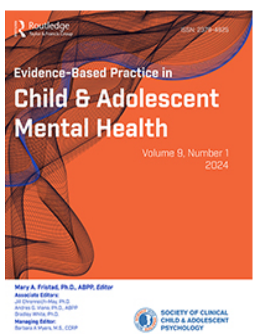

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# Working Together: Interdisciplinary Training within Live-In Treatment

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**ABSTRACT**

A strong and cohesive interdisciplinary support team is critical to the success of children's mental health live-in treatment program. Kinark Child and Family Services, a leading child and youth mental health organization in Ontario, Canada, assessed the degree to which its community-based live-in treatment programs align with identified best practices and used the findings to inform the implementation of an interdisciplinary team that delivers a unified clinical approach to treatment and care. This paper reviews the results of the assessment, focusing specifically on interdisciplinary teamwork and the collaboration, consultation, and training that is crucial for staff working in live-in treatment programs. The benefits of this collaboration on the therapeutic milieu for complex children and youth cannot be overstated as clients are supported by multiple professionals throughout their treatment journey, including child and youth care practitioners, clinical therapists, psychologists, case managers, and nurses. Training in dialectical behavior therapy (DBT) is provided to all staff to ensure that all members of the patient's interdisciplinary team offer a consistent approach in the delivery and support of individualized treatment plans. We contend that our training approach for interdisciplinary staff in our live-in treatment programs, including comprehensive training in DBT, is beneficial for clients and families. Consideration for future program evaluation and interdisciplinary training initiatives are presented.

## Introduction

The nature and intensity of child and youth mental health services is best determined in accordance with a stepwise system of care framework (Stroul & Friedman, 1986) wherein the right services are offered at the right time, in the right modality, and in the right setting (School and Community System of Care Collaborative, 2022). Intensive out-of-home (i.e., residential[1]) mental health services are accessed by children and adolescents under the age of 18 who present with the most severe, complex, rare, or persistent psychological, emotional, social, and/or behavioral presenting concerns that significantly impair their functioning at home, school, and/or in the community (Preyde et al., 2019). To provide comprehensive and effective treatment, a variety of professionals, including child and youth care practitioners (CYCPs), social workers, psychologists, nurses, and case managers are required. An interdisciplinary team approach helps identify and support clients' needs and strengths and considers the mental, physical, social, and daily care domains of health and wellbeing. Research has demonstrated that interdisciplinary teams offer considerable benefits that include increased satisfaction and acceptance of treatment interventions among clients, as well as reductions in suicidality and treatment duration (World Health Organization, 2010). From an organizational standpoint, benefits include reduced treatment costs, increased staff satisfaction, and more effective treatment due to collaborative efforts of the team (Norgaard et al., 2013; World Health Organization, 2010).

Despite their clear benefits, the functioning and effectiveness of interdisciplinary teams is often hindered by differences in training requirements, regulatory oversight, and theoretical approaches to treatment across professions (e.g., biomedical versus psycho-social health models). Differences in professional standards and lack of regulation introduce inconsistencies in treatment provision within and

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[1]Despite being a legal term, there is increasing emphasis to move away from "residential" in favor of live-in treatment to acknowledge the deeply traumatic history of the Residential School System on Indigenous peoples in Canada.

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across programs. For this reason, we assert that a regulated approach to live-in treatment that delineates an interdisciplinary framework of roles and responsibilities should be the service standard for child and adolescent mental health treatment programs. We suggest that this framework requires training for all direct-service staff in the program's evidence-based practice to ensure that all members of the interdisciplinary team, regardless of their profession, have a shared understanding of the treatment to adequately support the treatment plan.

We begin this paper with a brief discussion of the research on interdisciplinary teams and factors that affect their efficacy while contextualizing training requirements for live-in treatment programs within Ontario, Canada. As a leader in the field of mental health services for children and adolescents aged 0 to 17, and one of the largest transfer payment agencies for live-in treatment programs in Ontario, we at Kinark Child and Family Services (Kinark) share our approach to training live-in treatment staff to demonstrate the ways in which an interdisciplinary program can effectively support young people with complex needs. We offer feedback from a comprehensive evaluation of our live-in treatment programs and recommendations for the development of interdisciplinary training initiatives within child and adolescent live-in treatment.

