and staff break spaces, using technology-enabled safety systems (surveillance, alert tools) and conducting ongoing risk assessments to identify and address potential concerns.
- Young people are engaged in personalizing the physical space with safety parameters (decorating their rooms and bringing their own blankets, for example).
- Agencies have access to spaces that are open and multi-use to support recreational activities and offer components of treatment programming in outdoor green spaces, intentionally integrating treatment and care considerations.

Implementation considerations

Barriers

- There are inconsistent approaches to integrating treatment and care in live-in treatment programs, especially when many programs lack a defined clinical treatment model.
- Inconsistent supervision and training on the clinical model, as well as high staff turnover, make it difficult to integrate clinical treatment models with fidelity in milieu work.
- Distinctions between clinical treatment and care, and an understanding of roles, responsibilities, and professional boundaries, are unclear.
- Variation in treatment competency among staff impedes individualized therapeutic interventions and the integration of milieu therapy.

Core principle 6
Live-in treatment programs purposefully integrate treatment and care.

Mitigating Strategies

- Develop and deliver program-specific training focused on practical applications of the program's clinical treatment modalities and milieu intervention techniques.
- Develop policies that clearly articulate the unique role the milieu plays in achieving positive outcomes for children and young people in live-in treatment settings.
- Establish clear protocols for safely supporting young people with different treatment needs (for example, young people with anxiety and those with externalized aggressive behaviours) in the same setting.
- Create opportunities for young people to spend time practicing skills in the community, such as volunteering.

What we heard from young people and caregivers

"To me, this principle means creating and facilitating a warm, responsive, and safer environment where young people feel supported in all aspects of their well-being. It involves understanding and integrating a range of therapeutic approaches based on individual needs, and co-developing care plans from the get-go."

- Young person

"If you're going to purposely integrate treatment and care, all of these things [core principles] become a priority. You have to have competent, trustworthy staff. You have to have reliable, evidence-based programming, etc."

- Caregiver

What this means for our audiences

To children, young people, and caregivers

All elements of your care are intentionally integrated throughout your live-in treatment journey. Your treatment plan clearly and thoughtfully outlines and connects your clinical treatment and your daily programming. Your treatment is holistic and not limited to structured sessions, but woven into daily life through meals, cultural practices, creative activities, and opportunities to connect with your community. Staff are approachable and build trusting relationships with you, fostering a sense of connection and belonging that supports your care both within and beyond formal therapeutic interactions. The live-in treatment program supports your growth, development, and ability to thrive.

Core principle 6
Live-in treatment programs purposefully integrate treatment and care.

To service providers and agency leaders

As service providers, you thoughtfully and purposefully integrate treatment and care across all aspects of the live-in treatment experience, guided by clear frameworks. You create a warm, responsive environment that is physically, emotionally, culturally, and spiritually safe. You connect clinical interventions with everyday experiences to support a consistent and holistic approach to treatment. You build responsive relationships with children, young people, and caregivers, recognizing that connection and trust are central to treatment success.

As agency leaders, you create conditions that support this approach by monitoring the creation and implementation of integrated treatment plans. You align program design, staffing, supervision, training, and partnerships to ensure treatment and care can be delivered in a coordinated, complementary, and holistic way.

To system decision makers

As decision makers, you set direction that supports the integration of evidence-based treatment and the therapeutic milieu as interconnected components of live-in treatment. You support the development and use of integrated programming frameworks that guide how treatment and daily care are connected in practice, ensuring that the live-in treatment environments are responsive to the diverse needs of children, young people, and caregivers.

Quality indicators

- Percentage (%) of children and young people who report that skills learned in therapy are actively reinforced and supported by staff during daily routines and interactions.
- The program has a documented plan for integrating treatment and care for each client (Yes/No).
- Percentage (%) of staff who report feeling adequately equipped to contribute to the integrated treatment and care approach.
- Percentage (%) of children and young people who report participating in recreational activities that seem meaningful and relevant to their treatment.
- Percentage (%) of integrated treatment and care plans that include complementary activities and skill-building opportunities.
- Percentage (%) of staff who report having the knowledge and skills to integrate complementary activities with evidence-based treatment.

Core principle 6
Live-in treatment programs purposefully integrate treatment and care.

- Percentage (%) of children and young people who report that the live-in treatment environment is safe, fosters belonging, and supports expression of their identities.
- The program has formal procedures to maintain and improve physical, emotional, spiritual, and cultural safety (Yes/No).
- Percentage (%) of staff who report that the live-in treatment environment is physically, emotionally, spiritually, and culturally safe for clients and staff.

Related standards and guiding documents

- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standard Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- Ministry of Children, Community and Social Services (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- Newfoundland Labrador Department of Health and Community Services, Health Canada, & Rush, B. (2015). Concurrent disorders guidelines.
- School and Community System of Care Collaborative. (2022). Right time, right care: Strengthening Ontario's mental health and addictions system of care for children and young people.
- Thunderbird Partnership Foundation, Indigenous Services Canada, & Health Canada. (2011). Honouring our strengths: A renewed framework to address substance use issues among First Nations People in Canada.

OITP Clinical and Operational Standards.

Mapping to the clinical standard

This core principle maps to Topics 10.2, 13.1, 13.2, 19.1, and 19.2 of the clinical standard, as well as the following criteria: 12.1.6, 12.1.15, 12.1.17, 20.1.1, 20.1.2, 20.1.4, and 20.2.4.

Sources

Coll et al., 2019; Creed et al., 2021; Espenes et al., 2023; Frensch et al., 2022; Gharabaghi, 2024; Johnson et al., 2015; Knowledge Institute, 2025a; LAC, 2021; LIT QS Consultations, 2024-2026; MCCSS, 2020; Vogelsang et al., 2024.

Core principle 7

Live-in treatment is grounded in staff capacity, competencies, and well-being.

Quality statement

Live-in treatment programs are supported by a qualified, collaborative, and capable interdisciplinary team. Clinically trained staff provide treatment according to a clinical program model. All staff receive ongoing training on the program's treatment modality and clinical program model, and are supported through fair compensation, comprehensive training, clinical supervision, and a positive team morale.

- Interdisciplinary teams collaborate to provide integrated treatment and care.
- Staff have the educational qualifications to provide effective treatment and/or contribute to effective treatment for children and young people.
- Staff receive ongoing training and clinical supervision.
- Agencies support staff well-being and safety through organizational practices that are trauma-informed.

Promising practices

Interdisciplinary teams collaborate to provide integrated treatment and care.

Children and young people in live-in treatment have complex needs that require the support of interdisciplinary teams. The composition of each team, including staff ratios, is guided by the program's clinical model and the specific needs of the children and young people the program serves. Teams include professionals with different expertise such as child and youth workers, psychologists, psychiatrists, social workers, behavioural therapists, nurses, cultural brokers, and peer support workers. Interdisciplinary teams also reflect the cultural and linguistic diversity of the populations they serve, including staff in culturally based roles (Elders, Knowledge Holders). When children and young people need specialized support, agencies have access to staff with specialized clinical expertise through collaboration and partnerships. Children and young people receive support from interdisciplinary team members whose expertise aligns with their individualized treatment plan, with staffing ratios reflecting the treatment and care needs of children and young people.

Core principle 7
Live-in treatment is grounded in staff capacity, competencies, and well-being.

All staff operate within clearly defined roles and scopes of practice, and collaborate to deliver purposeful, integrated treatment and care, with evidence-based interventions led by clinical treatment providers and reinforced by staff in the milieu. There are shared documentation systems, communication protocols, and regular interdisciplinary team meetings to ensure all team members have access to treatment plans and deliver consistent treatment.

Staff have the educational qualifications to provide effective treatment and/or contribute to effective treatment for children and young people.

Agencies determine for all staff the required educational background, prior experience, and college certification requirements and standings (as applicable). This ensures that all staff are well-prepared to meet the needs of the children and young people the program serves and to deliver treatment consistent with the program's clinical model. All staff have core clinical competencies in the program's treatment modality, evidence-informed interventions, concurrent disorders and substance use health, and behavioural and developmental challenges. Staff also have core competencies in trauma-informed practice, youth- and family-centred care and engagement, cultural safety and inclusion, and safety and crisis response. Depending on the clinical program model and focus, some programs may require staff with specialized clinical expertise. Staff have core personal attributes such as adaptability, resilience, interpersonal abilities, and skills in professional practice and self-development (self-awareness and reflective practice, safe and effective use of self, professional boundaries).

Staff receive ongoing training and clinical supervision.

Ongoing training and clinical supervision support the physical, emotional, and cultural safety and well-being of children, young people, and staff. All interdisciplinary team members receive ongoing training in the program's treatment modality and clinical program model, ensuring a shared understanding and consistent implementation of treatment plans. This promotes a unified and consistent approach to treatment across the team. Staff also have access to continuous, high-quality training and professional development opportunities in areas such as delivering trauma-informed, identity-affirming, culturally safe, and child- and youth-centred care. Staff also use measurement-based care to identify areas for professional development.

Core principle 7
Live-in treatment is grounded in staff capacity, competencies, and well-being.

All staff receive ongoing clinical supervision that is trauma-informed and culturally safe to support them in delivering treatment and maintaining fidelity to the clinical model. Clinical supervision also helps staff build clinical competencies to respond to the needs of children and young people, engage in reflective practice and the safe and effective use of self, and navigate complex clinical situations. Staff and leaders share responsibility for training and engaging in the safe and effective use of self.

Agencies support staff well-being and safety through organizational practices that are trauma-informed.

Live-in treatment environments are among the most demanding settings within the sector, as staff work around the clock in shift-based schedules with children and young people who have some of the most complex needs. Agencies recognize the demanding nature of this work and the challenging experiences of staff and aim to ensure staff feel supported in their roles. A trauma-informed approach to prioritizing staff well-being and safety in these settings improves workplace satisfaction, strengthens retention, and promotes child- and youth-centred care.

Agencies regularly assess and make improvements toward fair compensation and provide comprehensive training and clinical supervision to support all staff in maintaining healthy boundaries and self-awareness when working with children and young people. Staff safety is supported through safety plans and clear incident response procedures, and agencies respond to staff safety concerns with meaningful action. Staff also have safer spaces to debrief their work that are inclusive, culturally safe, respectful, and free from judgment, and avenues to access trauma-informed supports such as employee assistance services for mental health and substance use health care. Agencies foster positive team morale by celebrating and recognizing staff contributions and by promoting collaboration, trust, and support within teams. Through their commitment to continuous improvement, agencies regularly collect feedback from staff on organizational concerns, service delivery, and safety, and improve the work environment.

