Service Guide, Standards, Benchmarks, & Literature Review:

Standard 2: Psychological Safety, Dignity, Rights, Inclusion, & Participation

Literature review, discussion and standards including: Protecting Rights, Promoting Dignity, Assessing Capacity & Obtaining Consent, Assuring Confidentiality, Promoting Least Restrictive Care, Providing Psychological Safety, Promoting Positive Identity & Self-Esteem, Reducing Stigma, Using Positive Psychology, Providing Compassionate Care, Valuing Diversity & Promoting Inclusion of Very Young Children, Indigenous Children and Adolescents, Youth with Autism and Developmental Disabilities, LGBTQ2SIA, Refugees and Immigrants, Youth in Foster Care, & Youth in the Forensic System, Engaging Youth in Person-Centred Care, Safewards, Working Motivationally, Engaging Parents/Caregivers & Families, Engaging Community Partners, Providing Trauma Informed Care, Providing Attachment Supportive Care, Using Feedback & Engaging in Advocacy.

Recommended Citation: 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 plan is to continue to update all sections in response to your feedback and new research. Future update and Standards will be available for review as they are published at www.oncaips.ca/. Please direct questions and feedback to persijoe@gmail.com..

STANDARD 2: PSYCHOLOGICAL SAFETY, DIGNITY, RIGHTS, INCLUSION, & PARTICIPATION

The unit assures and promotes psychological safety, dignity, rights, inclusion, and participation in care.

QUESTIONS OF INTEREST

- What are basic human rights children and adolescents?
- How should child and adolescent mental health units protect human right and dignity?
- Can an excessive focus on physical safety threaten the ability to provide a psychologically, emotionally, and socially safe therapeutic climate on the unit?
- What can elements of positive psychology, protection and promotion of positive identity, compassion, and prevention of stigma provide?
- How can units accommodate diversity, assure inclusion, and protect vulnerable cultural minorities and marginalized groups from discrimination?
- Do all units provide young people with sufficient opportunities to affect their own care, the unit procedures, and the environment? Do youth have a voice and does the system listen?
- Why is it important for units to assess what children want, including their readiness for change and self-efficacy?
- Should providers distinguish and separately address motivation for change and motivation to engage in treatment?
- How should units address wishes and needs of parents/caregivers without compromising the rights and wishes of the young person?
- How can units incorporate the basics of person-centred care, trauma informed care, and attachment supportive care?
- To what extent should families and community providers also be engaged in care?
- Do inpatient units routinely collect, publicly report, and utilize satisfaction measures as well as qualitative feedback about the experiences of young people and their families?
- Should units be engaged in advocacy?

INTRODUCTION

The first section of the Guide, Standards, Benchmarks & Literature Review: Standard 1: Physical Safety discussed the importance of physical safety. It noted that an excessive focus on physical safety to the exclusion of psychological safety can precipitate discouragement, and some very risky physical behaviours on the parts of young patients. Excessive surveillance, restrictions, and searches, and controlling measures like seclusion and restraint can lead to feelings of resentment, fear, devaluation, and discouragement that can increase rather than reduce the potential for harm to self and others. They can lead to a sterile confining psychological environment with diminished opportunities for the development of relational closeness and trust important for collaboration and recovery (Reavey et al., 2017).

The present section proposes standards that can help balance the focus on physical risks with psychological safety needs (Björkdahl, Hansebo, & Palmstierna, 2013). This section of the standards considers the needs of child and adolescent inpatients for psychological safety, dignity and rights, and participation as active partners in their care decisions. The section provides a literature review, a set of aspirational standards, and a self-audit checklist that units can use to track compliance and progress. Standards and the best practices they support are intended to be flexible guides that can change as society changes and new discoveries are made by research.

Units responding to past ONCAIPS surveys have indicated that inpatient units in Ontario view themselves as physically safe, and highly committed to protecting and promoting psychological safety, inclusion, dignity, rights, and participation. There is little doubt that units in Ontario and internationally strive to protect human rights, to be inclusive and to accommodate diverse needs and preferences such as those related to age, gender, identity, culture, religion, sexual orientation, and disability. But units have also indicated that there is room for improvement as significant problems can be difficult to avoid considering recurring influences from societal and fiscal pressures. Pressures include stereotypic views of mental illness. Some in society continue to view individuals with mental disorders as dangerous. This in turn incites fears that can lead to actions which seriously impinge on dignity and freedom (e.g., routine or excessive use of handcuffs and restraints to transport young people to hospital and physical restraint to keep them there (e.g., Kogstad, 2009)). Similar views of inpatients as dangerous and of the need to control can create tensions in hospitals and among staff. Staff and organizations may differ in what they consider the best balance of patient dignity and control (Matthews & Williamson, 2016). The present section of the standards considers best practices that can help maintain physical safety while at the same time protecting personal rights, dignity, freedoms, and inclusion. Challenge, and approaches to help assure a good balance between physical safety and rights and dignity are discussed and standards for assurance and promotion of best practices to maintain psychological safety, rights, and engagement are proposed in each of the sections below.

1. PROTECTING RIGHTS
2. PROMOTING DIGNITY
3. ASSURING CONSENT & CAPACITY
4. ASSURING CONFIDENTIALITY
5. PROMOTING LEAST RESTRICTIVE CARE

6. PSYCHOLOGICAL SAFETY
7. PROMOTING POSITIVE IDENTITY & SELF-ESTEEM
8. REDUCING STIGMA
9. USING POSITIVE PSYCHOLOGY
10. PROVIDING COMPASSIONATE CARE
11. VALUING DIVERSITY & PROMOTING INCLUSION
    - Very Young Children
    - Indigenous Children & Adolescents
    - Youth with Autism & Developmental Disabilities
    - LGBTQ2SIA
    - Refugees & Immigrants
    - Youth in Foster Care
    - Youth in the Forensic System
12. ENGAGING YOUTH IN PERSON CENTRED CARE
13. SAFEWARDS
14. WORKING MOTIVATIONALLY
15. ENGAGING PARENTS/CAREGIVERS & FAMILY
16. ENGAGING COMMUNITY PARTNERS
17. PROVIDING TRAUMA INFORMED CARE
18. PROVIDING ATTACHMENT SUPPORTIVE CARE
19. USING FEEDBACK & ENGAGING IN ADVOCACY

It is hoped that this section will promote the continued development of provincial and national standards, indicators, benchmarks, and dissemination of best practices across units provincially and nationally. It is also hoped the information in the section will promote research and provoke feedback that can help with the ongoing goal of providing the most helpful and effective inpatient care possible. Although these standards have been written for inpatient care, most of them can equally apply to residential care, group homes, and foster care settings.

PROTECTING RIGHTS

2.1 The unit protects the human rights of all child and adolescent patients, staff, and visitors.

Basic Human Rights. Children and adolescents in inpatient care, like all other individuals, are entitled to basic human rights irrespective of their (or their parent/guardian's) age, race, colour, sex, language, religion, political or other opinions, national, ethnic or social origin, property, disability, birth origin, or other status (United Nations General Assembly,1948; World Health Organization, 2005). Basic rights include the right to physical safety, nutrition, shelter, clothing, hygiene, education, exercise, play, rest, sleep, access to health care, dignity, and respect. Core principles are detailed in the United Nations Convention on the Rights of the Child (United Nations General Assembly, 1989), https://www.ohchr.org/en/professionalinterest/pages/crc.aspx. All principles are based on the fundamental premise that children and adolescents, and their parents/caregivers have the right to express and manifest their religion, cultural practices, or beliefs

so long as these do not violate the safety, public health, laws, morals, or the fundamental rights and freedoms of others and of society in general. On inpatient units, this includes the expectation that the expression of rights by children adolescents and their families must also respect the rights of others including the rights of co-patients, staff, and visitors. The protection of basic rights of children and adolescents must in addition be balanced by the societal obligation to withhold certain rights in the interests of the child's safety, the child's health and development, and in the interest of allowing parents/caregivers to exercise duties and responsibilities.

Mental Health Acts. Mental health legislation provides statutes that help balance rights of a person with mental illness with the need to assure personal and public safety. Mental health legislation is supported by national Charters and guidelines (e.g., Canada Constitution Act, 1982, Canadian Charter of Rights and Freedoms, https://laws-lois.justice.gc.ca/eng/const/), as well as by national and provincial legislation some of which is specific to the rights of those with mental disorders and their services (e.g., Ontario Mental Health Act, 1990). The Mental Health Act in Ontario is further supported by additional legislation that promotes the right to make informed treatment choices (e.g., The Health Care Consent Act, and The Substitute Decisions Act), and the right to confidentiality (e.g., The Personal Health Information Protection Act) (Byrick & Walker-Renshaw, 2009). Mental health acts include protections that help safeguard unnecessary infringement of basic human rights such as sometimes occur with involuntary hospitalization and restraints. Basic rights include the right to prompt access to legal assistance, and the right to challenge the legality of the deprivation of personal freedoms before a court or other competent, independent and impartial authority. The Ontario Mental Health Act (1990, https://www.ontario.ca/laws/statute/90m07) for example, permits a patient to apply to have a Consent and Capacity Board hearing in front of a panel of three to five members with at least one psychiatrist, one lawyer, and one public member, if they disagree with their involuntary status.

Implications & Challenges for Inpatient Units. Experience and training that promote improved understanding of the rights of children and adolescents is important to assure freedom from discrimination. Training should include understanding and protecting for the right of young people given the tendency to discount their capacities based on age, the right of young people to remain informed and participate in decision making, the right to a receive services in a safe and healthy environment, the right to privacy, the right to interact and communicate with family, friends and the outside world, the right to be informed about their rights and appeals processes, and the right to protection from institutional exploitation (World Health Organization, 2005). Staff and managers who lack sound developmental, cultural, and operational knowledge can misunderstand needs in ways that lead to imbalances between assurance of safety and protection of rights. Staff and hospitals generally appreciate that infringements on rights do occur, and that when they do occur, that they often do so with good intentions such as in the pursuit of physical safety (Szmukler, 2001). Overriding concerns about safety may result in unnecessary compromises of personal rights during inpatient care and at admission. Excessive fears that children and adolescents may harm themselves or others may precipitate excessive control and loss of freedom on the unit and prior to admission. This can include excessive use of involuntarily admission to assure safety when no such controls are required. A significant number of youth in Ontario lose their rights only to have them rapidly restored after inpatient assessment determines they need not have been admitted, that they do not require continuing stay for inpatient safety or treatment, and that they can be

immediately discharged (Persi, Bird & DeRoche, 2016). Because it is not always easy to reliably determine risk prior to admission and afterwards, it is not unusual for disagreements to arise among children and adolescents, their parents/caregivers, community partners, staff, and managers. It is important that discussions take place among all who are engaged in such conflicts in order to better understand what rights should be protected, whether a child should be involuntarily hospitalized or restrained, about needs for restrictions, about how best to deploy limited numbers of staff and resources. Making time to exchange information and to discuss how best to protect basic rights with youth, their parents/caregivers, and other staff is essential but can be lost on busy and overworked units. Making the time to listen, to understand, and to share the responsibilities for protection of rights and dignity of patients should be as fundamental to inpatient care as the communication of a diagnosis or the provision of medication.

PROMOTING DIGNITY

2.2 The unit protects the dignity of patients, staff, and visitors.

Protection of Dignity as a Human Right. The responsibility to treat all young people and their parents/carers with dignity and respect is a well accepted standard for child and adolescent inpatient care (Lucas, 2019; Saxena & Hanna, 2015), and an ethical responsibility of all health care professions (e.g., Reed et al., 2003). Dignity is a basic human right recognized by the United Nations General Assembly (1948). The Assembly declared that all human beings are born equal in dignity and rights, and that dignity, rights, and freedoms are entitlements without restrictions of any kind, including restrictions related to race, colour, sex, language, religion, political or other opinion, national or social origin, wealth, birth, or other status. This declaration recognizes that all individuals, including children and adolescents, are worthwhile persons who are entitled to dignity and respect.

Dignity of Children and Staff. The dignity of children and adolescents is often at relatively higher risk of infringement than that of adults. This is because children and adolescents have lower social standing, political power, and less capacity to defend themselves from age-related discrimination, exploitation, and abuse. Protecting youth dignity requires and awareness of how children and adolescents like to be treated at different ages and how their needs differ from those of adults (Jamalimoghadam et al., 2019). There are also individual and cultural differences in addition to age-relate ones. It is therefore essential for units to encourage children and adolescents to express what they consider respect and dignity (Cheetham, Ellins, & Callum, 2013). Attitudes that young patients are "just children" or are "mentally ill" should not be allowed to permit unnecessary infringement of dignity. Dignified and respectful care is not a privilege which inpatient children and adolescents need to earn by proving themselves to be safe or compliant (Slemon et al., 2017). Rights to dignity and respect apply also to staff, parents/caregivers, and visitors. This is consistent with the view that all individuals have a right to be free of devaluation, stigmatization, and discrimination. Everyone has the right to be treated in respectful ways regardless of their social role or profession, age, gender, culture, religion, race, physical appearance, sexual orientation, social standing and other personal characteristics and group affiliations. Not only does everyone

have the right to be treated in a dignified manner but everyone on the unit has a responsibility to treat others in the same way.

Threats to Patient Dignity. Despite unit and staff commitments to treat patients with the level of respect and dignity they are entitled to, breaches occur. Difficulties arise when customs, value systems, and opinions among patient groups are incompatible or when groups compete for dominance and engage in mutually demeaning behaviours (e.g., Geppert, 2016). Ingrained cultural biases and divisive "us versus them" attitudes that compromise respectful behaviours can arise. Differing values and beliefs about what dignity is and its importance relative to safety can create discord among young people, between young people and their parents/caregivers, between staff, and between staff and patients. Witnessing the use of handcuffs to involuntarily transport youth to hospital (Kogstad, 2009), forcing youth to change out of day clothes and into hospital pyjamas (Lakeman, 2011), and restraining youth in front of others (Barton, Johnson, & Price, 2009; Huckshorn, 2006) may be seen by some staff as valuable whereas other staff may see the practices as undignified, unfair, unnecessary, or excessive. Communication and collaboration can do much to help align staff efforts to prevent infringements of dignity, though early discussions that seek to prevent misunderstanding and help accommodate differences of opinion. Unfortunately, this requires a significant commitment of time; time that staff may not always have. Staff surveys suggest that it is not uncommon for many nurses to feel they lack the amount of time they need to provide a level of care that best assures the dignity of their patients (Baillie, et al., (2009). Time constraints can result in inability to find opportunities to hear and understand needs and concerns about respect and privacy of young people and their families. Rushed inaccurate communication can lead to frustration and resentment. Such problems will be more likely to arise when units are understaffed, when numbers of admissions surge and exceed unit capacity, and when the dependency of patents and risk severity are unusually high. But some threats to dignity can also arise from staff attitudes even when census is low. The unit and the staff can prioritize paperwork or other hospital demands over patient needs un ways that are disrespectful (e.g., "Can't you see I'm busy right now" versus "I think what you want to discuss is important, but I'm tied up right now. Can I come to talk with you in 10 minutes when I'm done"). Staff may regard children and adolescents as more incapable than they are and speak for them rather than giving them opportunities to speak for themselves. The unit and staff may fail to provide sufficient opportunity for youth to participate in decision-making about their care (e.g., "It will only upset her if we invite her to conference to discuss her plan"), and break promises such as failing to provide promised or advertised elements of care like psychotherapy (e.g., "Well we can afford a psychotherapist, we are stretched as it is" or "Sorry, our therapist is away this week") (Chambers et al., 2014; Walsh & Kowanko, 2002).

Dignified Caregiving. It is essential that protection and respect for young people's dignity be considered as early as possible in the admission. Young people should be welcomed by staff members in a respectful way, shown the unit, introduced to other patients and staff, and and encouraged to discuss their expectations and needs (Department of Health (England), 2011; Lucas, 2019). Understanding the differing ways in which diverse groups maintain and express their dignity is important for knowing how best to respect it. The unit should provide staff with education that will help better understand threats to the dignity of the youth who are admitted so that customs and religious practices can be accommodated whenever possible without disparaging

or reducing analogous opportunities for those who have no religious affiliation (Lucas, 2019). Staff will need to understand what is important for each patient and patient group. For example, autonomy, consent, confidentiality, and control over care tends to be more important for adolescents than younger children (Jamalimoghadam et al., 2019).