## Interdisciplinary teams in the context of child and adolescent mental health

Effective interdisciplinary teams are synergic, collaborative partnerships that bring together knowledge from their members' respective disciplines to achieve common goals (Summers et al., 2002). At the system level, interdisciplinary healthcare teams can reform a fragmented health system into one that promotes cohesion and integration through collaborative practice. At the individual level, interdisciplinary teams can improve client outcomes (World Health Organization, 2010). The presenting needs of youth with complex mental health needs often cross biological, psychological, and social domains of health that require input from professionals representing a variety of disciplines to offer a biopsychosocial approach to treatment and care. A biopsychosocial formulation, as the name suggests, brings together a multitude of biological, psychological, and social factors to provide a holistic, individualized, and contextual understanding of one's presenting concerns (Bashimi et al., 2023). Through a biopsychosocial framework, interdisciplinary approaches to mental healthcare provide a more nuanced understanding of case conceptualization and offer a depth to patient care that cannot be provided solely through a biomedical or psychological approach. When determining the best mental health service options, a biopsychosocial interdisciplinary model aligns well with the system of care approach that is needed for young people receiving live-in treatment. Among this population, there are myriad factors that influence their mental health and well-being; without a biopsychosocial interdisciplinary system of care, interventions are unlikely to address their spectrum of need and risk overlooking vital factors that will affect treatment uptake and sustainability. To this end, biopsychosocial interdisciplinary collaboration can support clinicians with holistic case conceptualization and treatment planning, thus benefitting clients and families through a wrap-around approach to care.

In the context of live-in treatment, interdisciplinary teams often include professionals with varying educational backgrounds and scopes of practice, such as psychologists, therapists, nurses, psychiatrists, and CYCPs.[2] The structure and duration of live-in treatment (i.e., 24/7 environment with youth typically residing for at least 6 months; Preyde et al., 2019) means that CYCPs spend more time with clients than other service providers involved in their treatment and care; they observe clients within the milieu and are most often present during times of dysregulation. CYCPs therefore offer rich and valuable information about clients, including their capacity to engage in treatment and progress toward treatment goals, yet their skills and knowledge are often underutilized. Postsecondary programs in child and youth care offer generalized training with a limited focus on psychological theories and

[2]CYCPs typically hold a three-year college diploma in Child and Youth Care combining academic course work and applied practicum placements.

mental health treatments, and hierarchical structures within organizations mean that CYCPs are typically not offered the same professional development and training opportunities as social workers, psychologists, and other clinical staff. As a result, CYCP skills are often overlooked and underleveraged. These biases permeate the mental health field and while we highlight the experience of CYCPs, we acknowledge the hierarchy within mental health that affects perceptions of practitioners' competence and contributions to practice and the field more broadly. Organizational training in the program's treatment modality should therefore be provided to all members of the interdisciplinary team to equip them with the knowledge and language needed to contribute to treatment planning and empowers them to fully participate in interdisciplinary teams.

Given the varying training and skill offered by interdisciplinary team members, it is important that scopes of practice be clearly defined. Failure to do so may lead to role ambiguity, which can negatively impact quality of care (Bronstein, 2003). Role ambiguity creates room for hierarchical power dynamics and biases toward team members with less education (Bronstein, 2003), potentially silencing their input on client care discussions and fostering distrust. Further, role ambiguity can result in duplication of service as well as team members working outside of their scope of practice, which poses ethical and safety risks to clients. To mitigate these risks, agencies should establish a framework of care that delineates scopes of practice and clear terms of references for all staff working in live-in treatment programs; though, this is only part of the solution. Effective interdisciplinary teamwork requires a dynamic and reciprocal process of collaboration. Bronstein (2003) describes five components of collaborative interdisciplinary models: interdependence, co-created professional activities, flexibility, collective ownership of goals, and reflection on process. These critical elements involve shared responsibility, compromise, and feedback to strengthen working relationships, suggesting that an effective interdisciplinary treatment environment is more than just the sum of its parts. It involves integration and accountability through consultation and applied practice from all staff to support client outcomes (Summers et al., 2002).

Within the field of mental health, effective interdisciplinary teamwork involves collaborative discussion and decision-making on the assessment, formulation, and treatment planning processes. Training staff to effectively engage in interdisciplinary collaboration is important for transdiagnostic client care. In a study by Marcussen et al. (2019), a diverse group of health professionals (e.g., nurses, social workers, and medicine) who participated in an intervention aimed at developing their interprofessional collaboration skills showed greater readiness for interprofessional collaboration and more positive attitudes toward other professionals in comparison to the control group who received discipline-specific training-as-usual. This study suggests that collaborative interdisciplinary training improves working relationships, increases awareness of role differentiation and scope, and enhances knowledge of how to effectively work together to support real-life cases. Within a live-in treatment program, interdisciplinary training can support staff to collaboratively address complex mental health and behavioral challenges among adolescents, examining and responding to their treatment needs from multiple perspectives.