Core principle 7
Live-in treatment is grounded in staff capacity, competencies, and well-being.

Practical examples

- Agencies implement a clear clinical supervision structure including regular opportunities to debrief with a mentor or supervisor, peer supervision program, and/or community of practice, to provide staff with the opportunity to collaboratively debrief, problem-solve, and learn.
- Agencies develop and regularly assess self-care plans with staff and dedicate time for pre- and post-debriefs, and to support staff through long shifts.
- Training in cultural safety, responsiveness, and competency (IRMHP: Immigrant and Refugee Mental Health Project, for example) is built into staff orientation processes.
- Staff are actively engaged in the co-creation of training content. Mechanisms for gathering input on training themes, staff experiences, and impacts on practice help shape training offerings.
- Agencies use the Core Competencies Framework outlined within the OITP's Clinical Standard, as well as job descriptions from comparable live-in treatment programs, to guide their hiring processes.
- Agencies establish partnerships with college and university programs to establish training and career pathways for clinical staff.

Implementation considerations

Barriers

- High staff turnover, administrative burden, and poor staff-to-client-ratios disrupt continuity of care and therapeutic relationships.
- Agencies have inadequate post-incident support for essential staff following workplace violence.
- Unclear role clarity can undermine teamwork and the skills of less formally educated staff.
- Existing training lacks focus for live-in treatment settings.
- There is limited time for and access to training, support, supervision, team meetings, and case conferences for staff.

Mitigating Strategies

- Offer standard in-service training with prescribed topics and frequency for evaluation, review, and renewals.
- Develop a funding framework linked to critical success factors and in line with the program's clinical treatment model to ensure that resources match staffing ratios and program needs.

Core principle 7
Live-in treatment is grounded in staff capacity, competencies, and well-being.

- Enhance job satisfaction through continued review and updating of compensation packages, stable employment contracts, flexible hours, and training opportunities.
- Schedule team meetings, trainings, and case conferences at regular timeslots to allow participation from all staff, including relief and overnight staff.
- Clearly define roles and responsibilities among staff to reduce ambiguity and promote multi-disciplinary collaboration.

What we heard from young people and caregivers

"When it comes to staff capacity, competencies, and well-being, being able to trust the team that is caring for me allows me to be vulnerable and to truly open up to receive the care that I ultimately need. When there's no capacity and the staff are not caring for themselves and are unwell, it is felt by the clients. Often, in my experience, I withdraw, I do not trust the team, and because of that, I don't open up or be vulnerable."
- Young person

"As somebody who is a caregiver myself and also someone who works in healthcare, this is important to me. If the staff are well trained, not overwhelmed, and mentally healthy themselves, patients in live-in treatment are more likely to receive good care and recover better. I am an advocate for training and well compensating folks who work in healthcare, so they can provide needed care to our loved ones."
- Caregiver

What this means for our audiences

To children, young people, and caregivers

You are supported by a team that works together to meet your needs. The team brings together diverse areas of expertise and collaborates to provide coordinated care. Team members are trained and knowledgeable in the approaches used in your treatment and provide care that is trauma-informed, culturally safe, and centred on children, young people, and caregivers. Your team is confident and engaged. You experience consistency in how treatment is provided, as the team shares a common understanding of your treatment plan and works together to support your goals. You build trusting relationships with those involved in your treatment.

Core principle 7
Live-in treatment is grounded in staff capacity, competencies, and well-being.

To service providers and agency leaders

As service providers, you work as part of an interdisciplinary team with clearly defined roles, collaborating to deliver coordinated and integrated treatment. You maintain core competencies to support delivery of the program's clinical model and treatment approaches and apply these consistently in your work. You engage in ongoing training and supervision to strengthen your skills and ensure treatment remains safe, responsive, and aligned with best practices.

As agency leaders, you ensure appropriate staffing capacity and team composition to meet the needs of children, young people, and caregivers. You provide access to ongoing training, supervision, and professional development to support staff competency and consistent implementation of treatment approaches. You prioritize staff well-being by fostering supportive work environments, including opportunities for debriefing, access to mental health and wellness supports, and practices that promote team cohesion.

To system decision makers

As decision makers, you promote conditions that enable interdisciplinary collaboration and consistency in treatment, ensuring staff are supported to deliver high-quality care. You recognize the importance of staff well-being and support system-level approaches that foster healthy work environments, contributing to staff retention, employment stability, and continuity of care for children, young people, and caregivers.

Quality indicators

- Percentage (%) of staff who report that the roles and scopes of practice within their interdisciplinary team are clear, appropriate, and consistently adhered to.
- The program has established processes (consultation models, embedded disciplines) to ensure that members of the interdisciplinary team collaborate effectively for the benefit of clients (Yes/No).
- Core competencies, including required educational qualifications, are embedded in the program's hiring practices, clinical interventions, and service delivery (Yes/No).
- Percentage (%) match between the evidence-based model and how staff deliver the live-in treatment program.

Core principle 7
Live-in treatment is grounded in staff capacity, competencies, and well-being.

- Percentage (%) of staff who have received/are receiving training or professional development to support the program's clinical interventions and service delivery model.
- Percentage (%) of staff participating in ongoing supervision that supports their clinical practice and/or skills development.
- Percentage (%) of staff who report feeling safe at work.
- Percentage (%) of staff who report that the organization supports their well-being.
- Percentage (%) of staff who report that staff-to-client ratios support consistent and effective delivery of treatment plans.
- Rate (%) of staff turnover.

Related standards and guiding documents

- Canadian Centre on Substance Abuse. (2010). Building on our strengths: Canadian standards for school-based youth substance abuse prevention (version 2.0).
- Canadian Centre on Substance Use and Addiction. (2023). Behavioural competencies for Canada's substance use and mental health workforce.
- Canadian Centre on Substance Use and Addiction. (2023). Technical competencies for Canada's substance use and mental health workforce.
- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standards Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- HealthCareCAN & Mental Health Commission of Canada. (2021). The quality mental health care framework.
- Hernandez-Basurto, M. A., Bate, E., & Taha, S. (2024). Substance use health competencies for all prescribers. Canadian Centre on Substance Use and Addiction.
- Mental Health Commission of Canada. (2026). The national standard of Canada for psychological health and safety in the workplace.
- Ministry of Children, Community and Social Services. (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- Persi, J., & Greenham, S. (2020). Ontario network of child & adolescent inpatient psychiatry services: Service guide, standards, benchmarks, & literature review: Standard 2. psychological safety, dignity, rights, inclusion & participation. December 3, 2020 update.

Core principle 7
Live-in treatment is grounded in staff capacity, competencies, and well-being.

Mapping to the clinical standard

This core principle maps to Topics 8.1, 15.1, 16.1, 16.2, 16.3, 17.1, and 18.1 of the clinical standard, as well as the following criteria: 2.1.3, 2.1.7, 7.1.1, 7.1.2, 7.1.3, 7.1.4, 8.2.1, 8.2.2, 9.1.2, 10.1.1, 10.1.2, 10.1.3, 11.3.1, 12.1.16, 12.2.6, 12.2.8, 13.2.2, 14.1.1, 14.1.8, 14.1.9, 14.1.10, 19.2.4, 20.1.1, 20.1.5, and 22.3.6.

OITP Clinical and Operational Standards.

Sources

Brend & Collin-Vézina, 2022; CMHO, 2015; 2016; Coll et al., 2019; Daly et al., 2018; Geoffrion et al., 2021; Gharabaghi, 2010; Green et al., 2019; James, 2017; Johnson et al., 2015; Kor et al., 2021; LAC, 2019; 2021; LIT QS Consultations, 2024-2026; MCCSS, 2020; MCYS, 2016; Ninan et al., 2014; O'Leary et al., 2024; Pinheiro et al., 2024; Residential Treatment Working Group, 2017; Strides Toronto, 2022; Woody et al., 2019.

Pathways in and out of treatment

The practices, processes, and supports for seamless movement into, through, and out of live-in treatment.

Core principle 8

Live-in treatment programs ensure a smooth and coordinated transition into treatment, where the right services are matched to a young person's needs and goals.

Quality statement

Live-in treatment programs have clearly defined inclusion guidelines and use a comprehensive, strengths-based and trauma-informed screening to ensure the best fit live-in treatment program is matched to a child or young person's needs, goals, and preferences, with thoughtful planning and preparation to support smooth access to and transition into treatment.

- Live-in treatment is recognized for its unique strengths and as an important part of the continuum of care.
- Clearly defined inclusion guidelines, validated screening tool(s), and the clinical program model are used to determine whether a specific live-in treatment program is best suited to meet a child or young person's needs.
- Children and young people have equitable and inclusive access to live-in treatment.
- Children, young people, and caregivers are supported throughout the transition into live-in treatment and are engaged as partners in treatment decisions.

Core principle 8

Live-in treatment programs ensure a smooth and coordinated transition into treatment.

Promising practices

Live-in treatment is recognized for its unique strengths and as an important part of the continuum of care, not as a last resort.

A comprehensive, community-based child and youth mental health, substance use health, and addictions system provides a full continuum of services and is designed to support all children and young people, including the small percentage with severe and complex needs that require intensive, around-the-clock care, or whose home environments cannot support intensive mental health treatment. Live-in treatment is considered when children and young people require a higher level of support than can be provided in a less intensive setting. The aim is to match the right level of care and the right live-in treatment program with a child or young person's needs, at the right time, and not to use live-in treatment as a 'last resort'.

Clearly defined inclusion guidelines, validated screening tool(s), and the clinical program model are used to determine whether a specific live-in treatment program is best suited to meet a child or young person's needs.

Live-in treatment programs establish clear inclusion guidelines that reflect the clinical profiles of the children and young people they are designed to support. Each program has a defined focus, intensity, and level of specialization that is clearly and transparently identified and communicated. This ensures the program's characteristics (the clinical program model) are effectively matched to children and young people's needs. Programs also establish clinical profiles to define which children and young people would benefit most from their services.