ASSESSING CAPACITY & OBTAINING CONSENT

2.3 The unit assesses capacity and obtains consents for treatments.

Consent. In Ontario, informed consent is required prior to provision of treatment. Consent is said to be informed if, before giving it, a person received information about the nature of the treatment, the expected benefits, the material risks and side-effects, alternative courses of action (including alternative treatments, traditional medicines and culturally appropriate treatment), and the likely consequences of not having the treatment. This requires the staff who are proposing a treatment to meet with patients or/and substitute decision makers to assure they understand what is being proposed and to answer all questions they may have about the treatment. The legal right of children and adolescents to make treatment decisions, to the extent that they are capable of doing is supported in Ontario by the Ontario Mental health Act (1990) and supplemented by the Health Care Consent Act, (1996, https://www.ontario.ca/laws/statute/96h02). For consent to be valid, it must be related to the treatment, informed, given voluntarily, not coerced, or pressured, and not obtained through omission or misrepresentation of important information. Consent is not intended to be a simple 'green light' or rote endorsement on the patient's part of something solely suggested by the health care provider. Consent is intended to be a process that requires joint discussion among patients, families, and providers in a way that helps to explore and then consolidate a plan of care that is most likely to be helpful and effective (Gross & Goldin, 2008). Young people are intended to be partners in care and to the express their views freely about the any proposed treatments, including inpatient treatment. Youth and parents/caregivers should be engaged as early as possible so they can come to understand the role of capacity and consent in care, when capacity and consent is to be solicited, and the nature of the processes. Ongoing discussion is important to help prevent misunderstandings and decisions that are later regretted.

Capacity. Ontario there has no legislated age that is assumed to set a limit on the capacity to provide consent, but the presumption of capacity can be rebutted when a youth is unable "to understand the information that is relevant to making a decision about treatment". It is important for the provider who is proposing a treatment to determine capacity. Determination of capacity requires the unit provider to consider the child's age, maturity, culture, special needs, and circumstances in assessing the individual's general and specific level of understanding. Capacity is restricted to decisions about a proposed treatment and not intended to apply to all other decisions, although ideally a similar process should be used to understand a young person's capacity to make other important decisions. Capacity for informed consent is specific to the treatment proposed at the time it is being proposed and provided. This is important, because a young person may lack capacity to make decisions at admission but still retain the ability (capacity) to make decisions regarding a certain treatment. It is also important to appreciate that capacity is

not fixed in time. A patient may be incapable at one point and capable at another given course of a disorder (e.g., recovery from a brief psychotic episode or intoxication) or maturation. Given the complexity of care, it should be kept in mind that provider judgments of capacity can vary between evaluators (Hein et al., (2012) and may require additional discussion when there is a history of discordant information.

Substitute Decision Makers. When young people do not have capacity to consent, when they do not understand the information relevant to the proposed treatment, and do not appreciate the reasonably foreseeable consequences of consenting or refusing consent an appropriate substitute decision maker needs to be identified and engaged. Substitute decision makers are typically parents/caregivers. The substitute decision-maker for a young person under 16 will likely be one or both parents. In some cases where the parent or alternate custodian is unable or incapable of making treatment decisions, a court may appoint a legal guardian to decide on the child's behalf. If the person is under the age of 16, the substitute decision-maker must consent to or refuse the treatment based on the young person's best interests. This includes considering the preferences of the young person. A person under 16 years of age who is found to be incapable regarding admission to a psychiatric facility has the right to meet with a rights advisor who will inform them of their legal rights and assist them in asserting those rights.

Not Enough Time for Consent. Although one would expect that staff would always assure informed consent for treatment and for other important decisions, the process of consent is sometimes compromised when the unit lacks the time to gather reliable information and discuss options with a patient. There have been findings that some young people on different treatment units may have differing and at times poor information and minimal amounts of input into care decisions from point of referral to discharge (Tulloch, et al., 2008). Tulloch et al. (2008) in a survey across units found that although some youth felt they were adequately informed and provided with sufficient opportunities to consent, whereas others felt that they were not asked and had no say whatsoever in the treatment they received.

Disputes. Disagreements about whether youth have capacity and about treatment choices can and do sometimes arise among staff, patients, and parents/caregivers. Disagreements arise among youth and parents/caregivers when youth with or without capacity want to accept or refuse treatments when their wishes contradict those of the parents/caregivers. Ideally decisions and support for treatment is improved when all key individuals involved in the care process are informed and have an opportunity to contribute. Parents/ should be consulted and allowed to participate in decisions to the extent they are allowed and whenever they do not pose risks for the patient. Parents/caregivers should minimally be informed when their children with capacity refuse to have them be part of the care circle. It is, helpful for the unit to have a published protocol for responding when a young person does not consent to parent/caregiver involvement (Lucas, 2019). Staff should not presume but should evaluate whether the behaviours of parents/caregivers and substitute decision makers suggest they are not acting in the best interests of a child or are incapable themselves. Occasions will arise when the unit may seek supports from child protection or apply for a legally appointed substitute decision maker who can better further the best interests of a child. Parent/caregiver education, family therapy, and involvement of the patient advocate or rights advisor should always be available.

ASSURING CONFIDENTIALITY

2.4 The unit encourages helpful sharing of information while at the same time respecting confidentiality.

Confidentiality & Disclosure. Confidentiality is a legal and ethical obligation not to disclose information obtained in confidence during inpatient care without the client's consent. Confidentiality includes protection of the patient's health care records. Information about a young person and their care should not be accessible to third parties without consultation and consent from patient or their substitute decision maker. In Ontario the rules governing confidentiality are detailed in the Personal Health Information Protection Act, 2004, https://www.ontario.ca/laws/statute/04p03. Sometimes, children and adolescents who are anxious about behaviour like substance use, sex, or embarrassing behaviours, or fearful of parent/caregiver behaviours may want to and have the legal right to speak to staff and to keep the information from patents/caregivers. Addressing such information requires a sensitive balancing of a young person's privacy with the parents' right to know and so they can more effectively support care and discharge planning (Sharfstein, 2009). Adolescents relative to children, tend to be more guarded about disclosing important information if they think the information will be shared with parents/caregivers who may be upset by the information (Carlisle et al. 2006). Child and adolescent concerns about sharing information with any third parties should be respected and reviewed regularly because failure protect confidentiality can become a barrier to trust and use of needed health care services in the future (Adams, 2004; Tulloch et al., 2008). Units can also inadvertently create unnecessary problems if the information they gather extends beyond what is germane to the individual's health care. Information that is not going to be used to inform care, constitutes unnecessary invasion of privacy, can add to patient anxieties about what is being collected and why, and can complicate decisions about what should be shared and what should not.

Capacity and Limits of Confidentiality. The protection of confidentiality is fundamental to hospital policies and procedures and is a standard of inpatient care except in conditions where doing so may place the child or others at risk (Lucas, 2019). Consent from a youth or their substitute decision maker should always be obtained prior to the disclosure of personal health material to parents/caregivers and third parties and the implications discussed (Lucas, 2019). Adolescents have sensitive confidentiality issues that involve a delicate balancing of privacy with the parents' right to know what inpatient care is providing. This is particularly challenging in situations involving reproductive health or substance abuse (Sharfstein, 2009). Limits to confidentiality should be explained to children and adolescents and their parent/carer both verbally and in handouts. The young person's parent/carer should be contacted by a staff member (with the young person's consent) to notify them of the admission if they were unaware, to discuss the plan of care, and to establish who their primary staff contacts will be (Lucas, 2019). The young person and parents/caregivers should be informed that the inpatient team is a unified team with no restrictions on information exchanges or 'secrets' among staff (e.g., "I want you to know but not the other staff"). It is important that the unit be clear with the youth and parents/caregivers that the health care provider can also release confidential information to the young person's substitute decision-maker, if the young person has been judged incapable. Limits on confidentiality include situations

where the unit health care providers are subpoenaed by court, reports of suspected child abuse, and duties to prevent serious harm or death to self or others that will arise if information is not shared. The best way to avoid potential misunderstanding and problems related to confidentiality is to be open about legislation and policies at the beginning of an admission rather than later. Referral and transfer sources should ideally begin this process which is then continued by inpatient providers.

Staff Competencies. The determination of a patient's capacity presumes staff have the training, procedures, and supports to make accurate decisions about capacity and consent based on good developmental and cultural knowledge, and language competency. This requires staff to understand the cognitive skills and information needs of patients at different levels of development and with special needs including having different linguistic needs and culture than the predominant one s) of the unit (e.g., Not having English or French as a first language). It also requires staff who propose treatment on behalf of a physician or other provider to be able to answer all questions arising and for the unit to allow meeting with the person proposing the treatment if they are not satisfied.

Developmental, Linguistic, Cultural, and Cognitive Considerations. Staff can seriously underestimate capacity when they fail to provide information at a level and in a way that children are more likely to understand. There appear to be risks of children being treated as adolescents, and adolescents as adults depending upon context. Compared with being in an adolescent ward, 15- to 17-year-olds on adult wards where staff are not as familiar with the needs of adolescents were less likely to report they were provided with appropriate information and involvement in own care (Viner, 2007). All units should consider developmental needs and provide discussions, written information, pictures and videos, translators, and cultural supports. It is often helpful for younger children to break up the information into smaller pieces, to engage parent/caregiver supports, and to take more time and repetitions.

Protecting Patients from Problematic Self-Disclosures. There are occasions when youth may compromise their own privacy, and times when they may feel pressured, and may pressure other patients to disclose things that may lead to significant later regret. Patient-to-patient potentially harmful disclosures include providing information about their own sexual history and interests. Patients may also infringe on the privacy of their parents/caregivers, co-patients, and third parties when they disseminate information that was intended to be kept private. Sharing address and phone numbers is not uncommon among co-patients, but these may be exchanged at times of emotional vulnerability or thought disturbance and may then later be regretted as they lead to subsequent unwanted contacts and stresses for both youth and their parents/caregivers.

PROVIDING PSYCHOLOGICAL SAFETY

2.5 The unit has a psychologically, emotionally, and socially safe climate.

A Climate of Psychological, Emotional, Cultural, and Social Safety. A unit climate is an aggregate of the values, beliefs, opinions, procedures, behaviours, relationships, communications, and

expressed emotions. These variables contribute to whether the environment is experienced as psychologically, emotionally, and socially safe by patients, parents/caregivers, and staff. Psychological, emotional, and social safety include freedom from fears of physical and sexual assault. It also includes freedom from fear of dehumanizing, disempowering, punitive, rejecting, stigmatizing, and re-traumatizing experiences (Bloom, 2005; Delaney & Johnson, 2008; Dollard, et al., 2012; Shattell, Andes, & Thomas, 2007; Slemon, Jenkins, & Bungay, 2017). A psychologically, emotionally, and socially safe climate values and celebrates diversity and provides accommodations that allow all patients, their families, and their community supports to have significant control over the care process. Related terms such as positive 'socioemotional climate', 'emotional ecology', 'unit culture', and 'cultural safety' are similar. So too are terms such as 'family climate' and 'atmosphere at home' are sometimes used describe the overall emotional and safety climate at home (Hansson et al., 1992). All these terms describe desirable psychological characteristics of social environment. Positive climate in schools and classrooms has been reported to be associated with academic achievement, school satisfaction, and psychological wellbeing (Alonso-Tapia & Nieto, 2019). More particularly, positive climates have also been noted to be important for patients as well as for the well-being of staff (Aarons, & Sawitzky, 2006).

<u>Physical Safety is not Enough</u>. The psychological and emotional climate of the unit environment is as indispensable for patient wellbeing and recovery as physical safety (Langdon, Swift, & Budd, 2006). Residential settings should be places where all youths with mental health needs can find respite or sanctuary from maltreatment, discrimination, bullying, devaluation, rejection, and re-traumatization (Bloom, 2005). The achievement of an emotionally, culturally, and socially safe unit climate can best be developed and maintained if all children and adolescents, staff, parents/caregivers and visitors work together. Only by working with youth and families can staff help identify psychological threats and maintain a psychologically and socioemotionally safe environment. The unit has a responsibility for developing and maintaining a positive psychologically and emotionally safe setting, but all individuals including patients and visitors can contribute to the common wellbeing to the extent they can.

<u>Assessment & Monitoring</u>. It is important to appreciate that the unit socioemotional climate is never static, and that units need to monitor and be aware of changes. Unexpected and at times problematic changes can result from changes in rules and procedures, from changes in staff complements, from changes in numbers of youth on the unit, and from the arrival of more dependent or risky patients (Lewin et al., 2012). It is important that the unit to engage patients, parents/caregivers, professional partners and staff in monitoring for the possible changes that indicate the emergence of a psychologically unsafe environment. Signs of potential loss of psychological safety include increased and excessive use of confinement to bedrooms, excessive restrictions on contacts with friends, extensive reliance on seclusion and restraint, excessive use of observation and surveillance to assure compliance, and a lack of positive recovery-oriented staff-patient collaborative interactions. Although there are measures available to specifically evaluate the socioemotional climate of schools and classrooms (e.g., Alonso-Tapia & Nieto, 2019), there were no measures in use that have been specifically for inpatient care that were known to the authors at the time of writing. Nevertheless, this does not mean that unit climate cannot be assessed using adaptations of measures developed for other settings such as the classroom,

through interviews, and the use of staff observation. Surveys can yield rich data about the state of the unit. Studies suggest that youth perceptions of the unit climate can range from appreciative ones comparing a unit to a 'holiday camp' and 'youth club', to very negative ones, such as comparing the unit to a 'zoo' and 'prison' (Reavey et al., 2017). Unit staff have also sometimes noted that units can slip into control states as reflected in language that compares unit stays to "'doing time' within the system," and to patient discharges and visits home being compared to being "on parole or release" (*Ramjan & Gill, 2012).*

PROMOTING LEAST RESTRICTIVE CARE

2.6 The principle of least restrictive care is promoted and practiced.

The Least Number of Restrictions After Admission. Youth should have the fewest restrictions and greatest number of normalizing opportunities that allow preservation of their safety and that of others. Youth should not be subjected to unnecessary and unhelpful restrictions that are without apparent benefit to their recovery and that of their co-patients. In part this is an ethical position and a practical one as many youths find confinement, especially unnecessary confinement, to be undesirable and unhelpful for their recovery (Martin et al., 2006; Moses, 2011). Inpatient units should work with communities to monitor and prevent unnecessary infringements of the liberty and freedom of movement and choice which are guaranteed under the United Nations Convention on the Rights of the Child (United Nations General Assembly, 1989) and the number and types of inpatient restrictions should be monitored on a continuous basis (Vargas & Brambila, 2005). Rauktis et al. (2009) have proposed measures that can help with monitoring of the degree of restrictiveness on units.

Inpatient Admission is the Least Restrictive Alternative. Placement in the "least restrictive environment" is a principle guiding mental health services (Knitzer & Olson, 1982; Rauktis et al., 2011; Schoenwald, 2002). No child or adolescent should be in a more restrictive setting such as an inpatient unit because of societal failures to provide less restrictive supports and services (World Health Organization, 2005). Unfortunately, this does not always occur. There are obstacles that get in the way such as lack of funding, poorly integrated systems of care, and consumer and provider choices to use more restrictive services rather than more available less restrictive community services. A significant number of children and adolescents are not directed to less restrictive options prior to being admitted (Akin et al., 2010; Gottlieb, Reid, & Fortune, 1990; James et al., 2006). Many community services, including those offering intensive outpatient services, dialectical behavior therapy, and multisystemic therapy provide viable alternatives that are less restrictive, less expensive, but no less effective relative to hospitalization (e.g., Greenfield et al.,2002; Henggeler et al., 2003; Sunseri et al., 2004). Failures to fund or use available alternatives contributes to increased likelihood of readmissions, blocked beds, increased costs to the mental health system, excessive disruptions to peer, school, and family life, and no less importantly to the loss of personal rights and freedoms (Blanz & Schmidt, 2000; Friedman & Street, 1985; Kiesler & Sibulkin, 1987; Knitzer & Olson, 1982; Lewis, 1989; Persi, Bird, & DeRoche, 2016; Shepherd, et al., 1997; Weithorn, 1988). Having 'nowhere else to go', for example because of a lack of less

restrictive community services, or because community services are inaccurately perceived to be ineffective, are questionable reasons to admit and may only promote continued use of hospitals while undermining the development of equally effective less restrictive community services. The task of identifying and assuring least restrictive effective practices is complex given the many variables in play. Additional research will be required to better identify the numbers and types of restrictions that are helpful and necessary and those that are not.

PROMOTING POSITIVE IDENTITY & SELF-ESTEEM

2.7 The unit promotes the development of positive identity and self-esteem.

Negative self-concept from stigma from mental illness is discussed in greater detail in 2.8 below as it is a particularly important part of identity and self-esteem. This section reviews literature and discussed importance of general self-esteem and positive identity. In the course of developing an identity, and evaluating it, young peoples constructs are shaped by both internal constructs and social forces that define the importance and desirability characteristics like age, sexual orientation, religion, culture, language, visible characteristics, and personal strengths and weaknesses (e.g., identifying as an athlete or an academic).