Training for milieu-based or live-in treatment staff is largely unregulated in Ontario, Canada (Ministry of Children and Youth Services [MCYS], 2016). Although annual training is mandatory for certain topics, such as crisis intervention, specialized training in mental health and treatment modalities is not prescribed, and individual organizations have considerable autonomy in how they train staff and deliver treatment. In 2013, the Ontario Centre for Excellence (2013) in Children and Youth Mental Health highlighted the importance of employee qualification(s) and ongoing training to support the increasing complexity of clients being served. Later, the Residential Services Review Panel (MCYS, 2016), which offered wide-ranging recommendations across live-in services in Ontario, acknowledged that many relief and casual staff are exempted from in-service training, supervision, and clinical consultation. This panel noted that absence of consistent training for all clinical staff compromises staff competency and affects the standard of care that clients receive. Research has shown that

interdisciplinary professionals can deliver a treatment model with high fidelity after thorough training, regular practice, and supervision. For instance, research from Hawkins and Sinha (1998) demonstrated that, after completing in-service training in dialectical behavior therapy (DBT), educational background and discipline accounted for little of the variance in examination results among social workers, nurses, and psychologists among others. Instead, knowledge development largely depended on the amount of effort attendees put into learning the material. These findings offer promising support for a model of in-service clinical training that aims to cultivate a shared understanding of treatment among a diverse staff that occupy distinct roles.

Training staff in a high-turnover field can be costly and challenging (Haynos et al., 2016; Popowich et al., 2019). High staff turnover taxes training resources and compromises treatment fidelity (Haynos et al., 2016). Furthermore, organizations must consider how ongoing training affects program operations, including accommodations for overnight, rotational, or relief staff, staff vacations, shift coverage, and access to technology. Nonetheless, self-directed and cost-effective training methods, such as workshops, web-based programs, and videos, combined with interdisciplinary training can facilitate the sustainability of an organizational-wide knowledge base that leads to improved self-efficacy, greater awareness of role differentiation, and decreased burnout (Haynos et al., 2016; Norgaard et al., 2013). By offering regular clinical training, organizations can reduce gaps in competency due to employee turnover and assist ongoing capacity-building and clinician endorsement of evidence-based programs within existing staffing complements.

## Evaluating and implementing a unified training model within live-in treatment at Kinark

Within the largely unregulated field of live-in treatment, Kinark has been a leader of evidence-based mental health treatment for many decades. In line with the stepwise system of care, live-in treatment at Kinark is reserved for youth with the most highly complex and severe mental health disorders that cannot be adequately served by outpatient community-based mental health services. Those accessing live-in treatment at Kinark include children and adolescents aged 6 to 17, though our typical age range is 9–17 years. In a sample of our clients from 2015 to 2022, approximately nine in 10 presented with more than one diagnosis at admission and almost two-thirds had at least three diagnoses. There were high rates of verbal and physical aggression toward others, and more than half had self-harmed. One-quarter of clients had attempted suicide prior to admission. Clients commonly presented with anxiety disorders, disruptive behavior disorders, and mood disorders as well as attention-deficit/hyperactivity disorder. Almost one-third of clients presented with a dual diagnosis of autism spectrum disorder. Learning and communication disorders were also common.

To meet their complex needs, our live-in treatment programs offer an interdisciplinary staffing complement to provide holistic care for young people within a therapeutic milieu that includes support from CYCPs, therapists, case managers, psychologists, clinical supervisors, and nurses. Research from Ranahan and Thomas (2016) indicates that CYCPs are well situated to work on interdisciplinary teams due to the breadth of practice areas where they serve alongside other professionals, including those in educational and live-in treatment environments. At Kinark, CYCPs meet with youth weekly to review treatment goals, progress, and to identify and address their concerns. CYCPs also advocate on the clients' behalf during interdisciplinary team meetings. All staff, including CYCPs, regularly engage in clinical supervision to promote skill development, self-reflection, and efficacy in care for clients in the program.

With a vision to inform and engage the sector, government funders, and policy makers, Kinark released a position paper in 2015 entitled, *"Strengthening Children's Mental Health Residential Treatment Through Evidence and Experience"* (Johnson et al., 2015). Through a comprehensive literature review, an analysis of the clinical composition of youth accessing live-in treatment, and extensive internal and external consultations, the authors identified nine critical success factors for effective live-in treatment, including clearly defined eligibility and suitability criteria, family-centered care, a cohesive

interdisciplinary staff team, minimizing physical interventions, cultural and linguistic competence, individualized programming, seamless transitions and integrated aftercare, connected residential and community partners, and performance measurement. These factors provide a framework for an effective and efficient approach to live-in mental health treatment for children and youth.