Admission to a live-in treatment program is determined through a comprehensive, individualized screening rather than exclusion based on diagnosis alone. Screening is trauma-informed, using tools that are validated and adapted for diverse populations. Screening is used to assess needs, strengths, and risks, and to match the right live-in treatment program to children and young people's needs. Admission considers the match between children and young people's needs and safety considerations, program capacity, expertise, staffing, and environmental factors. Admission decisions are informed by the match between these program characteristics and capacity, as well as screening and collaborative decision-making between children, young people, caregivers, and interdisciplinary teams.

Core principle 8

Live-in treatment programs ensure a smooth and coordinated transition into treatment.

If a live-in treatment program cannot meet a child or young person's needs, agencies facilitate a referral to another program that is a better fit. When a best fit is not clear, live-in treatment programs collaborate through a regional planning table to identify a program that best aligns with the child or young person's needs. The referring agency remains actively involved to ensure continuity of care and shared responsibility until a best-fit program is identified. When ideal programs are not available because of system capacity constraints, programs, referral partners, children, young people, and caregivers make transparent and documented decisions grounded in the child or young person's safety, needs, and goals. While children, young people, and caregivers wait to access live-in treatment, there is regular communication and check-ins, and interim support is available. Children, young people, and caregivers are informed of all possible options, the rationale, benefits, and drawbacks of each, as well as alternatives, interim supports, and reassessment timelines.

Children and young people have equitable and inclusive access to live-in treatment.

Whenever possible, children and young people access live-in treatment in their home communities. When a program closer to home is not available or when specialized services farther away may better meet children and young people's needs, there are policies that allow for transfers across regions or provinces to access live-in treatment programs that are a better fit for their needs. When out-of-region or out-of-province placement is necessary, agencies arrange logistics of the placement and leverage tools, such as technology, to keep caregivers involved. At discharge, children and young people are connected to after-care supports in their home communities. Access to live-in treatment is also designed to respect cultural identity and language needs, with Indigenous-specific pathways and French-language services.

Equity considerations are described further in Appendix D.

Children, young people, and caregivers are supported throughout the transition into live-in treatment and are engaged as partners in treatment decisions.

The assessment process uses a trauma-informed approach to help foster a sense of safety and trust. This includes discussing all treatment options that reflect the expressed needs and goals of children, young people, and caregivers and creating space for open conversations about their preferences to ensure their voices are a central part of treatment planning. Disagreements in treatment decisions between caregivers and children and young people are acknowledged and addressed collaboratively.

Core principle 8

Live-in treatment programs ensure a smooth and coordinated transition into treatment.

Children, young people, and caregivers are supported and kept informed throughout the referral, admission, and intake process. Service providers communicate and share information in a clear and accessible way to support children, young people, and caregivers in making informed treatment decisions, and a designated contact is available to provide information throughout the process. Youth peer support is also a part of the intake process to share program information and expectations with young people who are admitted into live-in treatment.

As children, young people, and caregivers prepare to transition into live-in treatment, they are informed of the physical environment, daily routines, relevant policies, staff roles and responsibilities, and expectations for participation in treatment.

Practical examples

- Real-time, secure information exchange happens within a young person's circle of care to ensure continuity of care and streamline access.
- Regional agencies coordinate (through a single point of entry like One Stop Talk) to streamline access to the appropriate mental health, substance use health, and addictions services.
- In circumstances where a children's aid society is involved, ongoing consultations between the live-in program, Children's Aid Society, and First Nations, Inuit, or Métis Nation are held to help minimize jurisdictional disputes and provide timely services in accordance with Jordan's Principle.
- Agencies utilize the Complex Transition Fund to facilitate transition into, out of, or stabilization within a live-in treatment program.
- An agency has memorandums of understanding and data-sharing agreements that can facilitate the sharing of records to help navigate referral processes between community organizations.
- A regularly updated centralized inventory system is used to track available alternative and complementary services, including their eligibility requirements and capacities, to support placement decisions.

Core principle 8
Live-in treatment programs ensure a smooth and coordinated transition into treatment.

Implementation considerations

Barriers

- Children and young people, or their caregivers, may prefer a live-in treatment program for many reasons, including its ability to meet important needs (e.g., housing security). However, their acuity level, treatment intensity needs, and goals may be better aligned with a different level of care or approach, resulting in a mismatch between needs and services.
- The grouping of opposing profiles in a shared live-in treatment space can undermine individualized care and increase risk and liability concerns.
- Coordination across systems is hindered by differing ideologies, funding structures, and regional boundaries.
- Licensing requirements may conflict with clinical care needs and restrict some cultural practices. For instance, age limits that restrict live-in treatment to those under 18 may overlook the developmental needs of some young people, interfering with long-term planning and continuity of care.
- A lack of assessment and use of referral tools contribute to mismatched placements and duplicative assessments.
- Young people without a primary care provider may be under-referred to service.

Mitigating Strategies

- Work with community partners and other intensive service providers to define pathways to and through live-in treatment and to identify the providers who can support pathways.
- Engage in and champion shared language and understanding of the scope of live-in treatment as short-term, intensive treatment to achieve transformative mental health outcomes and describe how it functions.
- Maintain a clear and transparent agency mission, goals, treatment components, and placement criteria.
- Consolidate screening and assessments where possible to minimize duplication and burden on children, young people, and caregivers. Ensure that staff, children, young people, and caregivers understand the purpose and significance of screening and assessments.
- Share assessment frameworks openly to encourage continuity and comprehensiveness across the sector. Use these to inform collaborative care planning and progress monitoring.

Core principle 8
Live-in treatment programs ensure a smooth and coordinated transition into treatment.

What young people and caregivers told us

"To me, this principle means ensuring that transitions into live-in treatment are smooth, thoughtful, and supportive, ultimately setting young people up for success rather than creating abrupt or disruptive changes. This principle emphasizes the use of validated tools and clear criteria to guide decision-making, while also remaining flexible and responsive to what works best for each child or young person's unique needs."
- Young person

"In practice, this principle looks like having meaningful discussions with young people and their caregivers to determine which treatment model best suits their needs, and whether elements of a model can be tailored to better support them. It is about being intentional and thoughtful in both the process and delivery of care to ensure the best possible fit."
- Young person

What this means for our audiences

To children, young people, and caregivers

You are supported through a smooth and coordinated process to access the right care at the right time, based on your needs and goals. You participate in a comprehensive and individualized screening that helps identify your strengths, needs, and risks, and helps match a best fit program to your goals, preferences, and needs. You are provided with clear, accessible information about available options and what to expect, so you can make informed decisions about your treatment.

When a program is not the right fit, you are supported to understand why and to understand your options and next steps. Support is provided to connect you to another service that better meets your needs. Throughout your transition into treatment, you have a reliable point of contact for communication and support, and your voice is valued and included.

To service providers and agency leaders

As service providers, you use comprehensive, trauma-informed assessments and validated screening tools to understand the needs and goals of children, young people, and caregivers, guiding decisions about best fit. Assessments are conducted in ways that promote safety, trust, and collaboration. Admission is based on individual needs rather than diagnosis alone. You clearly communicate program focus and what to expect, supporting informed decision-making. When a program is not the right fit, you facilitate timely referrals and collaborate with other providers to ensure continuity of care and shared responsibility.

Core principle 8

Live-in treatment programs ensure a smooth and coordinated transition into treatment.

As agency leaders, you establish clear pathways and processes that support consistent, needs-based matching and coordinated transitions into treatment. You ensure programs have clearly defined clinical models, levels of specialization, and inclusion guidelines that are communicated transparently.

To system decision makers

As decision makers, you direct resources in ways that strengthen access to appropriate services, support collaboration, and enable consistent, coordinated pathways into care. You support coordination across services and regions to reduce fragmentation and ensure continuity of care, including when needs are complex or when the best fit is not immediately clear.

Quality indicators

- Average (#) time children and young people spend on service waitlists.
- Percentage (%) of clients who, upon completion of live-in treatment, are referred to less intensive or step-down services.
- The program has clear inclusion guidelines to ensure that live-in treatment is the right level of care for children and young people (Yes/No).
- Percentage (%) of children and young people matched to the live-in treatment program using validated screening tool(s) and inclusion guidelines.
- Percentage (%) of children and young people who have accessed less-intensive services prior to their admission to live-in treatment.
- Percentage (%) of clients who seek live-in treatment but do not meet the inclusion guidelines and are offered or referred to another program.
- Number (#) of admissions that do not meet the inclusion guidelines.
- Resources (transportation costs, childcare) are available to support young people who may have to travel far distances to access live-in treatment (Yes/No).
- Percentage (%) agreement between program demographics and community data.
- Percentage (%) of clients who believe the services and supports they have received matched their expressed needs and goals.
- Percentage (%) of children and young people who report that treatment decisions were made collaboratively with them.

Core principle 8
Live-in treatment programs ensure a smooth and coordinated transition into treatment.

Related standards and guiding documents

- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standards Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- HealthCareCAN & Mental Health Commission of Canada. (2021). The quality mental health care framework.
- Ministry of Children, Community and Social Services. (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- Newfoundland Labrador Department of Health and Community Services, Health Canada, & Rush, B. (2015). Concurrent disorders guidelines.
- The Knowledge Institute on Child and Youth Mental Health and Addictions. (2025a). Levels of care quality standard: Matching the right care to needs and goals.

OITP Clinical and Operational Standards.

Mapping to the clinical standard

This core principle maps to Topics 5.1, 5.2, 5.3, 5.4, 6.1, 7.1, 7.2, 9.1, 9.2, and 9.3 of the clinical standard, as well as the following criteria: 6.2.1, 6.2.2, 8.2.4, 8.2.5, 8.2.6, 8.2.7, 8.2.8, 8.3.2, 8.3.3, 8.3.4, 10.1.7, 10.2.1, 10.2.2, 11.2.3, 11.2.5, and 11.3.1.

Sources

Aderibigbe et al., 2022; Ali et al., 2023; CMHO, 2015; 2016; Coll et al., 2019; Daly et al., 2018; Gutterswijk et al., 2020; James, 2017; Johnson et al., 2015; Knowledge Institute, 2025a; LAC, 2019; Liddle et al., 2018; LIT QS Consultations, 2024-2026; Lynch et al., 2017; MCCSS, 2020; OITP, 2025; Optimus SBR, 2025; Residential Treatment Working Group, 2017; Stewart et al., 2023; Strides Toronto, 2022; Woody et al., 2019.