Identity. An identity which is positive, well-defined, stable, integrated, unconflicted, and socially aligned better supports recovery and health (Penner, Gambin, & Sharp 2019; Syed & McLean, 2016). Many young inpatients who are admitted unfortunately come to hospital with a negative identity. A negative identity creates additional challenges for recovery as it can promote helplessness, rebelliousness (e.g., resentment of others who think they are better, including staff), and resistance to change. Some identities, though negative, can also be resistant to change. Children can seek to maintain their negative identities though continued self devaluation because of the coherence, familiarity, predictability, and reinforcement from peer and family groups (Penner, et al., 2019). Some will have more severe disturbances and disorders of identity such as dissociation, dissociative identity disorder (Atlas, Weissman, & Leibowitz, 1997; Goffinet & Beine, 2018) and depersonalization (Gómez, 2019; Meares, & Grose, 1978) which may include many inflexible and maladaptive patterns of behaviour which are also very resistant to change. Occasionally these disorders of identity are principal contributors to admission (e.g., Rinaldi, Izarbe, & Kyriakopoulous, 2019). Negative identity is sometimes, but not always, related to low self-esteem as sometimes youth can feel quite proud of being "bad" or belonging to a gang or rebellious peer group. It is important that children's views of themselves be understood and worked with in ways that do not further alienate and hurt.

Self-Esteem. Negative self-esteem is often related to identity although it has also a separate defining set of characteristics. Self-esteem refers to the extent to which young people value who they are as individuals and who they are as individuals in different roles (e.g., I am a good or poor student). Children may have high esteem in one area but low social self-esteem in another. Like identity, self-esteem is impacted by the opinions of parents/caregivers and peers. Some will

develop negative identities because of experiencing discrimination, intimidation, abuse, blame, disempowerment, or repeated failures from lack of opportunity to succeed. Some will devalue their age, gender, culture, religion, language group, skills, or appearance. Others will have more global devaluations of themselves. Inpatients, for example, tend to have lower global self-esteem relative to both outpatients and other non-hospitalized groups (Choi & Ferro, 2018). Once developed, low-self-esteem and self-devaluing habits may continue and increase risk of suicidal thoughts, hopelessness, helplessness, and self-harming behaviours (Brausch & Gutierrez, 2010; Fehon, Grilo, & Martino, 2000; Kjelsberg, Neegard, & Dahl, 1994; Overholser et al., 1995; Robbins & Alessi, 1985), interpersonal conflict (Perez et al., 2001), reactive hostility, and aggression (Amad, Gray, & Snowden, 2020), and onset, maintenance and relapse in eating disorders (Fennig et al., 2008, Biney et al., 2019). Some findings have suggested that adolescents with lower self-esteem may be more attracted to peers with similarly low esteem and develop similar group identity (Claes et al., 2010). In contrast, positive self concept has been associated with higher motivation to change and a less dependent coping style (Pauli et al., 2017), as well reduced likelihood of hospitalization for suicidal risk (Junker et al., 2019). It should not be assumed that all inpatients have low self-esteem. Some will have generally positive self-esteem, and a few will have self-esteem that is excessively or unrealistically high and that can compromise effective action (Amad et al., 2020). Some may accurately perceive they are being devalued by others but do not allow these external devaluations to affect how they think of themselves, whereas others may engage in extensive self-stigmatization with no or minimal external devaluation (Corrigan, et al., 2006). It is important for units to understand the accuracy and effectiveness of processes that shape identity and self-esteem.

<u>Understanding & Promoting Effective Identity & Self-Esteem</u>. Units need to understand and then address unhealthy self-esteem and identity, as maladaptive views of the self can pose significant barriers successful inpatient treatment (Fennig et al., 2008). Staff need to take insufficient time to know children and adolescents and not only presume to know what youth need. Interventions should not be based on stereotypic or patronizing presumptions about what youth need but on discussions and observations with youth. Youth with excessively high, unrealistic positive self-esteem, who disparage and violate others will need a different approach from those with low esteem. They will need help to develop a less narcissistic and more realistic view of the self (Amad et al., 2020). Those who live in positive home and school environments will similarly need different approaches from those that don't. Inpatient interventions for improving low self-esteem with inpatients include those that use cognitive and behavioural group work (Adamson et al., 2019; Biney et al., 2019), and positive psychology (Toback, Graham-Bermann, & Patel, 2016). More effective attributional habits based on more accurate and less toxic mentalization and social perception can help. They can decrease negative views of self and others. They can also reduce imbalance in the attribution for success by shifting exaggerated responsibility for success from external factors like medication, staff, or hospital care, to internal ones like effort and personal competency (Rueger & George, 2017).

REDUCING STIGMA

2.8 The unit prevents and reduces stigma of mental illness and hospitalization.

Stigma of Mentall Illness and Hospital Admissions. Stigma originates from the view that a person with a mental disorder, particularly one who has needed hospitalization, is a less valuable, less trustworthy, less competent, and less desirable person than someone without a mental illness. Individuals who have been diagnosed with a mental disorder, and those who have been hospitalised, are too often likely to be views with negatively by others. Minorities and marginalized groups who have been stigmatized for other personal characteristics are particularly vulnerable (Moses, 2009). Many children and adolescents with mental disorders report being targets of ridicule, bullying, devaluation, distrust, and negative gossip from peers, family members, and teachers (Moses, 2010). Repeated exposure to devaluing statements and attitudes leads many vulnerable young people to eventually consolidate a self-stigmatizing set of beliefs and attitudes, and a core identity a mentally ill person (Goffman 1963; Link & Phelan 2001). As a mentally ill person they come to see themselves as incapable, defective, a threat, and a liability to family and society in general (Corrigan, Watson, & Barr, 2006; Moses, 2009, 2010; 2011). They come to believe that friends, families, and others would prefer to seem them 'out of the way' in hospital, and that others are relieved and do not miss them when they are gone from home, school, and community. Studies of adult inpatients have found stigma at admission has long lasting implications as baseline increases risks of suicidal ideation several years later (e.g., Xu et al., 2018). Feelings of shame associated with stigma can become a barrier to seeking or accepting mental health services (DeLuca, 2019). An unfortunate consequence of self-stigma is the development stigmatization of others. Children and adolescents can also then come to see co-patients and others who are mentally ill as similarly worthless.

Benevolent Stigmatization. Stigma is most often considered to be the of hostile and demeaning experiences with others. It is important to appreciate it can also develop out of well-intentioned sympathy, pity, overprotectiveness, and care. Helpful caring diagnoses can result in self-stigma as a helpless or damaged person when individual adopt a diagnosis as their core identity. Diagnosis can result in negative self-labelling on the parts of vulnerable youth others (e.g., "I am a psychotic that nobody will ever love") and negative labeling by others (e.g., "What do you expect, she is a borderline"). Hospitalization itself is intended as helpful and caring. Nevertheless, it can be stigmatizing. Some children and adolescents will feel more stigmatized than others. There are many young patients who will find acceptance and validation from co-patients, as well as genuine compassion, empowerment, and validation from inpatient staff that may reduce rather than increase stigma. On the other hand stigma can also arise out of well-intentioned adult and peer expressions of pity, out of excessive helpfulness that erodes independence by doing things for children that they should be able to do for themselves, and out of an excessive focus on the diagnosis or mental disorder that erodes positive self-evaluation, healthy identity and personhood, and confidence (Child and Adolescent Mental Health Services, 2014; Cohen & Struening 1962; Vandereycken, 2011).

Stigma & Inpatient Care. It is not unusual for children and adolescents to report unfair treatment, lack of respect, lack of engagement, and exclusion from care decisions as if they were more incapable than they are (Edwards et al., 2015; Mitten et al., 2016). Passive and angry youth seek support from others with similar coping styles creating groups with the inpatient group that help maintain the status quo rather than promote healthy change. There are both staff and co-patients who treat patients with certain labels or types of problems as less worthy of attention, less entitled to rights and freedoms, and as less capable of collaborating in care than they are. Slemon et al. (2017) noted that many staff members working in mental health care continue to hold views that individuals with mental illness are dangerous which increases the perceived need for control through seclusion, restraint, and restrictions while simultaneously reducing frequency of therapeutic interactions. Other sources of stigma include stereotypic beliefs and disparaging comments about parents/caregivers with addictions and mental health problems, and failure to notice and build upon strengths (Heflinger & Hinshaw, 2010). It is important for staff to identify stigma and related coping styles for youth who are likely to be harmed by care processes that may appear insensitive. Some youth will cope with discouragement by giving up hope and efforts to recover. Others may cope through expressions of anger and resentment directed against society and those thought to be responsible for stigmatizing them. The perceived 'enemy' may come to include parents/caregivers, teachers, peers, staff, and community professionals as well as inpatient staff. It is important for staff to identify stigma and provide care that is consonant with needs.

Discharge & Return to the Community. Leaving hospital and returning to the community is a difficult time for hospitalized youth with a majority experiencing significant stigma apprehension prior to leaving (Moses, 2011). Beliefs that mental illness and hospitals are undesirable can contribute to avoidance and acting out because of fears of returning to the community as an unsafe mentally ill person who needed to be hospitalized. This fear is not unwarranted as many children and adolescents report being targets of stigmatizing behaviours related to their mental health difficulties in the period after their discharge (Edwards et al., 2015). Addressing the possible stigmatization from peers upon a return to school or community is particularly important for older children and adolescents.

Stigmatization of Parents/Caregivers & Staff. Stigma is not restricted to children and adolescents who are admitted. Parents/caregivers can also experience the burden of stigma by way of empathy for the stigmatization of their children, when they or others see them as the causes of a child's or adolescent's problems, and when they have been diagnosed and hospitalized themselves (Hasson-Ohayon, et al. 2017). Stigmatization can also occur for professionals who work with hospitalized youth with mental illness. Individuals, and services and research in mental health may be seen to be less valuable, more likely to be targets of ridicule relative to other health providers, and less important to fund than other researchers (Heflinger & Hinshaw, 2010; Hugget et al., 2018).

Stigma Prevention & Reduction. Inpatient units need to 1) become aware of the extent to which individuals and their parents/caregivers and culture have a negative view of themselves as mentally ill persons, and a negative view of mental illness and hospitalization when they arrive on the uni (e.g., Hasson-Ohayon et al., 2017; Kaushik et al., 2017; US Department of Health and Human Services. Substance Abuse and Mental Health Services Administration (SAMHSA), 2006), and 2) provide activities and practices in place to prevent and reduce stigma, including self-stigmatization.

Unit activities are more likely to be effective are supported by explicit hospital wide drives to prevent and reduce stigma of mental illness. These activities should include a) educational videos and media to normalize and reduce stigma, b) formal collaborations on stigma reduction with schools, other community services, and youth and their parents/caregivers (DeLuca, 2019; Talbot, & Malas, 2019), US Department of Health and Human Services. (SAMHSA), 2006), c) assessment and interventions for familial patterns of stigmatization and d) strength-based (e.g., Toback, Graham-Berman, & Patel, 2016) and positive psychology to focus on hope and empowered action (e.g., Harrison, Al-Khairulla, & Kikoler, 2016).

USING POSITIVE PSYCHOLOGY

2.9 Staff use strength-based positive psychology approaches that balance the focus on problems and diagnosis.

Although the principal goal of inpatient care should be on addressing the serious problems that precipitated the admission and on contributing behaviours and mental disorders, this focus can sometimes inadvertently create a negative socioemotional focus. This focus can lead to recurrent discussion of the shortcomings of youth and families and on what they are doing wrong, rather than on strengths and what everyone is doing right. Positive psychology and strength-based approaches tend to balance this focus on deficiencies, diagnoses, and disabilities by promoting interactions that emphasize optimism, kindness, generosity, hope, humor, satisfaction, and gratitude (e.g., Fredrickson, 2001; LeBel et at., 2004; Seligman, 2002). Findings support the view that positive psychology approaches promote, at least, short-term gains in functioning (Harrison et al., 2016; Huffman et al., 2014; Johnson & Roberts, 1999). Shifting children and adolescents away from a negative and toward a more positive and hopeful attributional style is associated with improvements to depression (Joiner et al., 2005). Actions that help the shift include noticing, remembering, and then planning, writing down or listing, talking about, and taking actions that shift the balance from negative to positive mental states, emotions, and behaviours (Huffman et al., 2014). Some positive psychology activities will require accommodations for youth and youth with special needs such as taking dictation and reading back provided positive information for younger children or learning-disabled ones. The following is a list of positive psychology activities that can be used on the unit to help redress imbalances due to the focus on problems and deficiencies.

- *Thanking: Remembering and expressing (in interactions, statements, or writing) gratitude to self and/or others for 1) a past kindness or a recent one (including one from someone on the unit), 2) a recent best moment, relationships, or success.*
- *Noticing Positives. Making a list of personal strengths.*
- *Being Kind. Planning or doing one or several nice things with or for self and/or others.*
- *Daring to Hope. Writing down or telling staff about best possible future relationships and considering paths to success.*
- *Catching Joy. Catching (or remembering) positive emotions when these occur including moments of happiness and satisfaction.*

- *Forgiving & Letting Go. Remembering, noticing, or taking opportunities to forgive oneself and others.*
- *Appreciating. Noticing and reinforcing appreciation for things well done or simply appreciating oneself or others. Appreciation and of the other positive habits can involve games that keep score and include rewards for completing gratitude, kindness, hope, joy, forgiveness, and appreciation directed at self or others.*

PROVIDING COMPASSIONATE CARE

2.10 Staff provide compassionate care and promote compassionate self-care.

Compassionate care helps to make suffering more bearable and more dignified. Compassion for self and others requires being kind to self and others, appreciating the commonality of suffering as part of life, using social supports to reduce the burden of loneliness and emotional pain, and using mindful present-orientation rather than drifting into rumination, guilt, pity, and discouragement (Neff, 2003). Compassionate care is identified by its calmness, and by its soothing and reassuring interactions (Gilbert, 2009). The provision of compassionate care involved maintaining a kind attributional style rather than a primarily corrective, judgmental, or critical one. A shift towards a kinder caring style encourages change and is associated with improvements to health and well-being (Bluth & Blanton, 2015; Rueger & George, 2017). Compassionate care is helpful not only for patients, but also for providers. Mahon et al. (2017), for example, found that nurse non-judgemental self-calming and self-compassion training improved nurse ability to take care of their own needs as well as ability to be more present and more compassionate with patients. The presence of compassionate care on child and adolescent inpatient units is understudied. Although a compassionate approach is a promising one, additional research is required to identify what aspects of compassionate care are likeliest to be most helpful and in what situations.

VALUING DIVERSITY & PROMOTING INCLUSION

2.11 The unit values diversity, encourages inclusion, and protects children and adolescents from discrimination.

Marginalization & Discrimination. The main goal of inpatient care is to assess and address the problems that led to admission. These goals cannot be accomplished well or at times at all without addressing contextual factors which contribute to hospitalization and possible social opportunities to improve mental health. A history of exclusion, devaluation, and systemic discrimination is one type of contributor that can significantly increase likelihood of admission, and that is important for units to acknowledge and understand. Inpatient units should see themselves as part an imperfect system of care that has its blind spots and prejudices. It is also important for units to look for

opportunities and partnerships with culture, society, and other community groups. Many inpatients come to inpatient care from disadvantaged communities. For some of these youth, devaluation, exclusion, marginalization, and systemic discrimination are important contributors that exacerbate mental health problems and that compromise access to preventive mental health services. Youth and families who have experienced marginalization and prejudice may not trust the mental health system. Some may have difficulty communicating their needs and may have experienced futility when they did so. Many may have been unable access needed supports in ways they needed at the time they needed. Groups of inpatient children and adolescents who tend to face more challenges than others include very young children, indigenous children and adolescents, immigrants, refugees, youth who are part of the LGBTQ2SIA (lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, and asexual) allied community, those with physical and intellectual disabilities, visible minorities, youth in the foster care system, and those in the forensic system.