The above-noted paper urges the development of a system-wide approach to live-in services and improving live-in treatment programs across the sector. To facilitate this, we developed a standardized assessment that operationalizes the nine critical success factors to measure the degree to which live-in treatment programs are aligned with best practice. The tool comprises multiple indicators for each critical success factor, which can be measured by a team of assessors through observation, document reviews, questionnaires, and interviews with clients, families, staff, and community partners. Using this tool, we carried out comprehensive assessments of our four live-in treatment programs. Each program was assessed through an inter-rater scoring and agreement process and results were used to inform a quality improvement strategy aimed at strengthening treatment and care for young people receiving live-in treatment.[3]

A key recommendation that emerged from the assessment was a need for an overarching treatment model with clinical oversight and formal training for all direct-service staff. At the time of the assessments, individualized treatment plans were developed for clients and the treatment modality was selected by the therapist, based on the client's mental health concerns and treatment goals. To streamline training, guide clinical supervision, and ensure a common psychotherapeutic language among staff, clients, and families, the assessors recommended that a single evidence-based treatment model that is effective for clients with highly complex mental health needs be implemented across all programs.

After a thorough review of literature on suitable treatment models for live-in treatment, a team of clinical and operational leaders identified dialectical behavior therapy (DBT; Linehan, 1993) as the most appropriate and effective modality to address the severity and complexity of mental health concerns among those receiving live-in treatment. DBT is a third-wave cognitive behavior therapy rooted in the understanding of dialectics and biopsychosocial influences, such as the interplay among genetic, environmental, and intra- and interpersonal factors on an individual. It is an effective intervention for complex patient populations, such as adolescents with significant mental health concerns, multiple diagnoses, suicidal ideation, and self-harming behaviors (Espenes et al., 2023; Haynos et al., 2016; Lanier et al., 2020; Little et al., 2010; McCredie et al., 2017). Research has shown that completion of a full DBT program (i.e., minimum of 24 group sessions plus individual sessions, the number of which may vary based on program and length of stay) contributes to reduced live-in treatment stays and fewer hospitalizations due to suicidal behavior (Sunseri, 2004). Further, integrating families into the treatment approach improves clients' interpersonal skills and can provide caregivers with tools to support clients' mental health symptoms upon discharge (Preyde et al., 2019).

Within our live-in treatment programs, we adopted a developmentally appropriate, modified approach to DBT for adolescents aged 12 to 17 that incorporates elements of traditional outpatient DBT[4] (Dimeff et al., 2021; Linehan & Wilks, 2015; MacPherson et al., 2013; Rathus & Miller, 2002; Waitz et al., 2021) in addition to therapeutic work with the family and direct training and coaching of staff through the milieu environment. We provide family-centered care and individualized treatment to match the clients' needs. Treatment plans are developed in collaboration with clients and families and treatment plans are tailored to meet the clients' needs and goals. Neurodivergent clients, for example, may benefit from greater focus on behavioral interventions, including tangible rewards/reinforcements for practicing and using skillful behaviors.

The transition to an overarching clinical treatment model favored formal and ongoing training as well as regular clinical supervision for all staff

[3]Contact Claire E. McGill (Claire.mcgill@kinark.on.ca) for more information about the assessment.

[4]Traditional outpatient DBT typically includes individual and group therapy sessions, between-sessions coaching and a DBT consultation team to support ongoing capacity in DBT and encourage self-care among practitioners.

involved in direct-client service. Including CYCPs in training and supervision is crucial to the program's success, as DBT skills enhance their ability to support clients experiencing behavioral challenges, emotional dysregulation, and crises. Fluency in the therapeutic model empowers CYCPs to support treatment planning and communicate effectively with interdisciplinary team members about client progress and presenting concerns. Comprehensive in-service training is therefore required for *all* members of the interdisciplinary team to ensure a unified and consistent approach to client behavior and mental health in the treatment milieu. We require that all staff be trained in the foundations of DBT, dialectics and validation, and in coaching and behavior-chain analyses. Trainings were developed by agency psychologists and are delivered in the form of four 20- to 40-minute videos that all direct-service staff complete annually. At the end of each training, staff must complete a quiz to demonstrate their understanding of the material. Results are shared with program supervisors, who verify and monitor compliance. Ongoing staff participation in the DBT consultation team further reinforces their application of DBT training. Full- and part-time staff are also trained in structural model implementation (egregious protocol) and more in-depth, applied DBT skills; additional trainings in behaviorism and the foundations of trauma are currently being developed. Interdisciplinary staff are involved in the development of ongoing trainings through the consultation team and other feedback mechanisms that invite staff to indicate their preferences for training topics (e.g., applied DBT skills, trauma-informed approaches).