Core principle 9

Live-in treatment programs provide a smooth and coordinated transition out of treatment.

Quality statement

Children, young people, and caregivers are gradually prepared for their transition back to the community throughout treatment. This is done in coordination and collaboration with community-based mental health agencies and across sectors.

- Children, young people, and caregivers are connected to after-care supports along the continuum of care.
- Live-in treatment programs achieve smooth transitions through strong coordination and collaboration within and across sectors.
- A discharge plan that is individualized to the needs of children, young people, and their caregivers is prepared early and is flexible as needs evolve.
- Transition plans include support for caregivers.

Promising practices

Children, young people, and caregivers are connected to after-care supports along the continuum of care.

After-care support across the system of care that is individualized to the needs of children, young people, and caregivers is important for maintaining progress and to sustain the skills gained in live-in treatment. Children, young people, and their caregivers step down to less intensive services or step up to more specialized supports along the continuum of care, with the right level of care matched to their needs.

Children, young people, and caregivers are gradually introduced to new services while in live-in treatment. Programs progressively reintroduce children and young people to the home environment and connect children, young people, and caregivers with services and supports prior to discharge. This includes support for non-healthcare and practical needs, such as early learning and childcare, education, housing, financial security, accessibility, and employment. Gradual transitions ensure that services, supports, and resources are in place well in advance of

Core principle 9
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discharge to maintain continuity of care and that children, young people, and caregivers are prepared for the transition. Transitions may include overlapping periods where children, young people, and caregivers begin community services while in live-in treatment, supported by parallel systems and a gradual reduction in service intensity rather than experiencing abrupt discharge. This also supports children and young people in navigating changes in therapeutic relationships with service providers.

Following discharge from live-in treatment, there is a post-transition period where children, young people, and caregivers continue to receive follow-up and ongoing support from live-in treatment service providers. In the same way, young people who will transition out of child and youth services are supported to access services in the adult healthcare system, including access to education or employment support and transitional housing, if needed. In transition planning, service providers consider a young person's developmental stage alongside their age.

Live-in treatment programs achieve smooth transitions through strong coordination and collaboration within and across sectors, such as community-based mental health services, education, youth justice, child welfare, primary care, adult mental health, and substance use health and addictions services. Clear communication, coordinated planning, and warm handoffs support continuity of care for children, young people, and caregivers as they transition between providers and services. For example, transition planning meetings bring together children, young people, caregivers, and system partners to facilitate warm handovers. Throughout this process, informed consent is revisited as transitions are coordinated with partners. There is shared accountability for outcomes, joint care planning, and efforts to prevent children, young people, and caregivers from falling through sector gaps.

Core principle 9
Live-in treatment programs provide a smooth and coordinated transition out of treatment.

A discharge plan that is individualized to the needs of children, young people, and their caregivers is prepared early and is flexible as needs evolve.

Preparing for discharge is an important part of the treatment plan. Transition planning occurs early on and throughout treatment to help children, young people, and caregivers gradually prepare to re-enter the community. Effective planning includes ongoing communication about what transitions will look and feel like so that children, young people, and caregivers understand what to expect at discharge and how to navigate challenges. While these transition plans have clear goals, treatment duration is flexible and can be adjusted as the needs of children, young people, and caregivers evolve throughout treatment. Transition readiness is assessed regularly to determine if children, young people, and caregivers have the skills and supports needed to safely transition out of live-in treatment. Transition plans are developed in partnership with community service providers, children, young people, and caregivers, and are individualized to meet specific preferences and needs.

When out-of-region or out-of-province placement is required, children and young people are connected to after-care supports in their home communities at discharge, and agencies identify and mitigate geographical barriers to accessing support.

Transition plans include support for caregivers.

For children and young people leaving live-in treatment, the caregiving system plays a vital role in ensuring a smooth transition and sustaining progress. If a child or young person has identified a caregiver who is involved in their treatment, caregivers are prepared throughout treatment for children and young people to return home by developing skills and knowledge to support the child or young person. This helps strengthen relationships, build trust, and create a supportive home environment to help children and young people maintain the progress they made in live-in treatment. Transition plans include ongoing support for caregivers, including in-home support for a period of time after discharge. In cases where caregivers would like to be involved but children and young people did not give their consent, the live-in treatment program has resources and supports to help caregivers support the child or young person when they return home.

Core principle 9
Live-in treatment programs provide a smooth and coordinated transition out of treatment.

Practical examples

- Programs promote seamless therapeutic progression by exploring whether gradual transitions would be beneficial or whether children and young people can resume treatment (DBT, for example) in the community as they are transitioning out of live-in treatment.
- Child and youth workers facilitate skill-building opportunities through "home days." These include in-home weekend visits to help young people and caregivers practice and reinforce treatment strategies and keep young people connected to community activities and supports.
- Each young person is supported consistently by a case manager who works with them from intake to transitions out of live-in treatment.
- Technology-assisted interventions such as online parenting skills programs, parent networking forums, and parent coaching sessions such as Parent SMART help caregivers build confidence and maintain progress in a flexible, accessible format.
- Optional in-home booster sessions are offered after transition to address the socioemotional needs of children, young people, parents, and siblings to further sustain caregiver reunification.

Implementation considerations

Barriers

- There are systemic inequities in service and resource options (accessible, youth-specific live-in treatment programs) available in rural versus urban centres.
- Poor collaboration between live-in treatment programs and other levels of community-based support leads to reluctance in accepting young people post-treatment for fear of being unable to maintain treatment outcomes.
- There are insufficient community services — such as primary care and psychiatry — to support transitions and aftercare, especially in rural and remote communities. Transitioning to a waitlist can impede smooth and coordinated transitions into the community.
- Service providers report limitations in supporting some youth-led initiatives that build life skills because these activities fall outside of the typical scope of their roles or union agreements. As a result, opportunities may be missed to connect young people with broader aftercare supports that foster independence and community reintegration.

Core principle 9
Live-in treatment programs provide a smooth and coordinated transition out of treatment.

Mitigating Strategies

- Begin transition planning early on with caregivers and community supports including primary care providers, with goals for reunification, independence, and reintegration.
- Make resources, like transportation funds, available to support young people who may have to travel far distances to return home, and provide additional supports following "home days," recognizing that the at-home experience may be challenging.
- Connect transitional-aged young people with resources matched to their needs and goals — especially developmentally appropriate resources in the adult mental health and substance use health systems and complementary resources for life skills, employment, and supportive housing.

What young people and caregivers told us

"Programs really need to understand the realistic side of things. You want people to go through your programs seamlessly, but the reality is if people do it perfectly, they're not actually healing. So, your transitions aren't going to be a perfectly planned situation every time. You still need to make sure there's coordination. Even if it's unplanned, it should still feel coordinated at the end of the day."
- Young person

"It's so important that we're supporting home as well. I think it just needs to be highlighted again: kids are coming back to the same environment, to the same situations. Families maybe haven't had time to heal. I think that's an important thing to consider as well."
- Caregiver

What this means for our audiences

To children, young people, and caregivers

Early and consistently, you are supported in planning for life after live-in treatment. You have been given a gradual and coordinated transition out of live-in treatment that helps maintain the progress you have made. Your transition plan is clearly communicated in ways you understand. You are connected to after-care supports that reflect your goals and needs. You are provided with tangible, accessible tools and resources to help you transition back into your community, promoting stability and long-term success. Your caregivers and family members are included and supported throughout the transition process, helping to create a stable and supportive environment to sustain your progress. Your transition plan remains flexible and evolves as your needs change. As a young person, you are also supported in preparing for transitions to adult services in ways that are meaningful to you.

Core principle 9
Live-in treatment programs provide a smooth and coordinated transition out of treatment.

To service providers and agency leaders

As service providers, you begin transition planning early and support gradual, coordinated transitions out of live-in treatment. You work collaboratively with children, young people, and their caregivers to develop individualized and flexible transition plans that reflect their goals, needs, and preferences. You coordinate closely with partners to ensure continuity of care.

As agency leaders, you establish and sustain processes and partnerships that enable coordinated and consistent transition planning. You support structures for joint care planning, shared accountability, and strong communication between providers and community services to ensure children, young people, and caregivers experience continuity as they transition out of treatment.

To system decision makers

As decision makers, you support alignment and coordination across the continuum of care, and between child and adult services, to reduce fragmentation and enable smooth transitions between services and providers. You invest in approaches that ensure transition planning is flexible and responsive to evolving needs, and that children, young people, and caregivers are supported throughout the transition process with access to appropriate, continuous care.

Quality indicators

- Percentage (%) of children and young people who have a post-discharge, continuing care plan including pre-arranged after-care services and supports.
- Percentage (%) of clients who are followed until an outcome of the referral is confirmed.
- Percentage (%) of children and young people who receive an outcome assessment using a validated tool both prior to and following discharge (for example, 30 to 90 days post).
- Percentage (%) of children and young people who report feeling prepared for discharge.
- Percentage (%) of transition plans that are started at admission.
- Percentage (%) of treatment plans with documented confirmation that a final copy was received by the child or young person, and their caregiver, during transitions.

Core principle 9
Live-in treatment programs provide a smooth and coordinated transition out of treatment.

- Percentage (%) of caregivers who receive in-home support after discharge.
- Percentage (%) of transition plans that include post-discharge supports, services, or referrals for caregivers.

Related standards and guiding documents

- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standard Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- Health Quality Ontario (2022). Transitions from youth to adult health care services: Care for young people aged 15 to 24 years.
- Ministry of Children, Community and Social Services. (2020). Ontario's quality standards framework: A resource guide to improve the quality of care for children and young persons in licensed residential settings.
- The Knowledge Institute on Child and Youth Mental Health and Addictions. (2025a). Levels of care quality standard: Matching the right care to needs and goals.

OITP Clinical and Operational Standards.

Mapping to the clinical standard

This core principle maps to Topics 14.1, 14.2, 14.3 and 14.4 of the clinical standard, as well as the following criteria: 11.3.4 and 11.3.10.