Cultural & Group Identity. Culture is often thought of as defining a group with similar overarching and distinguishing ethnic, racial, linguistic, religious, and national characteristics (Hall & Du Gay, 2006). Members usually have a shared view of history, and common cultural knowledge, beliefs, values, customs, norms, and conditioned emotional responses (e.g., including what is liked and what is disliked in the way of food, art, music, values, and activities) of a culture (Harris 1975; Keesing, 1981). Shared knowledge, values, preferences, and practices are acquired primarily through reinforcement in interactions, instruction, and imitation among members. Conformity is usually promoted and deviation from core norms disapproved of. Individuals are taught to distinguish members from non-members and learn to maintain, protect, and promote the group's customs, rights, and interests. Every group tends to have more committed adherents as well as some rebellious non-adherents, outliers, which include the culture's own marginalized subgroups. Most groups are exposed to the forces of enculturation around the maintenance and norms of their own cultural heritage as well as the forces of acculturation which revolve around the integration or assimilation of parts of the other diverse groups they are exposed to (Graves, 1967; Herskovitz, 1948). In its broader definitions culture can refer to groups such as those with a common street culture, music culture, gang culture and similar communities not distinguished by race, language, or ethnicity. If units are to help in the best way possible., it is important for them to understand the preferences and groups pressures that children face, as well as the risks and benefits from their group membership. More units than ever are understanding the need for specific language services, and there has been a recognition of the possible advantages of developing units to address needs of a particular cultural group (e.g., Mathews, et al., 2002). These options remain to be well studied and would have to address more issues than just culture to understand and address diversity in the most helpful way possible, and to avoid segregating patients from each other in ways that could only reinforce lack of connectedness and alienation among communities and groups. Ontario has no units of this type and generally has tried to do its best to protect and promote diversity regardless of type.

Diversity. No child or adolescent can be completely defined, and their identity understood through the lens of a single group or culture. Diversity is complex and multi-dimensional and not one-dimensional. The reduction of a patient's identity to a single group identity such as male, Asian, intellectually disabled, or white are stereotypic and can get in the way of discovering who youth

believe they are, who they identify with, and what social structures can be engaged as supports. Diversity is complex for many reasons. Some young children have one parent that speaks a one language, practices one religious, or affiliates predominantly with one ethnic group whereas their parenting partner may be part of another group. Some young people are born to parents of mixed cultural heritage. Some are immigrants and refugees who are adapting to living in a new country, and some are searching new groups to affiliate with. The way in which children and adolescents identify with different groups can focus on the language they speak (e.g., Francophone), where they were born, what religion they practice (e.g., Muslim, Jewish, Catholic), the colour of their skin, whether they consider themselves as rich or poor, their gender identity and orientation, whether they are better at academics or sport, and where they currently reside (e.g., Davies, Nutley, & Mannion, 2000; Hall, 2005, Hallman et al., 2014; Van Beek & Gerritsen, 2010). Some children and adolescents are comfortable with who they think they are and with their affiliations whereas others are conflicted, uncertain, and questioning. At the very least units should be able to welcome and validate diversity including uncertainty and do no additional harm by presuming they know more than children and families do about what is best for evolving identities and cultures.

<u>Stereotyping.</u> Stereotypes are basic cognitive processes that people use to categorize information about others. Well intentioned and hostile stereotypes, though they reduce processing load, can get in the way of understanding the complexity which individuals bring to inpatient care (e.g., Bolden & Wicks, 2005; LeFrancois, 2013a). Reductionist assumptions and stereotypes about different social groups typically underestimate diversity. Many children and adolescents have multiple heritage cultures, affiliate with many differing groups, and some will have visible characteristics that do not fit the norm of their culture of origin. Staff who do not belong to a particular group or culture or do not know it or understand it, are vulnerable to treating inpatients in stereotypic ways that can lead to misunderstandings and harm. Individuals can be stereotypes as having the same characteristics as the perceived norms of a desirable dominant or undesirable oppressive dominant group or to desirable or undesirable minorities that are weak or incapable victims. It is important for staff to understanding that stereotyping occurs and to take the time to know the individual before them so they can gather information that can be most helpful for the provision of care. Children and adolescents have very individualized and evolving beliefs about who they and others are which can only be understood through discussion and interaction. Cultural identity and preferences of children and adolescents cannot be accurately understood based on their last name, country of origin, address, visible characteristics, or parent/caregiver cultural identities. Frequency and type of stereotyping vary from hospital to hospital and stereotypes on one unit may differently significantly from those on another (e.g., Manis, Nelson, & Shedler, 1988). It is important for units to strive to know their own patterns.

<u>Opportunities</u>. The process of working effectively with diversity which includes identification of stereotyping and systemic societal problems is being increasingly recognized as important for effective child and adolescent mental health services (e.g., Pumariega & Rothe, 2003; Pumariega et al., 2013). Working with diversity requires acquiring an understanding of the many aspects of diversity, an understanding that identity is not a static rigid construct but a developmental process, an understanding of the need to explore how young people see themselves, and an understanding of the need to respect the rights of individuals to explore who they are and want to be. This includes an appreciation that some youth will be comfortable being like most individuals in their culture of

origin or affiliation groups, that others may be working to balance two or more of their cultures and groups which may have different values and customs, and some may be rejecting or withdrawing from all or most groups (Cockburn, 2002; Rudmin, 2003). Conflicted and discouraged youth may have difficulty engaging with available supports sometimes because of distrust of all groups or of groups 'not like' them. This can includes distrust of adults or men or similar. Understanding how youth see themselves can help staff to avoid naïve efforts to enculture patients in their own image. Ultimately, it is not the job of inpatient unit care providers to choose for children and adolescents who they should be and which cultures or groups they should belong to. To avoid imposing one's own culture or group identity on children, it is helpful for staff to understand their own preferences, prejudices, and stereotypes. Units should strive to help youth integrate into the unit in ways that do not assimilate who they are, that do not marginalize, that encourages respect for the youth's own identity and its development. It is also important to encourage youth the advantages of getting along with and learning from others who may be different (Yoon et al., 2013).

Staff Competencies. Cross et al., (1989) summarized staff competence related to working with diversity. According to Cross et al. (1989) staff competence includes awareness/acceptance of diversity, awareness of staff's own cultural values, understanding the dynamics of diversity in the clinical encounter, development of cultural and social knowledge important for the provision of care to different groups (including understanding peer group cultures), and the ability to effectively adapt the provision of care in response to the information acquired. Staff are best to avoid judgmentally promoting one heritage culture, religion, or one group over another particularly without insight into their own preferences, biases, and prejudices. Ideally staff should adopt a nonjudgmental balanced exploration of youth and parent/caregiver group affiliation and culture. There are times when children and adolescents may be making choices about group affiliation and culture than differ from the choices parents/caregivers in ways that lead to discord. The task of inpatient units is to have enough knowledge to support and help a young's person's search for identity without being judgemental, without taking sides with or against parents, and without presuming staff know better than youth and families about what the best affiliation and identity of a young patient should be. This includes knowledge and awareness of the many types of diversity including usually non-visible differences such as spirituality and religion which though important to many youth may be ignored (Grossoehme, 2001).

Promoting Mutual Respect. Units must sensitively help to balance personal preferences that most patient have for socializing with "those like me or us" with opportunities to engage in adaptive ways with others "not like me or us". This includes helping young people themselves to identify the harm they can cause by targeting co-patients. Staff can help provide education and encourage youth to identify their own patterns of discrimination, harassment, shaming, and exclusion and how these impact co-patients. Staff can help youth appreciate the value and benefits of engaging in behaviours that value and validate others. Psychological safety on units is more likely to occur if all discrimination on the unit is identified, addressed, and opportunities for all young people to get to know each other as unique human beings rather than through the lens of prejudice and stereotyping are provided. Nobody on a unit should fear embarrassment or shame because of who they are or want to be. This includes visitors and staff as well. Units can facilitate exploration of diverse groups that provide positive peer support and social engagement with peer support networks, cultural and religious groups, and other volunteer organizations by providing media

access, telephone contacts, and visitors representing different organizations (Lucas, 2019). Units can celebrate diversity and holidays even when no individuals from the culture may be on the unit at the time.

The sections below consider services to groups of children and adolescents at risk for misunderstandings, and in need of care that can diverge at times from what is provided to patients from majority groupings.

Very Young Children

Inpatient units should be optimally supportive of the age-related needs of all the age groups they admit (Hazell et al., 2016). This includes younger children. Children's units attempt to address these needs separately from those of adolescents and are not uncommon internationally (e.g., Kyriakopoulos et al., 2015; O'Herlihy et al., 2003). Such units are developed in ways that assure the young child has an age-appropriate peer group and a physical environment geared to their age-related interests and service needs. Young children have different attachment needs, less developed communication and assertiveness skills, greater school support needs, greater likelihood of being intimidated by adults and adolescents, and different preferences for music, play and recreation activities. They are also more likely to be admitted because of problems stemming from parental psychopathology and family chaos, likelier to have more externalizing than internalizing behavioural problems, greater likelihood of receiving psychotropic medications at the time of admission, longer lengths of stay, and need for higher staffing ratios (Dalton et al., 1987; Fite et al., 2008; Rice et al., 2014).

There are no children's units in Ontario and children are admitted on units with predominantly adolescent inpatients (Greenham & Persi, 2014). Assuring age-appropriate environments and activities on Ontario's mixed child-adolescent units can be challenging. Assurance of play for its own sake, provision of age-appropriate materials and therapeutic activities, and of access to age-appropriate television and movies may be needed but challenging to provide (Roberts et al., 2002). Ontario's mixed-age units have exceedingly small numbers of admissions of the children age 4 to 8 in contrast to the large numbers of adolescents. The result is that younger children are typically admitted alone on units populated predominantly by teens. The young child often has no same-age peer to relate to on the unit during the admission. The predominantly adolescent social and physical environments can miss the different attachment and social-recreational needs of the young child. Units which admit young children in a predominantly adolescent setting should have policies and procedures that identify and support different services based upon developmental differences. Units should provides more opportunities to engage parents/caregivers. They should provides developmentally specific training for working with younger children and consultation from professionals who are familiar with how to best provide services to that age group (e.g., pediatricians, developmental psychologists).

Indigenous Children and Adolescents

All out-of-home health care settings, including inpatient ones, should accommodate, protect, respect, and value cultural identities and provide opportunities for inpatients to maintain cultural contacts and practices (Canino & Spurlock, 2002; Hendren & Berlin, 1991). Indigenous children and adolescents are minorities in most inpatient care settings. They have a history of colonialism has left individuals at greater risk for having their cultural practices and supports overlooked and at times devalued or invalidated. Lefrancois (2013b) pointed out that out-of-home care providers may at times be unaware of the fact they can harm individuals in a cultural sense. A unit can rationalize itself as "benevolent" while inadvertently perpetuating psychiatrization, colonialism, racialization, and adultism (Lefrancois, 2013b). Culturally competent and trauma informed services are essentials of good care. Although it can be challenging for units without indigenous staff and consultants, culturally responsible care, findings suggest that culturally responsible services can nevertheless be improved and harm reduced when culture is valued and promoted (Raman et al., 2017). This includes making independent interpreters, cultural consultants, and indigenous support teams should be made available for youth and families (Fielke et al., 2009; Lucas, 2019; Pumariega et al., 2013). Diagnostic instruments which are translated or validated for the child's language and cultural group should be used and results reviewed in a culturally aware and responsible manner. In connecting children and families with services, it is important to appreciate that there may be important differences in customs and identity depending upon community and nation of origin. Differences across indigenous groups and individuals and their preferences need to be appreciated. In rural and remote areas serving indigenous and remote communities, children and families may lack road access, face road conditions that make access difficult, and experience greater cultural disruption when children and adolescents must travel far from home. Admissions decisions should consider the costs and benefits of admissions where cultural disruption, risk of alienation from the community of origin, and threat to cultural identity may occur. It is important that inpatient care should not be presumed as the only and best option from a psychological safety viewpoint. Taking the time to understand patients and their parents/caregivers as well as familiarity with their community can help identify differences and potential conflicts among the cultural aspirations of youth and their parents/caregivers as well as preferences that are important to respect. Understanding the family and the differing community contexts whether these are urban, rural, or reserve are as important to promoting health and well-being as individual disorders. Understanding the communities of origin can help care providers better determine if children and adolescents should be hospitalized and to what extent the hospitalization involves a failure to have or to access earlier community intervention and prevention. If hospitalization is an unfortunate only option it is important units collaborate with communities and government to help improve the availability and quality of culturally responsible community services.

Youth with Autism, & Intellectual Disabilities

Children and adolescents with autism, and intellectual disabilities comprise a group of individuals who are at risk of being admitted when they are likelier to be better cared for in the community. This occurs when families and community providers misunderstand chronic recurring symptoms of

autism as being a comorbid mental disorder. It also occurs when problems that are precipitated primarily by interactional stresses and parenting problems and needs for parent/caregiver respite are not identified or addressed (Mandel et al., 2012; Siegel & Gabriels, 2014). Siegel and Gabriels (2014) noted that many of the individuals with autism who come to inpatient care are facing or have already faced placement breakdown resulting in out-of-home placements (residential or group home) because of problems parents have with coping. In such cases inpatient care becomes a way to escape recurring stress. Hospitalization inappropriately focuses on symptomatology when the problems are relational. Unresolved problems with parent/caregiver coping and placement breakdown can lead to extended and unhelpful stays, delayed discharges, and bed blockages while the hospital and community look for alternative residential care for youth who cannot return home. Parent/caregiver problems and stresses are better addressed by services focusing on attachments, family resources, and prevention of imminent placement breakdown than by admission for problems that short-term inpatient stabilization and treatment will be unable to address.

After admission, children and adolescents with autism, and intellectual disabilities are more vulnerable than other groups to having their needs misunderstood, their preferences left unknown, and their requirements for social inclusion unmet. Units that do not specialize in autism may be unable to provide the psychological safety, protection of rights and dignity, and best evidence-based care for such youth because of a lack of experience and training (Lunsky et al., 2007; Kalb et al., 2017; Siegel et al., 2012; Siegel & Gabriels, 2014). Specialized inpatient units providing tertiary care supports for secondary care generic units have been reported to have better outcomes in terms of symptom reduction and readmission rates (Fueyo et al., 2015; Gabriels et al., 2012; Siegel & Gabriels, 2014; Taylor et al., 2019). Although Ontario has a non-hospital setting providing this type of residential care it does not have the capacity to admit all children and adolescents with autism and developmental disorders and most continue to be hospitalized on generic units. Youth who are admitted to generic unit are then at higher risk to experience specialized care and receive care that may be appropriate for other patients but not for them. Problems can include triggering aggression, fear, and loneliness by failing to prepare for transitions, to resource the additional time to understand needs, to provide alternative modes of communication, to consider and address sensory problems, to provide calming places, and to have processes that best integrate these young people into the social life of the milieu. Children and adolescents with autism and intellectual disabilities, no less than other patients need to be appreciated as diverse rather than as defective. They need to be included socially, and to be helped to continue to be a part rather than apart from the diverse cultures and groups on the inpatient milieu. They also have no less need than others for opportunities to affiliate with other youth with similar problems who may best understand and support them.

LGBTQ2SIA

Children and adolescents who identify as lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, gender nonconforming, or gender discordant are often at increased risk for developmental challenges and mental health problems, stigma, and prejudice. These individuals face significant mental health challenges including reduced access to mental health supports and

reduced understanding of their needs (Reisner et al., 2015; Rutherford et al., 2012). Problems with sexuality, sexual trauma, and vulnerabilities related to trauma and bullying as well as vulnerabilities related to marginalization because of identity and orientation need occur prior to admission and can continue after admission on the unit. Lefrancois (2013a) observed that, whether they mean to or not, inpatient units tend to be heteronormative in their approach to inpatient care and that there is a need for all those involved with inpatient care to identify and change this approach to one that equally rewards and values all individuals for their expressed identity. Adelson et al., (2012) described practice parameters for service provision for these groups of youth that can be applied to inpatient care. Rutherford et al., (2012) noted that with the right knowledge and commitment it could be possible for most settings and professionals to provide a safe space or positive environment for youth, but also note that most providers do not receive adequate training in LGBT2SQIA health as part of their formal training and education. Gender sensitive and safe care includes a commitment to assure freedom from harassment for all, a commitment to address youth by their preferred gender, the development of a physical environment that is accommodating (e.g., unisex private toilets), initiatives to encourage openness about needs and how the unit can accommodate these, and reduction of the risk of victimization and re-victimization (State of Victoria, Department of Health, 2011; White & Fontenot, 2019). It is important for units to continue to be aware of the research and of service improvements (Hill & Shapiro, 2017; Walton & Baker, 2017). Given the importance of connectedness and community for all vulnerable groups, efforts should be made to encourage youth to access supports from the LGBT2SQIA community and for staff to access consultants with a sound knowledge of how to best provide services to LGBT2SQIA youth.