In addition to the videos, quizzes, and onboarding resources, more comprehensive DBT training is delivered to staff annually by agency psychologists. Clinical staff who provide psychotherapy services (i.e., therapists, psychologists, live-in treatment supervisors, nurse) receive more comprehensive DBT training that consists of a minimum of 5 days of theoretical and applied clinical training, also facilitated by agency psychologists. In-house trainers are an accessible and cost-effective resource (Noll et al., 2019), which is particularly advantageous due to the absence of direct funding for staff training.

Ideally, CYCPs would receive the same training as clinical staff; however, scheduling challenges and the demands of the 24/7 treatment environment make it difficult for CYCP staff to attend 5 days of training. Scheduling to accommodate overnight, part-time, and relief staff is especially challenging. To this end, the duration of training is reduced for CYCPs and content focuses on the skills most relevant to service provision in a live-in treatment setting (i.e., core fundamentals of DBT, coaching, behavior-chain analyses). Training for CYCPs is typically divided into two half-day segments and is delivered on days when most staff are on site (e.g., during all-staff meetings). While this approach works for the bulk of CYCP staff, alternative training dates and times are offered, including evening sessions, to those who are unable to attend. In addition to in-service training in DBT, CYCPs within our live-in treatment programs are invited to join the weekly interdisciplinary DBT consultation team, which is an integral component of high quality, high fidelity DBT and a mechanism for staff to further refine their DBT skills (Linehan, 1993; Noll et al., 2019).

The consultation team is a resource for staff to maintain competency in DBT, as well as a source of support for trainees (Noll et al., 2019) to reduce burnout. This consultation mechanism offers a different approach than traditional didactic training and supervision, providing trainees with opportunities to consult and hold themselves and each other accountable while accepting their own fallibility as therapists (Noll et al., 2019). Linehan (1993) suggests that the DBT consultation team is akin to therapy for the therapists wherein team members use DBT skills to address client concerns and provide validation and support to their colleagues. Additionally, the team lead integrates research into team meetings to ensure that staff are current in their knowledge of DBT. Consistent with Noll et al.'s (2019) description, our approach to the consultation team is dialectically transactional with mutual knowledge sharing, capacity building, and promotion of team cohesion. Our DBT consultation teams operate in alignment with standard consult practices (see Linehan & Wilks, 2015), wherein meetings are facilitated on a rotational basis among group members. The designated team lead, typically an agency psychologist, ensures the group's adherence to DBT principles.

## Discussion

The literature discussing the benefits of interdisciplinary training initiatives within child and youth live-in treatment programs is underdeveloped, thus contributing to inconsistent regulation and adherence to in-service training in evidence-based modalities. Based on research on the effectiveness of interdisciplinary mental health teams more broadly and findings from our assessment of our live-in treatment programs, we argue strongly in favor of interdisciplinary training all direct-service staff working in the therapeutic milieu, regardless of their scope of practice. Fluency in the treatment modality benefits young people and their families by ensuring that clients receive a consistent approach to mental health treatment. Consistency reinforces positive client behaviors, supports their treatment goals, and is modeled for caregivers to encourage generalizability to managing high-risk behaviors after-discharge. Training and adherence to DBT, for example, enhances clinical ability and self-efficacy, and a DBT consultation team provides a mechanism for self-reflection and ongoing interdisciplinary collaboration in case conceptualization and treatment planning.

Emerging research on the application of DBT for children (DBT-C; see Perepletchikova & Nathanson, 2020; Perepletchikova et al., 2011) and DBT for families (Fruzzetti et al., 2007; Payne, 2017) suggests that family participation in DBT offers considerable benefits for parents (i.e., their own emotion regulation) and for couple and parent–child relationships. Family participation in DBT also supports the child/adolescent's understanding and use of DBT skills. Throughout the course of the client's live-in treatment stay, families learn DBT principles to better support their child's emotional needs and provide a validating environment for their child after their discharge from the program. For pre-adolescent children (i.e., 6–12 years), DBT can be modified to support the child's developmental needs, including integrating role-play activities, condensing didactic materials, and using cartoon characters to model skills use through multimedia presentations (Perepletchikova et al., 2011). We offer modifications to DBT based on the client's age and developmental needs. For clients below age 12, we offer a modified version of DBT ("DBT for Kids" integrating elements from Fruzzetti et al.'s (2021) DBT for Families and DBT-C); and for clients aged 12 and up, we offer the modified version of DBT-A (Rathus & Miller, 2002). Clinical staff who provide psychotherapy receive additional training in DBT-for Kids.