Sources

Ali et al., 2023; Becker et al., 2021; CMHO, 2015; 2016; Coll et al., 2019; Frensch et al., 2022; Herbell et al., 2024a; 2024b; James, 2017; Johnson et al., 2015; Knowledge Institute, 2025a; LIT QS Consultations, 2024-2026; MCCSS, 2020; MCYS, 2016; Ninan et al., 2014; Optimus SBR, 2025; Patel et al., 2019; Preyde et al., 2018; 2020; Woody et al., 2019.

Sustaining high-quality treatment

How high-quality live-in treatment is sustained through ongoing learning and improvement.

Core principle 10

Live-in treatment programs commit to continuous quality improvement.

Quality statement

Live-in treatment programs conduct ongoing monitoring and evaluation so they can continuously adapt and improve services for children, young people, and caregivers. Programs aim to meet community-specific needs, mitigate gaps and challenges, and leverage strengths and opportunities for improvement.

- Live-in treatment programs have a common performance measurement framework in place to support ongoing evaluation.
- Live-in treatment programs continuously evaluate their practices to identify gaps and challenges, leverage strengths, and find opportunities for improvement.
- Young people and caregivers are meaningfully involved in quality improvement at the individual, organizational, and systems levels.
- Live-in treatment programs respond to the needs of communities and clients.
- There are methods of mobilizing knowledge that bring people together from relevant sectors to build a common understanding of challenges and successes, exchange ideas and practices, and work collaboratively to find solutions.
- Performance measurement includes diversity metrics to assess equity and outcomes among groups.

Core principle 10
Live-in treatment programs commit to continuous quality improvement

Promising practices

Live-in treatment programs have a common performance measurement framework in place to support ongoing evaluation.

Key performance indicators are defined and established for each live-in treatment program, based on a common framework to measure organizational performance (risk management, staff retention, job satisfaction) and child- and youth-centred outcomes. These include functional outcomes (mental health and substance use health symptoms, safe and stable living environment, peer relationships, meaningful daily activities) and experiences of treatment. These indicators provide evidence of quality: that live-in treatment programs are implementing evidence-based models with fidelity, improving outcomes, and prioritizing positive and safe experiences of care and meaningful engagement with young people and caregivers. These findings drive continuous quality improvement by informing practice at both the organizational and systems levels.

There are data infrastructure and mechanisms in place that leverage the strengths of existing systems and approaches to collect, evaluate, and report on common data across providers, and to support an ongoing, iterative process of improvement.

Live-in treatment programs continuously evaluate their practices to identify gaps and challenges, leverage strengths, and find opportunities for improvement.

Live-in treatment programs are evaluated through multiple and mixed methods that are culturally responsive and draw on diverse data sources — such as qualitative and quantitative data, lived expertise, research, and emerging evidence — to inform improvement plans. Processes are in place to ensure that what is learned through evaluation informs practice in organizations and across communities, drives continuous improvement, and is done in collaboration with young people and caregivers.

Core principle 10
Live-in treatment programs commit to continuous quality improvement

Young people and caregivers are meaningfully involved in quality improvement at the individual, organizational, and systems levels.

Ongoing feedback processes are in place to capture the experiences of young people and caregivers throughout treatment. This feedback helps service providers better understand where care and treatment need to be adjusted. Feedback is collected through various mechanisms to ensure all voices are heard and valued. Feedback is thoughtfully incorporated into treatment planning and service improvements, and changes made are communicated back to young people and caregivers. At the organizational and systems levels, young people and caregivers co-evaluate live-in treatment services. Evaluation findings are shared with young people and caregivers, who are involved in interpreting these findings and determining how they are used to make organizational and system improvements.

Live-in treatment programs respond to the needs of communities and clients.

Agencies draw on quantitative and qualitative data, feedback, research, emerging evidence, and expertise to identify trends and priorities in mental health, substance use health, and addictions in their communities, including where needs are not being met. This information drives continuous improvements to ensure programs constantly evolve and remain responsive and aligned with the needs of clients and the broader community.

There are methods of mobilizing knowledge that bring people together from relevant sectors to build a common understanding of challenges and successes, exchange ideas and practices, and work collaboratively to find solutions.

Feedback and improvements are shared with young people, caregivers, partners, and the community, using language that is clear and easy to understand and in formats that are visible and accessible. This exchange of information is used to continually improve live-in treatment in collaboration with young people, caregivers, and communities.

Core principle 10
Live-in treatment programs commit to continuous quality improvement

Performance measurement includes diversity metrics to assess equity and outcomes among groups.

Demographic data is considered when collecting information and evaluating program performance. This data helps identify which populations are accessing — or not accessing — live-in treatment services. Assessment of outcomes across different groups provides insight into whether live-in treatment is effectively meeting the needs of specific populations and where inequities may exist.

Feedback from young people and caregivers also helps determine if services are culturally responsive. Young people, caregivers, and priority population partners are engaged in determining diversity metrics that are used and how outcomes are understood. Throughout this process, data privacy, security, and sovereignty is respected, including Indigenous data sovereignty; and communities have ownership, control, access, and possession of data and information about themselves. These findings inform program goals, guide improvements to services and treatment approaches, and support program and system planning.

Practical examples

- A centralized or shared data resource containing a shared data dictionary and consistent definitions across live-in treatment programs is in place to support collective measurement and reduce the reporting strain on individual agencies.
- Performance measurement frameworks include risk management plans and are regularly evaluated to ensure the safety of children, young people, caregivers, and staff.
- Agencies use clear communication channels to relay back to young people, caregivers, and interest holders how their data is used and how their feedback is being honoured. For instance, this could be through an impact report, scorecard, poster, or infographic.
- Young people and caregivers regularly provide feedback to inform improvements to live-in treatment planning, including through activities like surveys, focus groups, agency advisory boards, involvement in staff training and hiring, and quality assurance reviews.
- Agencies make ongoing efforts to understand who is being served through their live-in treatment programming, as well as who is not being served, to identify service inequities. Other data resources, like information from public health, are used to help identify gaps and improvement areas.
- Knowledge is mobilized through resources like tip sheets, presentations, impact reports, and video instructions to support service providers in accurate and consistent data entry and interpretation.

Core principle 10
Live-in treatment programs commit to continuous quality improvement

Implementation considerations

Barriers

- The high cost of robust infrastructure and support for data collection and analysis can be limiting. As a result, investment in data infrastructure may detract from investment in another related area, like change management or quality improvement programs.
- Some agencies are lacking the resources to support robust change management, evidence-based decision-making, or quality improvement initiatives.
- Concerns about privacy and data-sharing processes among agency partners can create barriers when the processes are perceived as burdensome or when there is limited awareness about what information can be shared.
- There is a shortage of dedicated funding, trained and available staff, and technology to meaningfully engage young people and caregivers in continuous quality improvement efforts, especially in rural and remote communities.
- Some engagement opportunities can feel tokenistic or decorative to young people and caregivers, making them less likely to participate meaningfully in organizational continuous quality improvement efforts. This may mean some quality improvement projects lack youth and caregiver input and do not result in intended outcomes.

Mitigating Strategies

- Partner with research institutions to increase organizational capacity for more rigorous research and evaluation opportunities.
- Create a live-in treatment program-specific measurement plan (using the Measurement guide for quality standards or OITP plans) to define performance metrics that leverage existing data collection efforts, shared definitions, and tools.
- Ensure staff have ongoing access to professional development opportunities. Leverage supports from intermediary organizations for program evaluation, change management, and quality improvement, such as the OITP, Knowledge Institute and E-QIP: Excellence Through Quality Improvement Project.
- Provide honoraria to recognize young people and caregivers for their contributions and integrate practical supports (transportation, childcare costs) to support their equitable participation in feedback and quality improvement opportunities.

Core principle 10
Live-in treatment programs commit to continuous quality improvement

What young people and caregivers told us

"Staff capacity is an issue that contributes to [continuous quality improvement]. Active learning towards improving the system…is really rare. Definitely, the knowledge translation piece of these standards would have to be at the forefront to alleviate that."
- Young person

"To me, this core principle is about continuously examining how the current system operates and whether services are truly meeting the needs of children, young people, and their caregivers. It requires a strategic, open, and curious mindset, one that actively seeks out new possibilities, identifies gaps, and builds on existing strengths. Furthermore, this principle involves being intentional and critical in how knowledge is mobilized, ensuring that information is shared in accessible and inclusive ways so that all communities can develop a meaningful and equitable understanding. Ongoing evaluation, adaptation, and collaboration among healthcare teams are essential."
- Young person

What this means for our audiences

To children, young people, and caregivers

Your feedback and perspectives are valued and used to improve care. You are given opportunities to share your feedback throughout your treatment in ways that feel safe and meaningful to you. Your input helps shape how care is provided, including what is working and what can be improved. You have opportunities to be involved in broader discussions about how programs are designed, evaluated, and improved. You are included in conversations about how success is defined and measured, ensuring that outcomes reflect what matters to you and your community.

To service providers and agency leaders

As service providers, you take part in ongoing quality improvement efforts to strengthen treatment. You draw on multiple sources of information to understand what is working well and where improvements are needed, and you adjust your approach based on this learning. You are supported with time and resources to participate in training and professional development, helping to ensure your knowledge and skills in quality improvement, evaluation, and monitoring remain current. You also communicate clearly about care, outcomes, and improvements in ways that are understandable to children, young people, and caregivers, encouraging and empowering them to shape and strengthen programs.

Core principle 10
Live-in treatment programs commit to continuous quality improvement

As agency leaders, you establish and maintain a clear framework for performance measurement and quality improvement across programs.

To system decision makers

As decision makers, you set directions for continuous quality improvement across the system, ensuring that care is informed by data, evidence, and the experiences of children, young people, and caregivers. You support the use of common frameworks and meaningful indicators that reflect outcomes and experiences of care.