Refugees & Immigrants

Because refugees and immigrants often have different customs and language needs it can be problematic for many units to contextualize their care in a culturally competent way that can best promote recovery and health. There are few studies of child and adolescent populations that can help inform inpatient care about which groups may be more likely to require sensitivity to past trauma or those that may require additional supports from culture-specific services, although there is some evidence that adolescents who seek asylum as refugees may be a particularly vulnerable group (e.g., Ramel et al., 2015). Refugees more so than immigrant groups are more likely to have vulnerable youth in their families who have experience war, violence, loss, and other disasters and more likely to subsequently experience high levels of isolation, compared with non-refugee peers (Hodges & Tolmac, 2005). Some immigrant groups may do better in inpatient care than others. Chiu et al., (2018,) for example, reported that Asian inpatients had shorter lengths of stay and greater improvements in mental health and functional status at discharge compared with other inpatients, and that they were also less likely to have a psychiatric readmission or die one year following hospitalization. Because of the diversity among of immigrants and refugees, units should seek support from culture-specific consultation whenever possible. Units should also seek to provide trained independent interpreters (who may act also as cultural consultants) when staff are unable to communicate children and families (Lucas, 2019; Pumariega et al., 2013). It is important to be aware of possible errors in translation from interpreters are not fully capable in the two

languages they are translating or if interpreters are linguistically but not culturally competent and inadvertently distort information in a culturally specific ways that may mislead future care (Gong-Guy, Cravens, & Patterson, 1991).

Foster Care

Children and adolescents, particularly those who are long term members of the group, can be acculturated in a 'foster care culture' which includes repeated experiences of loss and attachment instability (Mitchell, 2016). This group of hospitalized children and adolescents which includes children in foster care and group homes typically have important needs that are marked by the continuously struggle with feelings of being unwanted, the loss of family supports, and recurring placement changes. Marriot (2018) recommended that mental health providers who provide services to this group, should understand the culture of foster care and have a sound knowledge of the foster care system. Children in the foster care system are a vulnerable group with higher rates of mental disorders (McMillen et al., 2005), admissions at earlier ages, seclusion and restraint in hospital, and readmissions (Persi & Pasquali, 1999). But it is therefore exceedingly important for inpatient units to understand how the foster care context can contribute to mental disorders, confuse attachment acting out and symptoms, and how apparent mental disorders may mask more severe attachment insecurities that may be more important to address than the apparent or diagnosed disorders themselves. Hospitalization for many of these children is precipitated by imminent or occurring placement breakdowns and symptoms are secondary. Some children in the system will intentionally act out in symptomatic ways to try to escape from an unwanted foster care situation and sometimes a bid to reconnect with the family of origin. Care for this group of children needs to consider how to improve attachment stability and provide a safe base for attachment trauma work and recovery, 2) improved access to community mental health treatment in early childhood and after any inpatient admission (Fawley-King & Snowden, 2012). Inpatient care is often not the best setting for this work. Treatment foster care and intensive in-home services can be much better alternatives (McDougall, 2014; Laukkanen et al., 2013). Farmer et al. (2008) noted that although treatment foster care has the strongest empirical base of the out-of-home residential placements, it is the least frequently used.

Youth in the Forensic System

Youth in the forensic system tend to be vulnerable to acculturating to peer norms, street, and subterranean cultures that include common codes, values, preferences for activities and music, and use of dominance, intimidation, aggression, and bullying to cope (Dyson, 2013; Rodger, 2006). They have high rates of mental disorders and comorbid substance abuse, experience negative stereotyping, and marginalization (Anoshiravani et al., 2015; Fazel, Doll, & Långström, 2008; Teplin et al., 2002). They can be targets of distrust, scorn, and ridicule (e.g., "once a thief always a thief, can't be trusted") and can regularly fear others may harm them including fear of what happens with re-incarceration (Flores et al., 2018). The potential of being seen to be weak or as having mental illness by peers adds to their mental health difficulties as it gets in the way of help seeking and collaboration (Brown et al., 2019). It is important for inpatient units to identify judgmental attitudes

and stereotypes that can reduce effective helping. At the same time, staff need to be aware of how past experiences, values, and aggressive coping habits can maladaptively impact their care as well as the well-being of others on the unit. Young offenders may often impress as defiant when they are in fact frightened. If youth with such problems are to be helped by inpatient care it is important they be treated with dignity and the opportunity of discussing their current needs, reviewing past experiences without prejudice and discrimination, as well as their motivation and interests going forward. Professionals staffing Ontario's general units are usually not highly trained to provide specialist services to youth in the forensic system. Some lack the confidence to manage youth with threatening antisocial patterns of behaviour, and some dislike doing so. Staff may require specialist consultation, supervision, and managerial supports to assure best practices are provided to this group of youth and to shore up their confidence and skill.

The goal of general inpatient units unlike the goals of forensic units and detention is to address the reasons for admission and the presumed contributions from mental disorders. It is not clear how many children in detention should be receiving inpatient care instead, and how many children in general inpatient care units should be in forensic settings. Interventions for conduct problems and offending are typically better addressed by services that specialize in reducing recidivism and that provide intervention at community and family levels. Ikaheimo et al., (2013) noted that appropriately planned community services and interventions may be important for mental health in this group by providing more stable community placements and engagement. There are no low or medium security types of inpatient units for children and adolescents who have offended in Ontario and too few intensive community services, although there are residential care settings. There are forensic inpatient settings in other countries (e.g., Nadkarni et al., 2012). There is a pressing need for research to better establish whether hospital or community residential settings are most helpful and how inpatient care that is psychologically safe for young offenders and co-patients should best be provided.

PERSON-CENTRED CARE

2.12 The unit provides patient centred care that engages children and adolescents as partners in planning, care decisions, and therapeutic alliances.

Children and adolescents who already tend to feel little and less powerful than parents/caregivers and professionals, can easily be further disempowered when they are not engaged in decisions and not listened to. Discouraged and disempowered youth tend to become passive and helpless youth. In order to empower or re-empower discouraged youth to engage in their own care, some units have adopted the principle of "No Decision About Me Without Me" which encourages young people to take on more central roles in their own recovery (e.g., Baxter, 2009). The amount and type of engagement will vary with capacity and development but should always be promoted to the extent possible. For example, parent/caregiver opinions will necessarily be more likely to play a bigger role with younger children than adolescents, but active involvement to the extent possible is important regardless of age or level of disability (Kroll & Green, 1997).

Children and Adolescents as Persons. Person-centred care recognizes that the young patient is the central person in the care process and the person with the greatest potential to make effective choices that can impact mental health (Rogers, 1951). Children and adolescents are moral agents with intentions, purposes, and opinions that adults should not presume to be identical or inferior to their own (Ignatieff, 2008). Person-centred care stands in contrast to approaches where the clinician is seen to be the primary decision-maker, the one with the knowledge, and the one with the authority to impose treatment on patients. Children and adolescents are recognized as autonomous persons with a right to express their mental health needs and take part in decisions even when their wishes are at odds with those of service providers and families (Regan, Curtin, & Vorderer, 2006; United Nations General Assembly, 1989). Person-centred care encourages staff to be as responsive as possible what children have to say rather than discounting their opinions in favour of what adults around them have to say (Gondek et al., 2017; Moses, 2011). This process can be helped along by assuring young patients are made aware of who their primary care providers are on the inpatient team and how to access them (Lucas, 2019). This approach uses regular contacts and participation in case conferences to discuss costs and benefits of extending inpatient care, the concerns such as side effects and limitations of medication, prospective changes and likely outcomes, concerns, plans for discharge (Brimblecombe, Tingle, & Murrells, 2007; James & Javaloyes, 1999; Lucas, 2019). Youth who are socially anxious or verbally limited should be provided with alternative ways to communicate such as using interactive writing (Barosso, Gautam, & Members, 2017). The interactive use of a whiteboard to in the patient's room has been used to facilitate information exchanges or reminders between staff and patients (Singh et al. (2011). Most young people appreciate being treated as "equals" in terms of their personhood, they like adults to listen non-judgmentally, without lecturing, and without being closed to new ideas (Martin et al., 2006). They like care providers who are caring and understanding, who take time for them and show respect, who answer all questions, and who focus on them as persons (i.e., staff who attend to "my needs" and focus "on me") (Martin et al., 2006; van Staa, Jedeloo, & van der Stege, 2011). Emerging awareness of the potential benefits of person-centred care, includes exploring how patients themselves can be more engaged in deciding when inpatient treatment is necessary (Strand, & von Hausswolff-Juhlin, 2015).

Children & Adolescents as Partners. The earlier children are exposed to working as active responsible partners the more likely they will be to acquire long terms collaborative health care habits. Engaged partnerships with children and adolescents is generally recognized to fundamental part of treatment including in behavioural activation, collaborative problem solving, behaviour therapy, cognitive behavioural therapy, behavioural therapy, dialectical behaviour therapy and inpatient care itself (Chu et al., 2009; Green, 2006; Greene et al., 2006; Katz & Cox., 2002; Kolko & Van Hasselt, 2013; Walter et al., 2010). Nonadherence to medication, resistance to counseling, poorer outcomes and need for readmission are all more likely in the absence of a working alliance (Green et al., 2001, 2006, 2007; Hintikka et al., 2006; Jacobs et al., 2004). The strength of the therapeutic alliance has been found to predict better inpatient outcomes (Green et al., 2001; Green et al., 2007; Jacobs et al., 2004). Failures to effectively engage children and parents/caregivers as active partners in the process of recovery can contribute to resistance, discouragement, and more passive service recipient roles wherein children and parents/caregivers (Hepper, Weaver, & Rose, 2005). Although therapeutic alliance has been found to be important

on units with stays measured in months, it will be important to clarify the extent to which alliance and motivation are as important on brief stay crisis units with median stays of 4 to 8 days or so. It is not clear the extent to which interpersonal trust which is important to a working alliance can be developed for children who are admitted involuntarily on a very brief basis.

SAFEWARDS

2.13 The unit utilizes 'Safewards' or a similar integrated and structured approach to optimally engage children and adolescents as partners in care.

'Safewards' is an integrated and well-structured care process that promotes person-centred care, psychological safety, and patient engagement. It has been trialed with promising results on both adult and adolescent units (Bowers et al., 2015; Fletcher et al., 2017; Hottinen et al., 2019). Integrated structured processes can lead to more efficient and consistent practice if they are flexible enough to accommodate care for different age groups, different participation and communicational skills, and different cultural needs. Promising components of Safewards include (1) discussing and posting standards for physically and psychologically safe behaviours which are developed by and for patients and staff, (2) displaying notifications about how to handle conflicts and flashpoints for all to see in the nursing office and changing these as situations change every few days, (3) having a de-escalation process led by one or more of the staff who are most effective at prevention and de-escalation and who can help support novice and anxious staff, (4) saying something good about each patient at shift handover and case conferences (see also positive psychology section), (5) being alert for rejection, loss and other bad news a patient might receive from friends, relatives or staff, and intervening promptly, (6) sharing of personal information between staff and patients (e.g. music preferences, favourite films and sports) through a 'know each other' folder kept in the patients day room; (7) having a weekly patient meeting to bolster, formalize and intensify mutually supportive patient interactions, (8) providing a crate of distraction and sensory modulation tools or spaces for agitated patients (stress toys, mp3 players with soothing music, light displays, textured blankets, (9) responding with reassuring explanations to all patients following stressful and frightening incidents, and (10) displaying of positive messages about the ward from discharged patients (Bowers et al., 2015). One of the desirable qualities Safewards is that it encourages the sharing of responsibility for the psychological and physical safety of the unit among staff and patients in ways that recognize the potential of patients to contribute to their well-being and that of co-patients.

WORKING MOTIVATIONALLY

2.14 Staff assess what motivates children and adolescents and work in a way that reduces resistance and improves collaboration.

Low Motivation. Youth who are not motivated to change their problematic behaviours are more likely to be admitted to inpatient care (Ametller et al., 2005) and less likely to successfully complete

their inpatient treatment (Callaghan et al., 2005). Different disorders, disturbed family process, and past treatment failures can all contribute to reduced motivation. Some youth will be less motivated to make healthy changes, and others will be resistant to working with health care providers, often because of prior negative experiences with the heath care system.

Understanding what children want is more important than knowing what they should want. What It can be easy to confuse what adults think children and adolescents should want with what children and adolescents do want. Staff who adopt such viewpoints tend to try to convince youth about what they should want and often find themselves frustrated when youth are resistant or hold on to their own sometimes unhealthy habits and goals. Adult positions that convey that staff know best and that what children think is not as or more important can alienate young patients. Staff reactions can then lead to unhelpful separations of patients into "motivated" "good patients", and "unmotivated" "bad patients". This categorization is founded in institutionalized beliefs that a "good patient" is a compliant one that follows doctor's orders and a "bad one" challenges the rules. This assumption can significantly threaten recovery by making compliance rather than recovery the principal goal for discharge. Understanding and addressing the reasons why patients may be resistant and what they want to change is much likelier to be more helpful particularly for youth with more severe problems who are also less able or ready to change in the directions staff hope.

Coping with discouraging, unmotivated, and defiant starts to care. Approaches to care need to be different when a young person is highly motivated to address their problems than when if they feel they were forced or coerced to come to inpatient care. Most of the youth in Ontario come to inpatient care involuntarily although some may be indifferent or may be agreeable to some extent. A good number come immediately after conflicts with adult authority figures like parents/caregivers, police, or teachers which makes some of them unready to seek or accept help from inpatient providers who they perceive to be the "enemy". Many will bluntly state that they don't want to be in hospital, that it was not their idea, and that their primary motivation is to leave as soon as possible (Salamone-Violi, Chur-Hansen, & Winefield, 2015). Parents/caregivers and partner professionals in the community may expect and demand that providers convince youth to want to cooperate and that lack of motivation is part of their problem or their main problem. Threats of continued stay on hospital are not known to shift motivation in the longer term although some youth have been known to say the right things and to become compliant temporarily so they can leave the hospital as soon as possible. Some youth can also "play the game" and agree to attend counseling and take medication with no intention of continuing to do so after re-gaining freedom of choice after their discharge. Parent/caregiver and community provider pressures to keep youth in inpatient care until they are more collaborative, though well intentioned may result only in blocking beds and increasing distrust and resistance to change rather than contributing to longer term health.

Parents/Caregivers and Community Partners. Assessment should include the evaluation of the readiness of parents/caregivers, community supports, teachers to support change and participate as partners in treatment. Parents/caregivers may be motivated to seek relief from their own emotional distress or problems by having a child admitted but not to participate in services. Community professionals may be motivated to support an admission because of fears that a child may commit suicide or become severely ill and feelings they cannot cope but may be hesitant to

see a risky patient post-discharge. Understanding what motivates children and of adults around them, and their readiness to change and provide supports allows the development of a more accurate clinical picture, a more effective plan of care, and some groundwork for common understanding. As with issues related to diversity and prevention of discrimination it is important that staff are aware of their own motivation so they can position themselves effectively. To be effective staff cannot act in ways that undermine the responsibilities and motivation of patients, staff, and community partners by either not working hard enough for change or working too hard.

Distinguishing Motivation for Change from Motivation for Engage in Treatment. Taking the time to get to know young patients can help inform staff about needs to adapt their approaches depending upon whether youth are motivated for both change and treatment provided by professionals, motivated for one and not the other, or motivated for engaging with neither. Although the two are often confused as being the same, it is important to distinguish motivation for change from motivation for treatment (DiClemente,1999). Staff can work more effectively if they know whether a young person wants help or prefers to help themselves. Some individuals may be unmotivated to seek or accept help from a professional but may be very interested in change using informal help paths relying on mentors (e.g., coaches, teachers) or self-help types of interventions (e.g., Freyer-Adam et al., 2008).