Future training initiatives should address the evolving needs of clients served within live-in treatment programs. For example, intersectional trauma-informed approaches can be integrated into trainings to enhance staff capacity to serve the increasing numbers of young people in live-in treatment programs with trauma histories and contribute to positive client outcomes (Purtle, 2020). Organizations also must update their training programs regularly to remain abreast of current research in evidence-based interventions that meet the needs of their clients, align with best practices, and foster effective interdisciplinary collaboration. As recommended by the Residential Services Review Panel (MCYS, 2016), training opportunities should be explicit and may include "a two-week new worker training program developed for all front-line [service] positions [...] based on core competencies including life-space interventions, strength-based relational practice, ethical decision-making and the unique context of [Indigenous], LGBTQ2S, Black youth and other groups" (p. 16).

We suggest that training should be initiated during the onboarding process with re-training offered on an annual basis. Ensuring that trainings include a diverse interdisciplinary staff group can promote team cohesion, mutual understanding and respect for team members, along with a richer understanding of the material and its operationalization. Training is best offered within a supervision model that has regular opportunities for consultation, review, and self-reflection. As we have discussed, DBT and its consultation team provide such an opportunity when it is composed of interdisciplinary staff. With formal trainings conducted annually, the DBT consultation team provides live-in treatment teams with ongoing, informal training opportunities that promote capacity building and team cohesion and reduce clinician burnout. Clearly defined scopes of practice, as we have noted, are necessary to prevent role ambiguity

and duplication of service, and a flexible training schedule is required to reduce barriers to participation for overnight and relief staff.

In addition to its benefits for clients and families, interdisciplinary training for live-in treatment staff offers future research, program evaluation, and policy development opportunities. As with the introduction of any program or training model, it is important to evaluate staff experience of the training and the extent to which training has influenced their practice. After completing a recent in-service training in DBT, 92% ($n = 14$) of Kinark live-in treatment staff reported that the topics covered in the training were a good fit for their needs in the program, and 86% agreed the training was appropriate for their level of knowledge and experience. Open-ended feedback was positive, with several staff expressing a desire for more frequent training opportunities that integrate practical strategies and skills application when using DBT with children and youth. One staff succinctly described the importance of ongoing trainings to maintain their level of competency in DBT: "I generally find refresher trainings provide an opportunity to remind, reinforce and enhance skill." A more detailed exploration of staff perceptions of the effectiveness of interdisciplinary training and consultation is forthcoming, as is a broader evaluation of client experience and outcomes. Currently, success of DBT interventions for Kinark clients is measured through diary cards and session-by-session outcome monitoring, and a comprehensive evaluation of client outcomes is forthcoming. We plan to survey clients and caregivers about their experiences with the interdisciplinary treatment environment, including their satisfaction with and perception of the effectiveness of DBT, and measure their impact on care using standardized psychological assessments.

There are also promising avenues for applied research that include an examination of the impact of foundational training in DBT through a quasi-experimental design that compares DBT specific training to training as usual on staff experience, treatment fidelity, and client and family outcomes. On a larger scale, evaluating client outcomes after introducing an interdisciplinary training program could help inform policy and legislative reform to address the significant regulatory gap in child and youth mental health care. We invite policy makers to consider streamlining funding for interprofessional education and practice activities within mental health programs that align with biopsychosocial formulations of patient care. Multi-ministry partnership agreements could facilitate enactment of interdisciplinary training within live-in treatment facilities. For example, education ministries could work collaboratively with other ministries to review program requirements for child and youth care and related support worker programs to identify and provide oversight for pre-service training in evidence-based practice in child and youth mental health. Ultimately, these recommendations are only a starting point to enhance quality and client outcomes within live-in treatment programs as future research and oversight is needed.

A consistent training program for interdisciplinary staff in live-in treatment programs is a crucial step toward standardizing services and operations within these programs for children and youth with complex mental health needs. Using DBT and an interdisciplinary consultation mechanism provides staff with ongoing training and support in managing high-risk client behavior, reduces role ambiguity within interdisciplinary teams, and aligns with the critical success factors for live-in treatment programs. The dearth of service standards (distinct from quality standards; Ministry of Children, Community and Social Services, 2020) for live-in treatment programs and numerous calls-to-action for regulating training and ensuring highly qualified personnel work with at-risk children and youth cannot be ignored. We encourage relevant legislative bodies to clearly articulate minimum education and training requirements for live-in treatment staff and mandate prerequisite education for staff in relief/casual positions. Further, legislation should outline mandatory, funded in-service training requirements for licensed live-in treatment programs, including prescribed course topics and frequency for renewal. Lastly, we recommend that providers have an interdisciplinary consultation mechanism, accessible by all milieu staff – regardless of their scope of practice – to ensure a clear framework for effective collaboration to

meet the complex needs of clients served by live-in treatment programs.


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No potential conflict of interest was reported by the author(s).