Quality indicators

- The program has a measurement plan that, in alignment with the treatment model, defines intended outcomes and how they will be assessed (Yes/No).
- The program uses a variety of data sources (quantitative and qualitative) to evaluate its practices (Yes/No).
- The program has a process to collect, review, and respond to feedback and complaints from children, young people, and caregivers (Yes/No).
- Percentage (%) of changes made to live-in treatment based on feedback from children, young people and caregivers.
- The program has a monitoring system to regularly collect and review community data and feedback to guide program improvements and respond to evolving client and community needs (Yes/No).
- Percentage (%) of clients and caregivers who report being informed of changes made to the program based on their feedback.
- Number (#) of knowledge mobilization activities delivered to support shared learning and continuous improvement (presentations, resources, workshops).
- Population health data (%) (including race-based, linguistic, Indigenous identity and sociodemographic data) is used to understand community needs and to inform annual planning, delivery, and evaluation of live-in treatment.

Core principle 10
Live-in treatment programs commit to continuous quality improvement

Related standards and guiding documents

- Canadian Centre on Substance Abuse. (2010). Building on our strengths: Canadian standards for school-based youth substance abuse prevention (version 2.0).
- Health Standards Organization. (2025). CAN/HSO 76000:2021 (R2025) – Integrated people-centred health systems (Reaffirmation).
- Health Standards Organization. (2023). CAN/HSO 22004:2023 – Mental health and addictions services.
- HealthCareCAN & Mental Health Commission of Canada. (2021). The quality mental health care framework.
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OITP Clinical and Operational Standards.

Mapping to the clinical standard

This core principle maps to Topics 1.1, 1.2, 8.4, and 21.1 of the clinical standard, as well as the following criteria: 3.1.4, 3.2.1, 3.2.2, 3.2.4, 3.2.6, 4.1.1, 4.1.4, 4.1.5, 4.1.6, 5.3.1, 5.3.2, 5.3.3, 6.3.3, 7.1.2, 8.3.1, 12.1.1, 14.2.1, 14.2.2, 14.2.5, 16.1.1, 17.1.8, 18.1.1, 19.2.2, 20.1.1, 20.1.3, 20.1.4, 20.1.5, 20.2.1, 20.2.7, 21.2.1, 21.2.2, 21.2.3, 22.1.5, 22.1.6, 22.1.8, 22.2.2, 22.2.5, and 22.2.6.

Sources

CMHO, 2015; 2016; First Nations Information Governance Centre, 2014; Herbell et al., 2024b; Johnson et al., 2015; Knowledge Institute, 2025a; Lanier et al., 2020; LIT QS Consultations, 2024-2026; MCYS, 2016; Residential Treatment Working Group, 2017; Yeheskel et al., 2020.

About us

For more than two decades, the Knowledge Institute has been bringing people and knowledge together to strengthen care for infants, children, young people, and caregivers. As a trusted partner and advisor to several of Ontario's ministries, we collaborate across sectors to drive high-quality mental health, substance use health, and addictions care. We mobilize evidence, strengthen knowledge and skills, and accelerate system change to improve services for mental health, substance use health, and addictions across Ontario. The Knowledge Institute invests in the development of provincial quality standards for the child and youth mental health, substance use health and addictions sector. Throughout 2018 and 2019, we developed two quality standards (Quality standard for youth engagement and Quality standard for family engagement) and, in 2020, a quality guideline (Quality guideline for virtual walk-in services). In 2025, the Levels of care quality standard was released. We have been conducting research and providing resources and programs to support agencies to implement these standards. To learn more about our work, please visit our quality standards webpage.

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Appendix A: Glossary of terms

Biopsychosocial approach

A biopsychosocial approach recognizes that health and well-being are shaped by the dynamic interaction of biological, psychological, and social influences, and that understanding and supporting an individual requires attention to all three domains rather than any single aspect in isolation (Engel, 1977; Vögele, 2015).

Care

"Care" encompasses a vast range of supports focused on enhancing the well-being of children, young people, and caregivers. It includes meeting the daily needs of children and young people while creating a stable and supportive environment grounded in consistent, trusting relationships. Care is inherently relational and responsive, emphasizing connection, co-regulation, cultural responsiveness, and active engagement of caregivers and support networks. It recognizes that well-being is supported through everyday interactions, relationships, and experiences. Care focuses on the milieu — the social environment, the people in it, and the quality of their interactions to support well-being. Care can be delivered through milieu therapy (see definition of milieu therapy).

Caregivers/Caregiving system

Caregiver(s) refers to people who support and look out for an infant, child, or youth. The caregiving system is a group of people connected by the support, care, and supervision of an infant, child, or young person. Caregivers include individuals recognized by the child or young person as important for their well-being (Ontario Centre of Excellence for Child and Youth Mental Health, 2021a; 2021b). They can be connected through family, biology, emotions, culture, or legal ties. Caregivers include parents, as well as family members such siblings, grandparents, aunts and uncles, and other supportive individuals, like partners, Aunties, Elders, mentors, peers, and legally appointed guardians.

Advocacy, consistency, and coordination throughout an infant, child, or young person's treatment journey is often led by, and relies on, a parent or primary caregiver. It is acknowledged that the term "caregiver" does not adequately represent the depth of connection and responsibility that is experienced and required of those most responsible for the young people in their care. The use of "caregiver" and "caregiving system" throughout this quality standard are meant to holistically represent these individuals and communities, and the pivotal role they play.

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; Infant and Early Years Mental Health Promotion, 2024).

Clients

Clients are defined in this document as children and young people from birth to age 25. In some cases, caregivers or the entire caregiving system are also identified as clients. For example, caregivers play an important role in the care, and the immediate and sustained well-being, of infants, children, and young people. As such, many members of the caregiving system (family, parents, siblings, others) may be identified as the client for care. There may be circumstances in which community-based child and youth mental health agencies provide care and services to caregivers, such as education, family navigation, and skill-building (Ontario Ministry of Health, 2024). All clients are people who have consented to care through an informed consent process.

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. These are funded by different Ministries — Ministry of Health, Ministry of Children, Community and Social Services, and others — all dedicated to delivering mental health, substance use health, and addictions 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. Under Ontario's *Child, Youth and Family Services Act*, Lead Agencies 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 Child and Youth Mental Health Lead Agency Consortium (LAC), to plan and provide leadership at the provincial level (LAC, 2019).

Community/sector partners

These are individuals and organizations who contribute to knowledge and expertise for child and youth mental health, substance use health, and addictions care. They can be from (but are not limited to) early learning and childcare, education, public health, primary care, child and youth mental health, substance use health and addictions, child protection and child welfare services, youth justice, parents/caregivers, and government.

Complex needs

Some children or young people experience significant, multiple, rare, or persistent mental health challenges that can impact their functioning at home, at school, and in the community. These are considered complex needs and often require intensive services. Examples of complex mental health challenges include bipolar and related disorders, emerging personality disorders, dissociative disorders, schizophrenia and psychotic disorders, gender dysphoria, and sexual and paraphilic behaviours (OITP, 2025). "Complex" also refers to the mental health needs of children and young people who have other conditions or challenges that impact the services they require. These might include developmental disabilities, autism spectrum disorder, or substance use disorder (Knowledge Institute, n.d.).

Concurrent disorders

When someone is experiencing a mental health and substance use health concern at the same time, we call it a concurrent disorder. An example of this would be an individual with schizophrenia who has a cannabis use disorder (Knowledge Institute, 2023b; 2024a).

Continuum of care

Continuum of care models include a spectrum of types and settings of care and treatment that reflect the concerns and severity of symptoms of clients. Principles of continuum of care models have inspired similar models, like levels of care. While both models include a spectrum of care and treatment that reflects the needs of the clients being served, levels of care include an additional component that matches and allows for movement.

Culturally safe

Culturally safe refers to an outcome of reflective and aware practice and policy, where providers and organizations address bias and barriers contributing to inequities. It is the recipient of care, and not the provider, who determines whether or not cultural safety is present.

Culturally specific care/treatment

Culturally specific care/treatment refers to the delivery of services 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 emphasize that care and treatment aligned with a client's culture are intentionally prioritized from the outset.

Equitable care

Equitable care is about care outcomes that are not impacted based on gender, ethnicity, socioeconomic status, ability status, or other characteristics, while ensuring that the needs of every individual are met fairly and effectively (Banerjee, 2020; Cunningham et al., 2022; Rooddehghan et al., 2017).

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.).

Evidence

Evidence is information used to inform decision-making processes and practices. In this standard, "evidence" refers to information from academic and grey literature, lived and living expertise, service provider experiences, and traditional knowledge and wise practices. Evidence-based practice is often defined as using the best available clinical research and expertise to make decisions, relying on individual or synthesized research studies to inform decision making. Evidence-informed practice expands on evidence-based practice by also including the lived and living expertise of clients or communities to inform decision-making (Woodbury & Kuhnke, 2014). In this document, we use "evidence-based practice" when processes or practices are informed by the best available clinical research (for example, assessments), and we use "evidence-informed practice" when processes or practices are informed by research, data, and collaborative decision-making between clients, service providers, and caregivers.

Implement, implementation, implementing

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

Interdisciplinary

An interdisciplinary approach integrates and synthesizes knowledge, perspectives, and methods from multiple disciplines to create a coordinated and coherent understanding or response that extends beyond the boundaries of any single field (Choi & Pak, 2006).

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, 2023a).

Appendix A

Levels of care

Levels of care models include different types and intensities of care that are organized from least to most intensive. Clients are matched to an optimal level of care and can move through levels as needed. People are matched according to their individual needs and goals in the present moment and as their needs shift and change over time (Berger et al., 2022; Body Brave, n.d.; Centre for Innovation in Campus Mental Health, 2019; Cornish et al., 2017). Levels of care models are also known as stepped care models and were inspired by continuum of care models, which also include a spectrum of care.

Live-in treatment

Live-in treatment is intensive out-of-home treatment for children and youth who are dealing with mental health challenges that impair their functioning at home, school and/or in the community, and who require an intensive level of intervention. Treatment is delivered within a 24-hour a day environment by an inter-professional, multi-disciplinary team, making therapeutic use of the daily living milieu (LAC, 2021; OITP, 2026). 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).

Measurement-based care

Measurement-based care is the systematic and ongoing collection of standardized data on an individual's symptoms, functioning, and experiences throughout care. The data is used to monitor progress and inform clinical decision-making (American Psychological Association, n.d.; Ontario Structured Psychotherapy Program Central North, n.d.). It emphasizes the routine collection of outcome and progress data at points of care, sharing results with clients, and collaboratively modifying treatment plans as needed (Barber & Resnick, 2022). Measurement-based care supports individualized care, improves service quality, and ensures that care is responsive to individual needs (American Psychological Association, n.d.; Ontario Structured Psychotherapy Program Central North, n.d.).