Working Motivationally. A number of units in Ontario have indicated they provide training in the transtheoretical and motivational interviewing models of change which are directed at understanding and enhancing patient motivation (Geller et al., 2008; Miller & Rollnick, 2002; Norcross, Krebs, & Prochaska, 2011). The transtheoretical model provides a structure to understand readiness for change (Norcross, Krebs, & Prochaska, 2011). Readiness is conceptualized as involving through a series of motivational states that range from precontemplation, contemplation, preparation, action, and maintenance (Norcross et al., 2011). Working motivationally in the transtheoretical model involves 1) Identifying the stage of change for a collaboratively discussed target goal, 2) avoiding the presumption that all children and adolescents want to or are ready to change for the target goal even though they may say so or their families may say they are, 3) setting a series of objectives that allow moving one stage at a time, 4) meeting the young person where the patient is at, and not pushing or rushing change prematurely, 5) using the interactional methods that work best at each different stages (e.g., awareness and cost-benefit of change discussions earlier, and stimulus control and conditioning for later), and 6) anticipating that setbacks will occur and providing supports that maintain motivation and avoid shame of failure (Norcross et al., (2011). Motivational interviewing is a counselling method that complements the transtheoretical model and that strives to enhance motivation by resisting the 'righting reflex' or the urge to fix things for the patient, understanding the patient's own motivations, actively listening to the patient with empathy; and helping the patient develop self-efficacy (i.e., confidence and beliefs they can make a difference and can be successful). Motivational interviewing has been used in child and adolescent mental health care and has been found to lead to improvements in the healthy behaviours of incarcerated adolescents with substance abuse (Stein et al, 2006), inpatient adolescents with chemical dependency (Collier et al., 2001), inpatient adolescents with suicidal risk who use alcohol (O'Brien et al., 2017), and inpatient youth with anorexia (Wade et al., 2009). Although more research is required, motivational

interviewing shows promise in helping young people to adhere to safety plans and to feel more confident (Czyz, King, & Biermann, 2019). Inpatients appear to respond better to a motivational interviewing approaches than to advice (Brown et al., 2009; Colby et al., 1998). Other approaches that use similar intervention strategies as those of motivational interviewing appear to be as successful. Van der Helm et al. (2009), for example found that an open group climate where staff promote meaningful interpersonal contact, mutual respect and trust, autonomy, equality, responsibility, and feelings of safety, enhanced treatment motivation and internal locus of control was also successful.

The role of self-efficacy. Confidence and self-efficacy as mentioned above are intrinsic parts of motivation for change. When young people believe there is nothing they can do, and that they will not succeed even if they try, their effort and therapeutic collaboration suffer. For example, more frequent purging behaviours are associated with lower self-efficacy for normative eating in adolescents in partial hospitalization or inpatient care (Ackard et all., (2011), and reduced length of abstinence for substance abusing youth (Ramo, Myers, & Brown., 2010). Lower self-efficacy is associated with development of depression (Frank et al., 1997). Lower self-efficacy in parents has also been associated with increased likelihood of admission to inpatient care (Holland et al., 2011), and in lower likelihood of engaging suicide prevention activities relative to parents with high self-efficacy (Czyz et al., 2018). Self-efficacy is an individual's belief in his or her capacity to succeed in performing behaviours required to meet target goals (Bandura, 1977). Discouraged parents and youth who lack confidence in their ability to cope may underestimate their competence and react in ways that increase rather than decrease their stress and symptoms. Many young inpatients, particularly those with repeated admission, will have become discouraged and may lost faith in themselves and in the ability of others to provide help. Many will have made attempts to change which may have been frustrated by others in their social environments or which may have been unsuccessful because of lack of knowledge or insufficient habit development. Clearly it is important to know when young individuals are ready and willing, but feel unable to change (Kelly, Myers, & Brown, 2000). Other inpatients may have received counseling or medication that did not help or that was premature given their stage of change. Setting up small steps that are more likely to end in success, highlighting small victories in past or present, and believing in the young person's competence can improve confidence and willingness to engage in inpatient recovery whether through self-help or supportive care (Delaney, 2006). Improving confidence and self-efficacy is as important for engaging youth collaboration as it is for engaging their sometimes discouraged and anxious parents (Czyz et al., 2018). Increases in self-efficacy have been found to improve health care outcomes. For example, increased self-efficacy has been found to predict improvements in substance abuse at several months after inpatient discharge (Kelly et al., 2012).

ENGAGING PARENTS/CAREGIVERS & FAMILY

2.15 The unit respects the important roles and responsibilities of parents/caregivers and engages them in planning, decisions, and care.

Engaging Parents/Caregivers. Parents/caregivers are difficult to engage and partnership unlikely if parents feel their culture is being disparaged, their parenting judged, and their rights and roles as parents discounted by inpatient providers. Unhelpful negative evaluations are sometimes mutual among parents/caregivers and staff. For example, parental reports of being poorly understood by staff have been found to correlate with staff rating of parental hostility (Green et al, 2001). Criticisms and negative evaluations by staff risk increasing parent/caregiver feelings of inadequacy, devaluation, blame, guilt, and discouragement in ways that further compromise care (Green, 1994; Gross & Goldin, 2008). Parents/caregivers and unit staff may both fall into defensiveness that blames the other, and after some time units can become entrenched in a 'culture of blame'. Parents/caregivers may come to increasingly blame staff for negligence, poor care, wrong-headed decision making, lack of understanding, and unsuitable facilities. If parents/caregivers are to be partners, it is important that they come to feel psychologically safe and able to discuss their concerns and staff concerns without hostility and blame. Parents/caregivers need to feel like their rights and roles are being respected, they need to feel they are being adequately included and informed, they need to feel their dignity is being protected, they need to feel like their voices are being heard, and they need to believe their needs, concerns, and problems are being understood and addressed. Staff too need similar respect. Good family work is important on units and requires both time and opportunities to develop skills through experience, training, and supervision. It is not surprising that the provision of opportunities for parent/caregiver engagement and collaboration (under conditions of appropriate consent) has been proposed to be a basic standard of inpatient care (Mental Health Commission of Canada, 2012; Lucas, 2019). The need for such a standard is supported by findings that parent/caregiver inclusion and engagement promote improved outcomes (Blotcky et al., 1984; Brinkmeyer et al., 2004; DeSisto & Koltz, 1985; Gosset, 1988; Jacobs et al., 2004), greater satisfaction with care (Brinkmeyer et al., 2014; Kazdin, 1989), and broadened scope to address attachment and placement stability (e.g., Parmalee et al., 1994).

Appreciating Parental Needs & Expectations. The circumstance around admission often cause parents/caregivers to become fearful for their children, to blame themselves, to become frustrated and discouraged with services, to worry about whether hospital and services will help, to become highly sensitive to corrections or criticism from inpatient staff, and not notice they are not taking care of themselves (Delaney & Engels-Scianna, 1996; Geraghty et al. 2011; Mohr & Regan-Kubinski, 2001; Santacroce, 2003; Scharer & Jones, 2004; Snell et al., 2010). Staff may inadvertently minimize parent/caregiver concerns and not have or make the time to work through differences of opinions that are the causes of frustration and distress (Gibson, 1995). Positive respectful interactions with staff who take the time to listen and support will help reassure parents/caregivers and improve mutual trust, whereas interactions with dismissive, overly busy, and inattentive staff will heighten anxiety and distrust (Scharer & Jones, 2004). The challenge for units is to assure that staff are provided with enough time is allocated to parent-staff interactions to address concerns, to promote partnerships, and to assure satisfaction with care, and better outcomes. Parents/caregivers tend to express that time to talk with staff is something they value and want (Demmitt & Joanning, 1998). It is unfortunate that a significant number of studies have reported that units do not make the time to discuss the admission, to adequately inform

parents/caregivers, and to reassure them (Akin et al., 2010; Hepper et al., 2005; Ronzoni & Dogra, 2012; Tonge et al., 2008).

Keeping Parents/Caregivers Informed & Engaged in Assessment, Planning, and Treatment. Good information flow is essential for building trust and partnership. As part of routine practice the unit should routinely notify parents/caregivers of any emergency admission (under conditions of appropriate consent) and parents/caregivers should partner in non-emergent treatment admissions. The unit should have an interview with parents within a minimum of 48 hours of admission to discuss concerns, help with assessment, and discuss some of their own needs (Lucas, 2019). While most units tend to report they involve parents/caregivers in their care planning this involvement can be limited as only a minority engage them in developing the treatment plan itself (Allen, Pires, & Brown, 2010).

Addressing Unrealistic Expectations & Mistaken Beliefs. Emergency departments and community mental health services should provide accurate information about the potential costs and benefits of admission in their contacts with parents/caregivers. This will require less "selling" of admissions and more willingness to suffer through discussions of possible enduring illness and possible harms from admission. Many parents/caregivers and some community providers can have inaccurate exaggerated beliefs about the efficacy or superior value of inpatient medical over community-based, parenting, and behavioural treatments which should be addressed (Akin et al, 2010; Carbray & Pitula, 1991). Parents/caregivers, particularly those with no prior admissions may expect that inpatient units will make large and lasting behavioral change (e.g., after discharge, the child will follow our rules or talk to us when upset) (Delaney & Engels-Scianna). Many parents are therefore disappointed when a child's behaviour falls short of their expectations and particularly disappointed after discharge and particularly when a readmission occurs. Unlike first-time users who may have higher expectations of care, parents/caregivers of children experiencing repeated admissions may have more accurate although at times, less hopeful expectations which will also need to be addressed (Reder & Fredman, 1996). Across the course of care some parents will tend to reduce unrealistic beliefs and become more accepting and appreciative of the efforts and limits of what inpatient care can achieve (Akin et al., 2010; Scharer & Jones, 2004). Units which take more time contract and admission, and to discuss mutual expectations. treatment expectations are not met are significantly more likely to prematurely terminate services (e.g., Plunkett, 1984)

Clarifying Roles. The provision of clear standardized expectations for the roles of parents/caregivers during care are generally well accepted (Lakeman, 2008) and parents/guardians are usually best engaged when they and the unit have a clearly identified roles with well-defined responsibilities during care (Byalin, 1990). The unit should support parents/caregivers before (to prepare), during (to understand and contribute) and after (to feedback outcomes) planning and progress review meetings and help with transportation and scheduling that accommodate parent/caregiver work obligations (Gross & Goldin, 2008; Lucas, 2019; Sharrock et al. 2013). Staff need to make time to discuss information, fears, concerns, preferences, roles, and decision-making control (Coyne, 2006). Work schedules, infants at home, illness, time-constraints, and discord among parents, can make it difficult to engage parents.

Flexible scheduling, listening, empathy, and support can help parents/caregivers who may have become discouraged, helpless, and hopeless recover a sense of hope.

Reconciliations. The unit should assesses the family for isolation and alienation from community mental health services, from child welfare and protection services, and other services and facilitate collaboration and reconciliation. Units can help families regain insights into how certain systemic and familial factors can be harmful and beneficial. The unit and family can discuss normative familial or cultural behaviours, including those that may have contributed to mistaken mislabeling of behaviours which deviate from normative family, culture, or institutional control as mental illness (LeFrançois, 2013b). Units can help assess for divergent opinions about needs among parents/caregivers and youth, and then explore how to safely and effectively engage both youth and their parents/caregivers as a family team with the unit and community helpers (Ahmann & Johnson, 2000).

Child Abuse & Neglect. In situations where a child has been removed from a home, or is subject to a protection order while on the unit because of child abuse or neglect it nevertheless remains important for the unit to work with the new foster parents, group homes, or other recently assigned caregivers, as well as with the prior parents/caregivers to the extent that is possible and helpful.

Family Units. There are units where family-centred care, rather than person-centred care is the focus. This exception occurs on inpatient units that admit entire families and the family and not the child is the patient or client. These admissions tend to focus as much on the problems of parents/caregivers as those of their children. Ontario has no family inpatient units, which means retaining the focus on the young person, on the young person's care, with the needs and wishes of parents/caregivers being the essential context.

Retaining a Focus on the Child. Working with parents does not imply that what children and adolescents have to say needs to be diminished. Parents should be engaged in a way that nevertheless is able to maintain a common focus on the child or adolescent as the formal and legal patient, and the individual with the greatest potential to make healthy choices and changes. This focus helps to assure child and adolescent expressed needs and preferences are not disregarded or diminished in their importance relative to what may impress as more credible and authoritative professional and parent/caregiver preferences (Youngstrom et al., 2011).

ENGAGING COMMUNITY PARTNERS

2.16 Unit staff engages community service providers as partners from the beginning to the end of care.

The Importance of Mental Health Service Partners. If units are to be an integrated part of the broader mental health system, rather than a stand-alone service, it is essential that they do their part to engage in respectful and appreciative ways with all the young person's service partners. Integrated and shared structures and processes with service partners disruptions such as misunderstandings, and failure to assure continuity of care goals and processes (Crofts & Hipkiss,

2014). Units need to have interagency agreements in place which include descriptions how gaps in services, service transitions, and interagency problems are to be managed (Stagi et al., 2015). Having similar processes and information among helpers promotes better informed admission decisions, better integration of previous assessment and treatment information, more informed inpatient care, and greater likelihood of good discharge planning and post-discharge care. Corollary information from community partners and other sources help reassure units they are accurate in their assessment and targeting the right goals for care or treatment (Youngstrom et al., 2011). Working with the youth, parents/caregivers and community mental health teams across the period of admission can better help to support the generalisation of any newly acquired or restored coping skills during admission, during passes, and post-discharge (Gill, Butler, & Pistrang, 2016).

Engaging Partner Services. The unit should contact and engage services partners as soon as possible and certainly before discharge even in cases of ultra-brief stays. The inpatient team should routinely invite a community team representative to attend and contribute to relevant information exchanges, planning, and progress meetings (Lucas, 2019). Starting the discharge planning with community follow-up providers and starting community service contacts prior to discharge can all contribute better transition and engagement with community services. Collaborative discharge planning that engages youth, family, existing and new service, and inpatient unit staff can help prevent interruptions to care, misunderstandings, and working at cross-purposes.

Reconciliation. Continuity of care suffers when parents become estranged from community providers and do not want to work with them. Similar continuity of care problems arise when community providers become upset with aggressive or disengaged parents/caregivers or youth and distance themselves. The unit needs to work in a context that recognizes the primary roles of parents/caregivers, and community services. Parents/caregivers and community providers are the more important longer-term supports for children and adolescents. Their collaboration and engagement, and not the collaboration with inpatient services, need to be recognized as the more important condition for recovery. Inpatient assessment should strive to understand how estrangement has developed, how it is being maintained, and how it can be reduced. In cases where the ability to work together has been eroded, unit care providers (often the case managers on the unit) should consider if and how reconciliation can be achieved, and a new more trusting relationship developed. Assessment should include assessment of the readiness for contact and for a meeting among alienated families and services. When families and partners are willing, units can help facilitate meetings and discussions that can resolve past problems and re-establish trust. At these meetings, the unit can provide a context that respects both parents and partner professionals.

PROVIDING TRAUMA INFORMED CARE

2.17 The unit provides trauma informed care.

Why is Trauma Awareness Important? Trauma awareness is essential for individuals working with children and adolescents on inpatient units. Severe stress and trauma are important contributors

to risky behaviours that precipitate admissions. The critical roles of stress and trauma are not always identified and addressed. Reasons for admissions includes contributions from stress-linked adjustment disorder, acute stress disorder, and more severe and lasting post-traumatic stress disorders. Studies report that between 46% to 96% of child and adolescent inpatients have been exposed to severely stressful and traumatizing types of events and that from 19% to 32% meet criteria for PTSD (Belivanaki, 2017; Gudiño et al., 2014; Lipschitz et al., 1999). O'Herlihy et al, (2004) found that in their sample of all units in England and Wales, many youth reported severe stressors such as physical (22% of admissions), sexual (23%) and emotional (38%) abuse. This is important because youth have been abused and traumatized are significantly more likely to be suicidal, depressed, and dissociative (Lipschitz et al., 1999) and to suffer from other comorbid disorders (Belivanaki, 2017; Lipschitz et al., 1999).

Trauma Informed Care is Not Just About Trauma. Trauma informed care appreciates that inpatient youth are more likely as a group to have experienced severely stressful, abusive, and traumatic experiences. Some of these experiences will not have resulted in post traumatic disorder but are nevertheless essential to assess and address as they can nevertheless be central contributors to admission. Stress can cause stress disorders and cause other disorders to worsen or relapse. Stress can lead to acting out at home and school and then to admission. Stresses which cause adjustment problems as well as trauma can be acute or chronic, can be current or past, can be experienced directly or by proxy, and can occur in individual or familial, intergenerational, community, or sociocultural contexts. Precipitants of adjustment reactions and trauma include sexual and physical abuse, serious medical procedures, and problems (e.g., Rees et al., 2004), loss of pets, friends or family, automobile accidents (e.g., Stallard, Velleman, & Baldwin, 1998), sports injuries, animal bites, threats of muggings, witnessing violence (Berkowitz, Stover, & Marans, 2011), and having a psychotic episode or other frightening symptoms (e.g., Jackson et al., 2004). Although exposure to severe stressors is common in inpatient groups, it has been suggested that stress-linked problems and trauma are under-diagnosed and that the numbers of patients these problems are significantly higher than current estimates suggest (Belivanaki, et al., 2017; Havens et al., 2012). Havens et al. (2012), for example, noted a large discrepancy between rates of probable PTSD identified through standardized assessment relative to the emergency department psychiatric evaluation (28.6% vs. 2.2%) (although this may be a function of the methods of measurement with standardized measure tending to be more sensitive).