## References


Bashimi, L., Cohn, A., Chan, S. T., Tobia, G., Gohar, Y., Herra, N., Wen, R., IsHak, W. W., & DeBonis, K. (2023). The biopsychosocial model of evaluation and treatment in psychiatry. In W. W. IsHak (Ed.), *Atlas of psychiatry* (pp. 57–89). Springer Nature Switzerland.

Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work*, *48*(3), 297–306. https://doi.org/10.1093/sw/48.3.297

Dimeff, L. A., Jobes, D. A., Koerner, K., Kako, N., Jerome, T., Kelley-Brimer, A., Boudreaux, E. D., Beadnell, B., Goering, P., Witterholt, S., Melin, G., Samike, V., & Schak, K. M. (2021). Using a tablet-based app to deliver evidence-based practices to suicidal patients in the emergency department: Pilot randomized controlled trial. *JMIR Mental Health*, *8*(3), e23022. https://doi.org/10.2196/23022

Espenes, K., Waaler, P. M., Keles, S., Saugestad Helland, S., Schmidt, H., Kjobli, J., & Tormoen, A. J. (2023). Implementing a residential dialectical behavior therapy informed treatment model to improve adolescent mental health: Feasibility, fidelity, and acceptability. *Residential Treatment for Children & Youth*, *40*(2), 132–155. https://doi.org/10.1080/0886571x.2022.2090481

Fruzzetti, A. E., Payne, L. G., & Hoffman, P. D. (2021). DBT with families. In L. A. Dimeff, S. L. Rizvi, & K. Koerner (Eds.), *Dialectical behavior therapy in clinical practice: Applications across disorders and settings* (2nd ed., pp. 366–387). The Guilford Press.

Fruzzetti, A. E., Santisteban, D. A., & Hoffman, P. D. (2007). Dialectical behavior therapy with families. In L. A. Dimeff & K. Koerner (Eds.), *Dialectical behavior therapy in clinical practice: Applications across disorders and settings* (pp. 222–244). Guilford Press.

Hawkins, K. A., & Sinha, R. (1998). Can line clinicians master the conceptual complexities of dialectical behavior therapy? An evaluation of a state department of mental health training program. *Journal of Psychiatric Research*, *32*(6), 379–384. https://doi.org/10.1016/S0022-3956(98)00030-2

Haynos, A. F., Fruzzetti, A. E., Anderson, C., Briggs, D., & Walenta, J. (2016). Effects of dialectical behavior therapy skills training on outcomes for mental health staff in a child and adolescent residential setting. *Journal of Hospital Administration*, *5*(2), 55–61. https://doi.org/10.5430/jha.v5n2p55

Johnson, L. L., Van Wagner, V., Sheridan, M., Paul, C., Burkholder, R., & Evans, R. (2015). *Strengthening children's mental health residential treatment through evidence and experience*. Kinark Child and Family Services.

Lanier, P., Jensen, T., Bryant, K., Chung, G., Rose, R., Smith, Q., & Lackmann, L. (2020). A systematic review of the effectiveness of children's behavioral health interventions in psychiatric residential treatment facilities. *Children and Youth Services Review*, *113*(3), 104951. https://doi.org/10.1016/j.childyouth.2020.104951

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.

Linehan, M. M., & Wilks, C. R. (2015). The course and evolution of dialectical behavior therapy. *American Journal of Psychotherapy*, *69*(2), 97–110. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.97

Little, L., Butler, L. S., & Fowler, J. (2010). Change from the ground up: Bringing informed-dialectical behavioral therapy to residential treatment. *Residential Treatment for Children & Youth*, *27*(2), 80–91. https://doi.org/10.1080/08865711003712527

MacPherson, H. A., Cheavens, J. S., & Fristad, M. A. (2013). Dialectical behavior therapy for adolescents: Theory, treatment adaptations, and empirical outcomes. *Clinical Child and Family Psychology Review*, *16*(1), 59–80. https://doi.org/10.1007/s10567-012-0126-7

Marcussen, M., Norgaard, B., Borgnakke, K., & Arnfred, S. (2019). Interprofessional clinical training in mental health improves students' readiness for interprofessional collaboration: A non-randomized intervention study. *BMC Medical Education*, *19*(27), 1–10. https://doi.org/10.1186/s12909-019-1465-6

McCredie, M. N., Quinn, C. A., & Covington, M. (2017). Dialectical behavior therapy in adolescent residential treatment: Outcomes and effectiveness. *Residential Treatment for Children & Youth*, *34*(2), 84–106. https://doi.org/10.1080/0886571X.2016.1271291

Ministry of Children and Youth Services. (2016). *Because young people matter: Report of the residential services review panel*. https://files.ontario.ca/mccss-because-young-people-matter-report-of-the-residential-services-2016-en-2022-02-14.pdf