Mental health

Mental health is a multidimensional state of emotional, psychological, and social well-being that reflects how individuals feel and function in their daily lives. It exists on a continuum from languishing to flourishing, independent of the presence or absence of mental illness (Keyes, 2002; Westerhof & Keyes, 2009).

Milieu therapy

Milieu therapy is an approach that aims to create a structured, supportive, inclusive, and safe environment to promote well-being. It is one of the ways that care can be delivered. While treatment focuses on evidence-based interventions for specific mental health and substance use health conditions and symptoms, milieu therapy involves the intentional and consistent use of daily routines, activities, and relationships to develop and practice coping and living skills (Huefner & Ainsworth, 2021).

Multidisciplinary

A multidisciplinary approach draws on knowledge and perspectives from multiple disciplines, with each discipline contributing within its own scope and boundaries without necessarily integrating or synthesizing across fields (Choi & Pak, 2006).

Multisectoral partners

Multisectoral partners are organizations and individuals that collaborate across sectors. This could include healthcare, public health, early learning and childcare, education, youth justice, primary care, child protection and child welfare services, other social services, community organizations, and government agencies in child and youth mental health and substance use health and addictions contexts. The objective of partnerships is to address the complex challenges related to mental health and substance use health in young populations through coordinated efforts. Strategies may involve joint programming, shared resources, and integrated services to create a comprehensive approach that supports the mental well-being of children and young people.

Normative data

Normative data refers to a set of standardized reference values derived from a large, representative population, used to establish typical ranges or distributions against which individual or group results can be compared (O'Connor, 1990).

Peer support

Peer support refers to care that is provided by and for individuals with lived and living expertise. Peer support exists on a continuum from a reciprocal, naturally occurring relationship in community settings on one end, to intentional, one-directional relationships in service settings on the other end (Ontario Centre of Excellence for Child and Youth Mental Health, 2016).

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 assurance

Quality assurance involves establishing standards and ensuring that programs consistently meet quality levels, such as minimum standards for brief services or the timeliness of client appointments (Ontario Centre of Excellence for Child and Youth Mental Health, n.d.).

Quality improvement

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

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 Standards Advisory Committee (QSAC)

The QSAC is comprised of a diverse table of interest holders (usually 20-30 members) with representation from across the sector who share topic-specific expertise to inform, validate, refine, and approve the Knowledge Institute's quality standards. The QSAC is co-chaired by one member of the Lead Agency Consortium and one member of the Knowledge Institute's Family Advisory Council to support representation from the key interest holders of our quality standards (i.e., lead agencies and caregivers), and to amplify the imperativeness of lived expertise at the expert advisory table.

Safer

Safer is used in some contexts instead of "safe" to communicate that feeling safe is specific to each person and that no space can feel safe to everyone. This term also reflects that discrimination and harassment occur even when great effort has been put forth to prevent them, and that improving safety is an ongoing, active process (Sexual Assault Centre of Edmonton, 2020).

Service providers and agency leaders

Service providers and agency leaders have overlapping, but distinct, roles. In this document, service providers are professionals that provide care and treatment to infants, children, young people, and caregivers at community-based mental health, substance use health, and addictions agencies. Some examples of service providers include child and youth workers, youth service workers, psychiatrists, psychologists, psychotherapists, physicians, nurses, allied health professionals, and social workers. They provide care and treatment under the direction of agency leaders, who may also be known as Executive Directors, Chief Executive Officers, Directors, or Managers. Agency leaders provide leadership and ensure good governance practices. They may also manage local planning efforts and make sure the agency provides care following the direction of Ontario's Ministry of Health and that care and treatment are aligned with the needs of the community they serve.

Substance use

Substance use is the consumption of any substance that affects a person's mood, emotions, or thoughts. This includes legal drugs such as alcohol and cannabis, and illegal drugs such as cocaine or heroin (Canadian Centre on Substance Use and Addiction, 2022).

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 (CAPSA, 2023). Addictions refer to behavioural or process addictions, such as gambling.

Treatment

Treatment refers to time-limited evidence-based interventions or modalities (CBT and DBT, for example), that address specific mental health and substance use health conditions and symptoms such as substance use disorders, depression, or anxiety. Treatment is delivered by regulated health professionals — such as psychologists, psychiatrists, social workers, and registered psychotherapists — who have the required education, clinical training, and competencies to provide treatment safely, ethically, and effectively.

Appendix B: Inclusion criteria for this quality standard

This quality standard focuses on live-in treatment programs within the community-based child and youth mental health, substance use health, and addictions sector in Ontario that serve 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 emphasizes the inter-sectoral and 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. It is designed to be accessible, relevant, and meaningful to all live-in treatment programs across Ontario, as well as for children, young people, and caregivers who may be receiving treatment or involved in evaluating live-in treatment programs. Although mental health and substance use health and addictions services should be inclusive of other settings (education and primary care, for example), the setting for this standard is community-based child and youth mental health, substance use health, and addictions agencies in Ontario. This standard is not explicitly developed for use by those in allied sectors (hospitals, education, youth justice, child welfare, and young parent and infant services), but it can support community-based agencies to foster relevant pathways and partnerships.

This quality standard is meant to be applicable, relevant, and meaningful to all live-in treatment programs run by Lead Agencies and Core Service Providers in the community-based child and youth mental health and addictions sector across Ontario. We have included substance use health and addictions alongside our mention of mental health. As such, this quality standard also applies to bed-based live-in treatment programs that support children and young people with substance use health and addictions concerns. This approach responds to the call to thoroughly coordinate and integrate services for mental health and substance use health throughout the sector (Office of the Auditor General of Ontario, 2025).

Appendix C: Data collection process for the live-in treatment quality standard

Table 2. Number of data points reviewed to inform the development of the live-in treatment quality standard

Scoping

- **67** academic and grey literature publications
- **51** organizations reviewed in environmental scan
- **85** total scoping consultations
  - **54** community-based agencies
  - **22** sector partners
  - **7** young people
  - **2** caregivers

Drafting

- **21** drafting consultations with QSAC members
- **18** total drafting consultations
  - **7** group consultations
  - **5** priority population focus group participants
  - **12** QSAC Indicator Working Group participants
  - **5** QSAC Implementation Resources Working Group participants
  - **14** QSAC full draft reviews

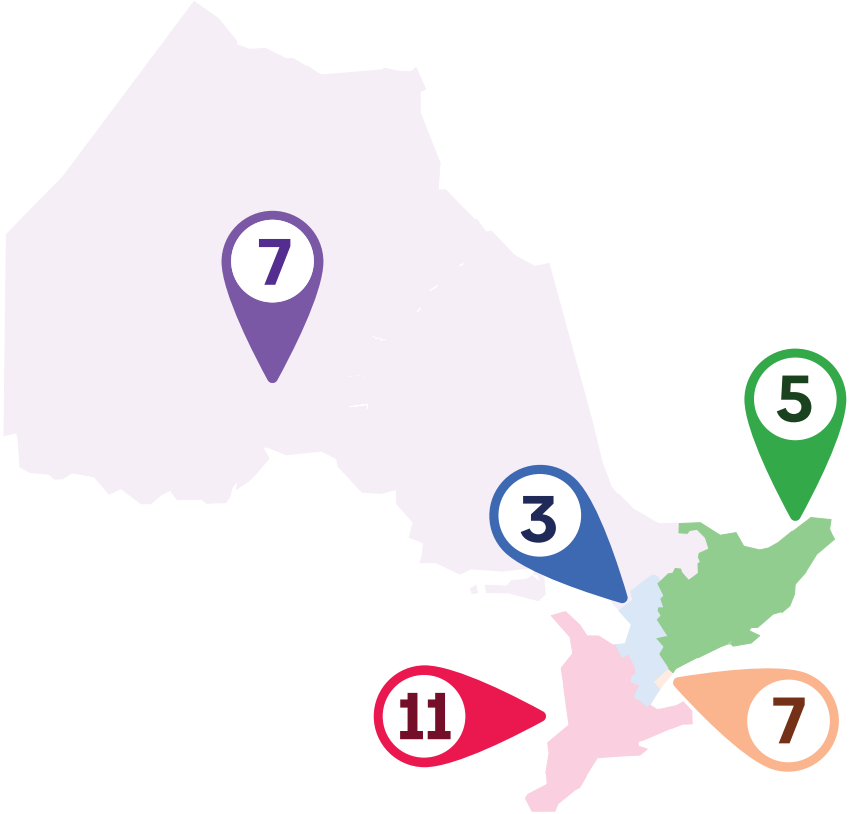
Public feedback

- **23** total public feedback survey responses
  - **21** responses in English
  - **2** responses in French

Appendix C

Table 3. QSAC members by regions of Ontario

Region of Ontario	n
North	7
West	5
Central	3
East	11
Toronto	7



Appendix D: Equity considerations

Equity is central to high-quality live-in treatment. Historical and ongoing inequities have shaped how children and young people experience mental health, substance use health, and addiction services, including live-in treatment. These inequities are rooted in systemic factors such as colonialism, racism, discrimination, and barriers related to language, disability, immigration status, socioeconomic barriers, and more. As a result, some groups have experienced harm, exclusion, or unmet needs within institutional and live-in care settings. A quality standard for live-in treatment must acknowledge these realities and support treatment that is culturally safe, inclusive, and responsive to the diverse identities, experiences, and needs of children, young people, and their caregivers.

In developing this standard, equity considerations were intentionally integrated throughout. This included reviewing the historical and current contexts shaping care experiences for diverse groups of children, young people, and families. These groups include those who are Indigenous, racialized, Francophone, and newcomers; those with varying abilities or complex needs; and pregnant and parenting young people. While each group has distinct experiences and needs, several common, system-level themes emerged, and these are reflected across the standard. These considerations also highlight that children, young people, and families may understand and approach mental health and substance use health in different ways, shaped by cultural, spiritual, familial, and community contexts. Live-in treatment programs should therefore be responsive and adaptable to diverse perspectives and approaches to care.