Awareness of Trauma Activation. Reactions to hospitalization are difficult to predict because while many will find admission to be acutely stressful there are some youth who will welcome the admission as an escape from even more stressful situations. For certain youth, traumatic activation may begin at admission or in Emergency Departments with feelings of loss of control. Others may react later with feelings of worthlessness and devaluation when faced with restrictions and separations from familiar supports (Haynes, Eivors, & Crossley, 2011). Some may have traumatic activation after finding they are unable to use their usual coping mechanisms such as regular texting and internet chats with friends. For a few, admission will be experienced as just another discouraging placement breakdown, which is just the latest in a series of failed placements in group homes, foster homes, and residential care. Events such search procedures, locked doors, exposure to sexualized, aggressive, and self-harming co-patient behaviours, and the use of

seclusion and restraint can all contribute to stress and trauma (Muskett, 2014). It is easy to confuse traumatic reactions with defiance. But youth who have been bullied or physically abused can become self-protectively angry and aggressive as they re-live past experiences of shame and loss of control. Not surprisingly, Comas et al. (2014) found that youth with a trauma history required longer stays particularly when they also had emotional dysregulation and intensely negative emotions.

Trauma Informed Inpatient Care. Out-of-home settings should ideally be places of sanctuary where young people can go to recover rather than simply places of containment where they can suffer emotional harm (Bloom, 2005). For units to provide sanctuary they need to focus on improving individual strengths, improving attachment interactions among family members, family and unit staff, and increasing use of praise and positive reinforcement. They need to develop trust, to provide frequent staff supportive interactions, to provide opportunities to partner in the development of rules and activities, to collaborate on safety plans, to increase knowledge, to develop habits to best manage memories, sensation, emotions, thoughts, situations and thoughts, and to teach self-calming skills to better manage crises (e.g., art, music and calming sensory activities like aromatherapy) (Arthur et al., 2013; Bryson et al., 2017; Kinniburgh et al., 201). Trauma informed inpatient care is an approach that recognizes the important of stress and trauma and the need for care providers to know about the neurobiological, psychological, and social effects of severe stress and the many varied ways that trauma can arise and manifest. Trauma informed inpatient care appreciates that many children and adolescents as well as staff members may have suffered, be suffering, or be vulnerable to suffering trauma. and stress-related difficulties before, during, and after an admission. Trauma informed care provided during an admission can help reduce incidents that can traumatize or re-traumatize youth and can help protect staff as well.

Preventing Need to Use Seclusion & Restraint. Central to the approach is an appreciation that inpatient environments that rely excessively on the use of seclusion and restraint tend to create a climate that increases probability of traumatizing and re-traumatizing those involved (Bloom, 2005). Although Paterson et al. (2013) asserted that the need to use restraint should be seen not so much as inevitable last resorts but as a treatment failure, reducing restraints and restrictions can be difficult because of both entrenched individual attitudes and service cultures. Happell and Koehn (2010), for example, reported that while most inpatient nurses regret using seclusion, almost half held on to questionable beliefs that patients feel safe and relieved after being secluded. Nurses also face systemic pressures. On one hand, they face pressure to enforce unit rules that can trigger escalation and restraint, while on the other hand, being expected to reduce seclusion and restraint. Such dilemmas are not easily resolvable. They often will supportive consultation and supervision as well as organizational commitments to change (Regan, 2010). Trauma informed care promotes the view that seclusion and restraint can be reduced and prevented (Azeem et al., 2011).

Trauma Informed Care & Treatment. It is important to distinguish therapies designed to reduce symptoms of trauma from care that seeks to provide a safe and healing context that manages current symptoms effectively. Trauma-specific' treatments in contrast to trauma informed care, more usually refer to therapies for specific trauma symptoms. Treatment unlike care, is usually provided by practitioners with specialist skills using protocol-driven therapies that target longer term

reduction of symptoms and not only stabilization. These stress and trauma specific therapies usually include grounding techniques which help trauma survivors manage dissociative symptoms, as well as exposure, acceptance, and desensitization which help to render painful images more tolerable and improve behavioral skills for the modulation of powerful emotions. Brief stay crisis will often not keep patients long enough to complete a protocol driven treatment. Regardless of whether inpatient admission includes longer treatment provided by inpatient therapists or brief crisis stabilization, both types of inpatient service can include common principles. Examples of protocol-driven treatments which include trauma-focused principles include Trauma Focused Cognitive Behavioral Therapy (Mannarino, Cohen, & Deblinger, 2014), Collaborative Problem Solving (Holmes, Stokes, & Gathright, 2014), and Dialectical Behavior Therapy (Brown & Dahlin, 2017).

Inpatient Applications. Elliott et al. (2005) suggest that trauma informed care should be utilized with all patients, because inpatient providers have no way of knowing which inpatients may have an undisclosed history of severe stress, and also because the admission and inpatient processes may themselves cause stress reactions and trauma. Trauma informed approaches strive to normalize and prevent need for hospitalization and readmission, and to reduce or eliminate need for seclusion and restraint in inpatient care, and to reduce medication use so that is more in line with what is for non-traumatized psychiatrically hospitalized children (Bryson et al., 2017; Keeshin et al., 2013, Muskett, 2014). Although the goal is to prevent seclusion and restraint, trauma informed care appreciates that there may be rare occasions when prevention is not possible. In such cases unit need to provide opportunities for debriefing with clients. Debriefing increases opportunities to recover from incidents, increases opportunities for collaboration in resolution and prevention, and increases opportunities to re-establish damaged therapeutic relationship. Units can access self-audit tools available that can help promote knowledge transfer about trauma informed approaches to inpatient settings (e.g., Fallot & Harris, 2002; Lang, Campbell, & Vanderploeg, 2015; Hummer et al., 2010).

Benefits. Boel-Studt, et al., (2017) noted that trauma-informed psychiatric residential treatment for children and adolescents resulted in greater improvements in functional impairment relative to typical residential treatment, with youth experiencing fewer seclusion room incidents, lower lengths of stay, and less restrictive post-discharge placements. Elwyn, Esaki, and Smith (2015) reported that their residential facility was a safer place for both residents and staff after implementation of the Sanctuary Model type of trauma-informed intervention.

Postvention. No unit is perfectly safe. Acutely stressful and traumatic events can and do happen. When these events occur, it is important that youth, parents/caregivers and staff on inpatient units debrief and work through the incidents and not become alienated from each other. Incidents include experiences of seclusion and restraint. They also include experiences such as witnessing self-harm, engaging in self-harm, and being subject to physical and sexual assault from other patients. Analyses of the root causes and contributors to incidents is an additional essential safety practice. One of the most traumatizing evens is the completed suicide of a co-patient. Most of literature on postvention for inpatient units is from the adult services and focuses on postvention for suicide (e.g., Vogel, Wolfersdorf, & Wurst, 2001). The Mental Health Commission of Canada

Website has some tools and ideas on its website for suicide postvention (https://www.mentalhealthcommission.ca/English/initiatives/11889/tool-kit-survivors-suicide-loss-and-postvention-professionals).

PROVIDING ATTACHMENT SUPPORTIVE CARE

2.18 The unit provides attachment supportive care.

Attachment for Survival. Attachment is a deep and enduring emotional bond that connects one person to another person, to a group, or to loved pets or objects across space and time. Attachment is essential for survival. It promotes protection from parents and affiliation groups and modulates the stress response (Luyten & Fonagy, 2018). Although attachment theory initially focused on mother-child bonds it has since been extended to recognize the importance of attachments with other caregivers, with culture and community, with friends, with romantic partners, and with one's own offspring later in life (Ainsworth et al., 1978; Berry & Drake, 2010; Bowlby 1982; Dubois-Comtois et al., 2013; Fraley & Roisman, 2019; Greenberg & Johnson, 1988; Hazan & Shaver, 1987). An exclusive focus on presenting problems, diagnoses, and medication may altogether miss the role of attachment needs in admission and for mental health (Bucci et al., 2015).

Secure and Insecure Attachments. Secure attachment provides resilience in the face of stress (Jardin et al., 2017). A securely attached individual can be equally successful playing and working alone and as part of the inpatient social fabric. Although other developmental periods are also important, infancy is a seminal time for developing secure attachment. Infants acquire feelings of security by learning that the attachment figure can be relied upon in times of hardship which allows the infant to leave the caregiver to explore the environment and to return for comfort and support as needed (Ainsworth et al., 1978; Bowlby 1982). On the other hand, children who have been raised in unsafe, insecure, or chaotic environments develop maladaptive coping mechanisms in response to anticipated and ongoing attachment hurts and threats. Some of these children will learn to escalate the expression of their emotional distress to pressure their caregivers to meet their attachment needs. This results in an insecure ambivalent or anxious type of attachment style (Shaver & Mikulincer, 2002). Others will learn that their protests are not helpful and will suppress their attachment needs. This results in insecure avoidant or dismissing attachment style (Shaver & Mikulincer, 2002). Some who have been exposed to severe attachment hurts such as abuse will develop a chaotic, disorganized, and labile emotional style. Attachment trauma, and insecure and disorganized types of attachment are associated not only with problematic relational behaviours in inpatients but also with suicidal ideation (Diamond et al., 2010; DiFilippo & Overholser, 2000), anxiety and depression (Goodman, Stroh, & Valdez, 2012), vulnerability to becoming defensive and volatile when criticized, ignored, or feeling rejected (Allen et al, 1996), and with disturbances in mentalization and development of borderline traits (Luyten & Fonagy, 2018), and poorer physical health and brain development (Luyten & Fonagy, 2018). Although early attachment patterns can change for the better or worse depending on later life experiences, early patterns can also become relatively fixed and insecure behaviours can continue well into adulthood (Allen, Hauser, & Borman-

Spurrell, 1996). Attachment problems can continue across the lifespan and across generations. Rosenstein & Horowitz (1996) noted that insecure adolescent and maternal attachment types were highly correlated suggesting a need to aware of the sensitivity to rection and insecurities of both admitted children and their parents.

Attachment Problems of Inpatients. Many children and adolescents who are admitted to inpatient care have had interrupted attachments, disturbed, and conflicted family relationships, and attachment trauma (Adam, 1996; Allen et al., 1996; Lampen & Neil, 1985; Nielsen et al., 1985). This is particularly true of inpatient children and adolescents in the foster care and child welfare system. Many of the children and adolescents in this system will have previously experienced disruptions to attachments and contacts with parents, siblings, aunts and uncles, grandparents, and foster parents (Mitchell, 2016). Some will precipitate an admission by acting out to escape stressful home or foster care when they feel emotionally abused, rejected, or unwanted.
Children and adolescents will bring their attachment history, attachment needs, and attachment styles when they come to inpatient care. Prior to and after admission, youth will tend to engage with staff and co-patients in ways that are consonant with their attachment history. Attachment problems on the unit are quite varied and need to be understood if the best care is to be provided. For example, a few adolescents will deliberately act out to precipitate admission to find or follow friends into hospital, to meet romantic partners, or to receive attachment support from caring professionals when they are unable to find such support at home or school. The unit should be aware that most inpatient adolescents report having been victims of dating violence (Rizzo et al., 2010). Problems with boundaries can arise among youth with such a history and some will be more vulnerable to feeling overwhelmed and harassed. The sexual safety of all their patients, with attention to the more vulnerable is important to assure. Inpatient units with vulnerable patients are better to have rules of no physical interactions such as handholding and hugging in the interests of providing as safe a psychological environment as possible (Ford et al., 2003). Certain adolescents will develop rapid romantic attachments to co-patients during a time when both are emotionally vulnerable and likely to regret sexualizes behaviours at later points. Although such situations are rate, attachment problems also inevitably arise for admissions where one or both partners have intentionally precipitated an admission to be together.

Attachment Styles in Inpatient Care. The attachment styles of youth are important contributors to behaviours prior to admission and during inpatient care (Phillips et al., 2019). Youth with an avoidant/dismissing attachment style, for example may find it difficult to engage in the therapeutic process, which may in turn precipitate staff counter-reactions. Service providers may see these children as oppositional and defiant as opposed to self-protectively disengaged. Youth with an anxious/ambivalent attachment styles on the other hand may be so attention-seeking that staff may find them excessively demanding, and emotionally draining to the point they may push them away only to find they come back even more (Barber, Tischler, & Healy, 2006). Because of the immensely powerful impact of attachment problems, inpatient care must routinely assesses attachment needs and styles to prevent the occurrence and recurrence of attachment injuries. Inpatient units cannot completely undo entrenched maladaptive attachment styles, or disturbed family attachments but they can moderate the impact of some past harms. On the other hand, inpatient units can make things worse by aggravating attachment injuries and engaging in

behaviours that compound insecurities. The severity and frequency of attachment conflicts during admission and afterwards can sometimes be reduced by fostering continuation of contacts with community social supports and promoting more attachment-informed secure interactions among inpatients, staff, parents/caregivers, and community providers. Activities that support attachment, feelings of belonging, and social connectedness can promote well being. Such activities can also help youth improve their ability to better use others as secure objects to help resolve past attachment injuries, past attachment trauma, and fears of possible or impending attachment loss. Provision of attachment supports on inpatient units helps to reduce aggression (de Decker et al., 2018).

Assessing Attachment Needs & Problems. Assessment of the potential for attachment injuries should ideally have started and been largely completed prior to admission because of the implications of separation from family that admission presents. Those considering admission for children and adolescents should routinely consider whether an admission is harmful from an attachment perspective. Helpful questions for example include "Will this admission further distance parents and children? Will it add to attachment trauma and increase likelihood of more permanent out-of-home care? Or "Will it help by making the parents/caregivers and youth more securely attached?" Ideally, these questions and the hypotheses they raise should be part of routine assessment by community services and emergency departments ones prior to referral or transfer. If attachment information is lacking at admission, then it falls on inpatient care providers to complete it as soon as possible Assessment of attachment in inpatient care can use psychometric (i.e., standardized questionnaires), observations, or narrative information (e.g., noting counter-reactions to the patient's behaviour) in nature (Bucci et al., 2015). Inpatient care that is informed by assessment of attachment can better assure appropriate boundaries, well-defined roles and expectations, and consistency of approach across attachment figures on the unit and at home (Rich, 2006).

Attachments with Parents/Caregivers. Attachment is important for youth but also for parents/caregivers. It is important to appreciate that attachment distress can manifest in child and parent interactions with staff, but that the more important attachment issues are usually about the relationship of children with their parents/caregivers. Not surprisingly, keeping in touch with parents/caregivers is one of the more important needs expressed by hospitalized youth (van Staa et al., 2011). It is important for inpatient unit care providers to not undermine, usurp, or displace the roles of the attachment of the child with the parents/caregivers. It is important that units promote healthy attachments among children and parents/caregivers to the extent that this is possible. Units should do whatever they can to encourage and provide means for attachments to continue with family and friends after admission. This should include encouraging parent/caregiver visits at admission, during care, and prior to discharge, as well as encouraging keeping familiar objects that help promote feelings of attachment security (e.g., stuffed toys, music, pictures) in ways that at times may resemble what is needed and used to provide security for infants and very young children (Many, 2009). Children in foster care, particularly those with unstable placements may lack consistent parent attachment figures. When they do, it is important that units do their best to help youth maintain contact with individuals who may be more consistent figures than others

such as volunteers from Big Brothers and Big Sisters, case managers, or other non-kin supports (Munson & McMillen, 2008)

Patient-Staff and Co-Patient Attachments. Attachment insecurities that may manifest as jealousies and competitive attention seeking can arise among both staff and patients. These can arise when there are threats or loss of attachment security because of too many changes to staffing, favoured staff absences, and discharge (Hooper, Tomek, & Newman, 2011; Kane, 2008). How patients perceive and manage the termination and interruption of supportive attachment relationships at admission and at discharge is important. For many youth, disruption of any attachment relationships can be stressful or traumatic (Schuengel & Van Ijzendoorn, 2001). Some youth make "make strange" when faced with reuniting with parents and caregivers. Parents/caregivers and youth may need time and supports to navigate transitions in and out of hospital. During admission, staff should be aware of risks that may signal that some patients are liked more than others. In order to promote security all care providers should provide empathic listening, warmth, attunement, and attachment promoting activities for all children and adolescents in a fair and responsive way (Berry & Drake, 2010; Keys, 2018). Staff should take the time to communicate that their relationship with each child is as important as their work with other children and as important as the rules, the paperwork, and the medication. Active listening, mirroring of emotions, reinforcing secure behaviour and exploration, and enjoying doing things together helps provide a secure base for recovery.