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*. https://files.ontario.ca/pdf/mccss-quality-standards-framework-en-2022-04-01.pdf

Noll, L. K., Lewis, J., Zalewski, M., Martin, C. G., Roos, L., Musser, N., & Reinhardt, K. (2019). Initiating a DBT consultation team: Conceptual and practical considerations for training clinics. *Training and Education in Professional Psychology*, *14*(3), 167–175. Advance online publication. https://doi.org/10.1037/tep0000252

Norgaard, B., Draborg, E., Vestergaard, E., Odgaard, E., Cramer Jensen, D., & Sorensen, J. (2013). Interprofessional clinical training improves self-efficacy of health care students. *Medical Teacher*, *35*(6), e1235–1242. https://doi.org/10.3109/0142159X.2012.746452

Ontario Center of Excellence in Children and Youth Mental Health. (2013). *Evidence In-Sight*. http://www.excellenceforchildandyouth.ca/resource-hub/evidence-in-sight-database?p=6

Payne, L. (2017). *The role of family intervention in improving individual and family functioning in DBT for adolescents (12495)* [Doctoral dissertation, University of Nevada Reno]. http://scholarworks.unr.edu:8080/bitstream/handle/11714/2804/Payne_unr_0139D_12495.pdf?sequence=1&isAllowed=y

Perepletchikova, F., Axelrod, S. R., Kaufman, J., Rounsaville, B. J., Douglas-Palumberi, H., & Miller, A. L. (2011). Adapting dialectical behaviour therapy for children: Towards a new research agenda for paediatric suicidal and non-suicidal self-injurious behaviours. *Child and Adolescent Mental Health*, *16*(2), 116–121. https://doi.org/10.1111/j.1475-3588.2010.00583.x

Perepletchikova, F., & Nathanson, D. (2020). An overview of DBT for preadolescent children. In L. A. Dimeff, S. L. Rizvi, & K. Koerner (Eds.), *Dialectical behavior therapy in clinical practice: Applications across disorders and settings* (pp. 327–344). Guilford Publications.

Popowich, A. D., Mushquash, A. R., Pearson, E., Schmidt, F., & Mushquash, C. J. (2019). Barriers and facilitators affecting the sustainability of dialectical behaviour therapy programmes: A qualitative study of clinician perspectives. *British Association for Counselling and Psychotherapy*, *20*(1), 68–80. https://doi.org/10.1002/capr.12250

Preyde, M., MacLeod, K., Bartlett, D., Ogilvie, S., Frensch, K., Walraven, K., & Ashbourne, G. (2019). Youth transition after discharge from residential mental health treatment centers: Multiple perspectives over one year. *Residential Treatment for Children & Youth*, *37*(1), 65–89. https://doi.org/10.1080/0886571X.2019.1597664

Purtle, J. (2020). Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings. *Trauma, Violence, & Abuse*, *21*(4), 725–740. https://doi.org/10.1177/1524838018791304

Ranahan, P., & Thomas, T. (2016). Interprofessional collaboration: Youth workers' perspectives on constraining and supportive factors. *Canadian Journal of Community Mental Health*, *35*(3), 69–81. https://doi.org/10.7870/cjcmh-2016-039

Rathus, J. H., & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicide & Life-Threatening Behaviors*, *32*(2), 146–157. https://doi.org/10.1521/suli.32.2.146.24399

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*. https://cmho.org/wp-content/uploads/Right-time-right-care_EN-Final-with-WCAG_2022-04-06.pdf

Stroul, B. A., & Friedman, R. M. (1986). *A system of care for children and youth with severe emotional disturbances*. Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Summers, J., Boyd, K., Reid, J., Adamson, J., Habjan, B., Gignac, V., & Meister, C. (2002). *The interdisciplinary mental health team. dual diagnosis: An introduction to the mental health needs of persons with developmental disabilities*. Habilitative Mental Health Resource Network.

Sunseri, P. A. (2004). Preliminary outcomes of the use of dialectical behavior therapy to reduce hospitalization among adolescents in residential care. *Residential Treatment for Children & Youth*, *21*(4), 59–76. https://doi.org/10.1300/J007v21n04_06

Waitz, C., Tebbett-Mock, A., D'Angelo, E., & Reynolds, E. K. (2021). Dialectical behavior therapy in inpatient and residential settings for adolescents: A systematic review. *Evidence-Based Practice in Child and Adolescent Mental Health*, *6*(4), 497–515. https://doi.org/10.1080/23794925.2021.1970052

World Health Organization. (2010). *Framework for action on interprofessional education & collaborative practice*. https://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1&isAllowed=y