First Nations, Inuit, and Métis children and young people

The history of colonialism in Canada has deeply impacted First Nations, Inuit, and Métis children and young people, particularly in relation to institutional settings such as live-in mental health treatment. Residential schools, which operated from the 17th to 20th centuries, forcibly removed Indigenous children from their families (Bombay et al., 2013). Though framed as educational and therapeutic, many children experienced various forms of abuse and involuntary cultural assimilation within these schools (Bombay et al., 2013; National Centre for Truth and Reconciliation, n.d.; Truth and Reconciliation Commission of Canada, 2015). These practices have been recognized as cultural genocide, resulting in deep intergenerational trauma that continues to affect many Indigenous people today (Bombay et al., 2013; Kielland & Simeone, 2013; MHCC, n.d.).

The Sixties Scoop further extended this harm by placing thousands of Indigenous children into non-Indigenous homes without consent, reinforcing mistrust in Canadian institutional systems and in child welfare (Catholic Children's Aid Society of Toronto, 2022; Duarte & Selmi, 2023). These patterns have continued in more recent decades, often referred to as the "Millennium Scoop," alongside the ongoing overrepresentation of First Nations, Inuit, and Métis children in child welfare systems (Fallon et al., 2021; Statistics Canada, 2024). These experiences reflect persistent systemic inequities and the continued separation of Indigenous children from their families, communities, and cultures. Cultural considerations, including Indigenous knowledge related to child-rearing practices and ceremonial use, are often insufficiently reflected in policies and procedures (LIT QS Consultations, 2024-2026; Statistics Canada, 2024).

As a result of these historical and many other ongoing forms of systemic settler colonialism, many Indigenous young people today continue to be disproportionately impacted by systemic inequities that undermine well-being. These inequities manifest in higher rates of mental health challenges, including anxiety, depression, and suicide (Hodgson et al., 2022; Owais et al., 2022; Weerasinghe et al., 2023). Despite this, many treatment programs remain culturally unsafe and inadequate in meeting the needs of these young people (MCCSS, 2020). Live-in treatment can also be experienced as retraumatizing when it involves separation from family and community, which highlights the importance of maintaining cultural connections and relationships with community leaders (LIT QS Consultations, 2024-2026; Smye et al., 2023). These experiences continue to shape how Indigenous children, young people, and families perceive and engage with institutional and live-in care.

Black, African, and Caribbean children and young people

Experiences of systemic racism and discrimination within health, social service, and child welfare systems have shaped access to, and experiences of, care for Black, African, and Caribbean children and young people. Historical and ongoing inequities, including over-surveillance and disproportionate involvement in child welfare systems, have contributed to mistrust of institutions and disparities in mental health outcomes (LIT QS Consultations, 2024-2026; MCCSS, 2020; Ontario Human Rights Commission, n.d.). Black children and young people may face bias in assessment, diagnosis, and treatment, as well as a lack of culturally

appropriate services (LIT QS Consultations, 2024-2026; Mental Health Commission of Canada, 2021). Racial profiling and stereotypes can shape how care is experienced by Black children and young people. These experiences occur within broader contexts of anti-Black racism in care environments, which can be both overt (explicit, direct acts of discrimination or bias) and covert (subtle, indirect, or systemic forms of discrimination embedded in everyday practices and decisions; Fante-Coleman & Jackson-Best, 2020; Ireland, 2024; LIT QS Consultations, 2024-2026).

These experiences may reflect a lack of culturally safe, responsive, and inclusive care. This can influence how care is accessed, experienced, and perceived, and may contribute to disengagement from services. Many Black children and young people access services through emergency departments but may not feel welcome due to how they are perceived, which contributes to mistrust and reluctance to share personal mental health or substance use health concerns (LIT QS Consultations, 2024-2026; Pathways to Care, 2020).

2SLGBTQIA+ children and young people

2SLGBTQIA+ children and young people have historically experienced and continue to experience systemic stigma, discrimination, and identity-based harm within health, social, and institutional systems. In Canada, the use of conversion therapy represents a clear example of institutionalized harm directed at sexual orientation and gender identity. Federal prohibition was only recently enacted in 2022 following earlier bans in some jurisdictions, including Ontario in 2015 (Government of Canada, 2022). These practices have contributed to long-standing mistrust of care systems and continue to shape experiences of safety and engagement in services today. Concerns related to identity validation, including misgendering and not having pronouns respected, have also been identified as contributing to experiences of being "othered' and feeling isolated within care environments (Government of Canada, 2022; Kingsbury & Findlay, 2024; LIT QS Consultations, 2024-2026).

Beyond this historical context, 2SLGBTQIA+ youth continue to experience elevated rates of mental health challenges, homelessness, and suicidality compared with cisgender heterosexual peers, reflecting the ongoing impact of stigma, discrimination, and social exclusion (Government of Canada, 2022; Kingsbury & Findlay, 2024). These inequities are shaped by broader structural and social conditions, including unequal access to affirming supports and variability in the extent to which systems are able to recognize and respond to diverse sexual orientations, gender identities, and gender expressions. Concerns have also been raised about rigid placement practices in live-in settings for trans youth, highlighting the need for flexible, person-centred approaches guided by the needs, goals, and preferences of young people (LIT QS Consultations, 2024-2026).

Stigma, discrimination, and identity-based harm can significantly impact the mental health and substance use health treatment experiences of 2SLGBTQIA+ children and young people. In environments that are not inclusive or affirming, children and young people may feel unsafe, misunderstood, or unable to fully engage in treatment. These experiences can contribute to poorer outcomes and disengagement from services, particularly when care environments do not reflect or support diverse sexual orientations and gender identities (Abramovich, 2016; Taylor et al., 2020).

Children and young people with complex needs

Children and young people with complex needs — including developmental disabilities, concurrent disorders, and medical complexity such as chronic illness — may face significant barriers in accessing appropriate and coordinated services. Historically, services for mental health and developmental needs have been siloed, resulting in gaps in care and challenges in meeting the full range of needs (Lunsky et al., 2018; MCCSS, 2020). In live-in treatment settings, this can lead to inadequate supports or environments that are not appropriately adapted to individual needs, including lack of staff trained in developmental and behavioural needs, limited individualized support, and inaccessible physical environments. These structural challenges can affect the quality and continuity of care, as well as the ability of children and young people to fully participate in and benefit from treatment.

Francophone children and young people

Language barriers can affect access to services, quality of care, and the ability of children and young people to fully engage in treatment. Receiving care in a non-preferred language may limit a child or young person's ability to express their needs, participate in therapy, and build therapeutic relationships (Yun et al., 2019). In Ontario, the availability of French-speaking service providers and programs specifically designed for Francophone communities remains limited in some regions, which can further constrain access to appropriate care (Centre for Addiction and Mental Health, 2023). Francophone communities in Ontario have long advocated for equitable access to services in French, reflecting the importance of language in shaping care experiences and outcomes (Office of the Ombudsman of Ontario, 2020).

Newcomer children and young people

For newcomer children and young people, experiences of migration, displacement, and resettlement may intersect with mental health and substance use health needs. Many may face language barriers, cultural differences in understanding mental health, and challenges navigating unfamiliar systems (Dumke et al., 2024; Sim et al., 2023). Some may also have experienced trauma prior to or during migration (Kirmayer et al., 2011; Saunders et al., 2018; Sim et al., 2023). Newcomer children and young people are sometimes not recognized as a priority population within service planning, despite making up a significant and growing proportion of the population in Canada. This lack of recognition can contribute to gaps in tailored supports (LIT QS Consultations, 2024-2026; Sim et al., 2023).

An increasing number of young people are arriving in Canada without family supports, increasing vulnerability and the need for appropriate services (Sim et al., 2023; Thomson et al., 2015). Trauma-informed approaches are essential for those arriving from contexts of violence or instability. It is equally important to distinguish between expected stress responses and clinical mental health needs so that distress is not unnecessarily pathologized (Beiser & Hou, 2016; LIT QS Consultations, 2024-2026; Sim et al., 2023).

These factors can influence how newcomer children, young people, and caregivers access, experience, and engage with care, particularly within unfamiliar or complex service systems. Additional barriers include limited awareness of available services and how to navigate them, as well as limited direct funding for newcomer-specific supports (LIT QS Consultations, 2024-2026; Sim et al., 2023; Thomson et al., 2015). Language barriers and cultural differences may also contribute to feelings of exclusion in school settings, increasing vulnerability to disengagement and involvement in systems such as youth justice when appropriate supports are not accessed (LIT QS Consultations, 2024-2026; Sim et al., 2023; Thomson et al., 2015). Creating safe spaces for newcomer children and young people to connect with peers who share similar experiences can support their belonging and adjustment in a new environment.

Children, young people, and caregivers from Northern, rural and remote communities

Children, young people, and caregivers living in northern, rural and remote areas of Ontario often face unique barriers to accessing mental health, substance use health, and live-in treatment services (Duncan et al., 2020; Ge et al., 2021). Services in rural and northern Ontario are more limited in scope and availability compared with urban centres, with fewer specialized programs, supports, and coordinated care options to meet diverse needs (Duncan et al., 2020; Ge et al., 2021; Mandal & Burella, 2021). Families may need to travel long distances to reach even basic supports, and limited local resources, transportation challenges, and social isolation can make accessing timely and consistent care difficult (Duncan et al., 2020; Ge et al., 2021; Mandal & Burella, 2021). Limited local capacity and funding can also result in children and young people being required to leave their communities to access care. In some cases, air travel is the only option. This means that access to live-in treatment is further limited due to barriers such as cost, limited availability, and lack of required documentation (LIT QS Consultations, 2024-2026). Transportation barriers, including lack of vehicles or public transit, can also restrict access even when services are nearby (Canadian Institute for Health Information, 2024; Canadian Mental Health Association, n.d.; LIT QS Consultations, 2024-2026). These structural and geographical barriers can reduce engagement in treatment, contribute to disparities in mental health outcomes, and limit access to culturally safe or population-specific care for children, young people, and caregivers from these communities.

Appendix D

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). Pregnant and parenting young people often navigate multiple, fragmented systems simultaneously (mental health, housing, child welfare, early childhood services), but services are not consistently designed to address the interconnected needs of both the young parent and their child(ren). This creates gaps in care, particularly in live-in treatment settings, which have historically focused on young people without fully integrating infant and early childhood considerations (LIT QS Consultations, 2024-2026).

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).

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