Staff Attachment Styles. Providing the right amount and type of attachment support requires awareness and acknowledgement of staff's own attachment styles and potential insecurities. This is important for staff well-being as well as for patients and families. Patients and their parents/caregivers value staff with an attachment style that is friendly, understanding, and caring, rather than excessively rule-focused, authoritarian, and rigid (Tulloch et al., 2008). Bowlby (1977) noted some healthcare professionals with insecure attachment styles may be vulnerable to what Bowlby (1977) termed 'compulsive caregiving'. The compulsive caregiving may originate during childhood when children are cast in roles of caring for a parent and suppressing their own needs to be cared for. Staff who are 'compulsive caregivers' may be overly involved with patients, blame themselves for failures, and be more vulnerable to burnout. Schowalter and Anyan (1973) reported that close supervision is often important for preventing attachments from becoming too close among some staff and adolescent patients.

USING FEEDBACK & ENGAGING IN ADVOCACY

2.19 The unit monitors, reports, and utilizes youth and parents/caregiver satisfaction, feedback, and complaints to assure and improve services.

Satisfaction & Feedback. Opportunities to confidentially provide feedback about inpatient services are already an established standard of care as is the expectation that the use of that feedback will be used to improve care (Lucas, 2019). Satisfaction and feedback about the quality of care provide important supplemental information to be used in conjunction of information from treatment

outcome measures. Satisfaction and feedback allow patients, families, and partners in care to speak to whether their rights and dignity are being respected and the extent to which they are being engaged as partners. Satisfaction ratings and feedback about the quality of care are important indicators, in their own right, because they provide insights into the quality of inpatient care beyond what is provided by treatment outcome measures (Kopec-Schrader et al., 1994; Ortiz & Schacht, 2012; Ruggeri, 1994; Salamone-Viole et al., 2015). Treatment outcome measures do not yield the type of important qualitative observations that can be obtained through feedback about care. Kaplan et al., (2001), for example, used patient feedback to discover that a significant proportion of children reported being verbally abused, and a smaller proportion, physically abused by certain staff. For these, and similar reasons, it is important that children and adolescents themselves are provided opportunity to provide feedback about their care. It is important that parents/caregivers and service partners also have similar opportunities to provide feedback about care. But as the primary recipients of care, patient opinions of the quality of care are particularly important as they provide information that is unique and important (Biering, 2010).

Assessment. Numerous methods and survey measures for describing client satisfaction on inpatient units have been utilized in child and adolescent inpatient units (e.g., Biering & Jensen, 2011; Blader, 2007; Brinkmeyer et al., 2004; Marriage, Petrie, & Worling, 2001; Tas, Guvenir, & Cevrim, 2010). The variety of measures and methods have provided rich insights although the lack of a common measures has made it challenging to compare different units and patient groups to each other. Satisfaction is typically assessed using standardized checklists. But because checklists do not capture patient experiences well as they allow limited opportunity for interactive elaboration and discovery. Ideally, checklists should include open ended questions and be accompanied by occasional surveys, interviews, "huddles", "walk throughs", and focus groups. The details obtained by qualitative measures are extremely helpful for informing unit operations and improvements (Gill et al, 2016). Global satisfaction is typically reported in terms of percentages satisfied and dissatisfied patients. Qualitative feedback reported verbatim and arranged in themes helps to make the satisfaction numbers more understandable and easier to address. Qualitative feedback can also help distinguish parent/caregiver and youth experiences, opinions, and needs. Parents/caregivers, for example, may place greater value on reducing their children's distress whereas children and patients may place more value on improving their externalizing behaviours (Ronzoni & Dogra, 2011). Information about the quality of care to marginalized groups and minorities can be important so their needs are not overshadowed by those of more populous groups. Minorities on the unit whose values, customs, and beliefs differ from the mainstream will often require more extensive interviews when they are admitted. Walk-throughs are another way of gathering detailed qualitative information. This consists of gathering feedback from a young patient, a family, or volunteer who "walks through" the process of care from admission to discharge (Ford et al. 2007). Youth and parents/caregivers have sometimes been given the opportunity to take on the roles of environmental consultants who can help to improve how feedback is gathered as well as commenting on unit design and processes (Ha et al., 2016; Hutton, 2005). Worrall-Davies & Marino-Francis, (2008) recommended that feedback surveys and interviews be adapted to suit the communicational abilities and preferences of youth, supported by reviewers with competency in evaluation, and accompanied by evidence that youth recommendations matter and are acted upon.

Findings Most youth, parents/caregivers, and partner professionals tend to report that they are satisfied with child and adolescent inpatient services regardless of measures and methods used (e.g., Barber et al., 2006; Bradley, & Clark, 1993; Kaplan et al., 2001; Kopec-Schrader et al., 1994; Tas et al., 2010). Tulloch et al. (2008) reported that satisfaction scores across treatment units was similarly high for both parent/caregiver and patient respondents. Although most users are satisfied, it is important to appreciate that there is also a significant minority who are dissatisfied and whose dissatisfaction needs to be understood and addressed (Kopec-Schrader et al., 1994). Satisfaction is higher at discharge and then reduces across time after discharge (Blader, 2007). Blader (2007) reported that the percentage of parents reporting dissatisfaction doubled between discharge and 3-month follow-up. This is perhaps because the feelings of respite and noted improvements from hospitalization dissipate in the months following discharge (Blader, 2007). Setbacks, relapses, and family stresses occur for at least some youth which lead to diminishing positive views about the value of their past inpatient experience.

Factors affecting Satisfaction with Inpatient Care. Patient variables as well as staff and process variables impact satisfaction (Barber et al., 2006; Fenton, Jerant, & Franks, 2014; Gill, et al., 2016; Tulloch et al., 2008). At the individual level, youth with conduct problems indicate lower satisfaction perhaps because their needs are poorly understood and addressed (Barber et al., 2008). At the process level findings suggest higher overall patient satisfaction for elective relative to crisis admissions (Fenton et al., 2014), and it remains to be seen whether this is also true for younger patients. Good communication with staff and opportunities to be supported by peers are important components for satisfaction (Gill et al., 2016; Tulloch et al., 2008). Parents/caregivers want regular discussions with staff about how their son or daughter is progressing (Tulloch et al., 2008). It is not surprising, that young people and parents/caregivers tend to express being more satisfied when staff are perceived to be friendly, understanding, and caring and to be dissatisfied when staff are perceived to be inflexible, authoritarian, or rude (Tulloch et al., 2008). Staff who give the impression of being too busy to take the time to talk with patients and parent/caregivers tend to reduce satisfaction with care.

Complaints. The ability for staff and patients to speak up about a psychologically unsafe climate, about loss of dignity, about unnecessary infringements on personal rights and freedoms, and about lack of consultation and opportunity for empowered participation is essential for reducing risk and promoting good mental health outcomes. A complaints procedure is a formal systematic process that is used by hospitals to receive, record, and respond to complaints made by young people and parents/caregivers. Youth and their parents/caregivers should be advised and have written information about how to raise concerns, complaints, and compliments at admission and as part of orientation (Lucas, 2019). Inpatients and their parents/caregivers must be able to complain without fearing that if they complain they will not be discriminated against and their care will not be compromised (Lucas, 2019). Daily feedback mechanisms in place on the unit should be able to address the everyday complaints about things like noise, food, or recreational activities in a responsive way as well as having opportunity to complain about things that may take some time to address. The formal complaints procedure should be well known and be able to bypass front line staff and be accessible to patient advocates to identify, prevent, and address abusive practices. If

children and adolescents are to be successful in using a complaints process to address serious problems, it is important that this use be encouraged by staff, supported by patient advocates, and responded to in a timely and effective way (Wallis & Frost, 1998).

Advocacy. Silence in acknowledging and advocating for needed changes to assure rights and dignity makes units complicit in maintaining unacceptable practices. Advocacy encompasses activism whose primary objective is to assure that all children and adolescents receive the type, intensity, and quality of services they need to assure best possible mental health outcomes. This includes identifying needed improvements to inpatient and partner mental health services. Advocacy can be informed by complaints, client satisfaction, and qualitative client feedback, as well as staff observations. Advocates can include young people who are or have been inpatients, parents/caregivers, inpatient, and community professionals, as well as any interested members of the public. Ideally all inpatients should have a chance to meet with a patient advocate at admission or shortly after because greater familiarity increases trust and enables youth to be more open and likelier to use a complaints process that does not involve opening up to a complete stranger (Lucas, 2019; Skinner, 1992). Inpatient units should record and evaluate all serious complaints and include an aggregate non-identifying summary in the unit annual report. Ontario patients and parents/caregivers would benefit from the support of legislated advocates guided by the principles of the United Nations Convention on the Rights of the Child which are intended to promote and safeguard the views and preferences of children and youth. Parents/caregivers have reported that it is valuable for them to have peer perspectives, peer validation, peer advocacy, and opportunity to seek advice and information around a wide variety of care topics from individuals who have faced similar problems but who are not directly involved in the treatment of their child (Geraghty et al., 2011). Peer advocates can provide specific information about parental rights and resources (e.g., legislation, entitlements), coaching about how to more effectively negotiate services, and education about how to advocate for policy and service system level change (Hoagwood et al. 2010; Wisdom et al., 2011).

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SELF-AUDIT CHECKLIST

Ontario Network of Child and Adolescent Inpatient Psychiatry Services

Unit Name_____

Date of Self-Audit: _____ for Fiscal Year April 1, 20 __ to Mar. 31, 20__

STANDARD 2: PSYCHOLOGICAL SAFETY, DIGNITY, RIGHTS, INCLUSION & PARTICIPATION.

The unit assures and promotes psychological safety, dignity, rights, inclusion, and participation in care.

Qualitative Indicators & Benchmarks	True	False
2.1 The unit protects the human rights of all child and adolescent patients, staff, and visitors.	☐	☐
2.1.1 The unit assures the right of patients to safety, nutrition, shelter, clothing, hygiene, education, exercise, play, rest, sleep, access to needed health care, and respect.	☐	☐
2.1.2 The unit protects the rights of children and adolescents, staff, and parents/caregivers to express and manifest their religion, cultural practices, or beliefs so long as these do not violate the safety, public health, laws, morals, or the fundamental rights and freedoms of others.	☐	☐
2.1.3 The unit works to assure that children adolescents, parents/caregivers, and visitors respect the rights of their child, of co-patients, of staff, and of visitors.	☐	☐
2.2 The unit protects the dignity of patients, staff, and visitors.	☐	☐
2.2.1 The unit policies and procedures protect the dignity of patients, employees, and visitors regardless of age, gender, culture, religion, race, physical appearance, sexual orientation, social standing, and other personal characteristics and group affiliations.	☐	☐
2.2.2 The unit supports staff education to ensure that their care providers best understand what is important for the protection of dignity of all the diverse groups they serve.	☐	☐
2.2.3 All health care providers are aware of their own preferences, biases, and potential for discrimination, and to address these effectively with support from colleagues and supervision.	☐	☐
2.2.4 The unit assures that care providers have sufficient time to spend with patients and families so they can get to know sensitivities and address potential infringements on the dignity of all patients and families.	☐	☐
2.2.5 Staff provide corrections, criticism, confrontation, and physical interventions in private whenever possible.	☐	☐

2.2.6 Staff respect the right to personal space, belongings, and privacy of all inpatients whenever possible.	☐	☐
2.3 The unit assesses capacity and obtains consents for treatments.	☐	☐
2.3.1 At admission, the unit provides understandable verbal and written information to young people and their parents/caregivers about capacity determination and consent processes.	☐	☐
2.3.2 The unit assures the patient and/or substitute decision maker engage in a new informed consent process for each new treatment or treatment change.	☐	☐
2.3.3 Written and verbal information about capacity and consent includes a description of how disputes among parents and children about staying in hospital and care are handled, and what rights parents/caregivers have when a consenting youth refuses their involvement.	☐	☐
2.3.4 When children and adolescents do not have capacity to make a treatment decision, they are nevertheless routinely consulted and allowed to participate in decisions to the extent that they can.	☐	☐
2.3.5 The unit has a protocol in place to address situations where parents/caregivers and other substitute decisions makers are either incapable or not working in the best interests of the child.	☐	☐
2.4 The unit encourages helpful sharing of information while at the same time respecting confidentiality.	☐	☐
2.4.1 At admission, the unit provides understandable verbal and written information to young people and their parents/caregivers about its process for sharing information and the limits of confidentiality.	☐	☐
2.4.2 The unit restricts collects information that is important for addressing the reasons for admission and does not collect incidental information that is not relevant to the plan of care.	☐	☐
2.4.3 The unit informs patients and their parents/caregivers that unless there are problems such as conflict of interest that all members of the inpatient team will have the same access to all relevant health care information without restrictions (e.g., 'secrets' only one preferred staff may know).	☐	☐
2.4.4 The unit engages young patients in decisions about what information is to be shared and with who, to the extent patients are capable.	☐	☐
2.4.5 The unit works with patients and their parents/caregivers to encourage the most helpful and safe information exchanges among youth, parents/caregivers and community mental health supports.	☐	☐
2.4.6 Staff encourage patients to avoid disclosing information to co-patients and others that they are likely to later regret or that may be harmful.	☐	☐
2.5 The unit is committed to the principle and provision of least restrictive care.	☐	☐
2.5.1 The unit assures that it is the least restrictive setting to which the child could be admitted for the provision of safety, stabilization, and treatment (otherwise it redirects referrals and transfers to less restrictive, equally effective and safe settings).	☐	☐
2.5.2 The unit provides the least number of restrictions necessary for safe care.	☐	☐

2.5.3 The unit provides an effective balance of restrictions for safety and opportunities for risks and freedoms important for well-being recovery.	☐	☐
2.6 The unit has a psychologically, emotionally, and socially safe climate.	☐	☐
2.6.1 The unit encourages health care providers, patients, parents/caregivers and community service partners to identify risks to psychological and socioemotional safety that arise among staff, patients, and visitors.	☐	☐
2.6.2 The unit measures and reports the state of the unit psychological climate at least annually.	☐	☐
2.6.3 The unit utilizes patient, staff, partner agency, and visitor feedback about the psychological, emotional, and social climate of the unit to maintain and improve it.	☐	☐
2.7 The unit promotes the development of positive identity and self-esteem.	☐	☐
2.7.1 Unit care providers take the time to understand, validate, and appreciate things youth say about who they are and what they value about themselves.	☐	☐
2.7.2 Care providers spend more time noticing and praising/reinforcing successes and adaptive positive self-identity and esteem, that correcting.	☐	☐
2.7.3 Care providers help youth reframe inaccurate and maladaptive perceptions and maladaptive mentalization (e.g., “Maybe she wasn’t thinking about how unattractive she thinks you are? Maybe…maybe she was looking at you because she thought you were attractive or interesting.”)	☐	☐
2.7.4 The unit has a set of structured activities that promote positive identity and self esteem for those with low esteem, and more accurate self-identity for those with exaggerated or narcissistic levels of esteem.	☐	☐
2.8 The unit prevents and reduces stigma of mental illness and hospitalization.	☐	☐
2.8.1 The unit has an inpatient stigma reduction initiative that engages patients and parents/caregivers.	☐	☐
2.8.2 The unit provides patients and parents/caregivers with brochures, videos, media, and consumer group on stigma.	☐	☐
2.8.3 The unit partners with patients and parents/caregivers to monitor, identify, and reduce stigmatizing processes and interactions on the unit.	☐	☐
2.8.4 The unit provides education for staff, patients, and parents/caregivers on stigma prevention and reduction.	☐	☐
2.8.5 The unit partners in public efforts with patients, staff, parents/caregivers, and community professionals to reduce stigma.	☐	☐
2.8.6 The staff and patients observe and celebrate Canadian Mental Health Week (Usually in May), Mental Health Awareness Month (October), World Mental Health Day (October 10) in ways that improve awareness and reduce stigma (e.g., fund raising, wearing green ribbons, invited speakers, special meals)	☐	☐
2.9 Staff utilize compassion, strength-based, and positive psychology approaches to balance the focus on safety, problems, and diagnosis.	☐	☐
2.9.1 The unit balances attention to past and present problems and treatment of mental disorders with attention to present patient strengths and positive behaviours.	☐	☐

2.9.2 Staff make it a point to spend significantly more time praising and catching children being good than criticizing and correcting.	☐	☐
2.9.3 Staff reinforce positive self-statements and help youth counter negative and harmful self-statements and beliefs.	☐	☐
2.10 The inpatient health care professionals provide compassionate care and promote compassionate self-care.	☐	☐
2.11 The unit values diversity, encourages inclusion, and protects children and adolescents from discrimination.	☐	☐
2.11.1 The care providers do not engage in stereotyping and judgmental comparisons of different cultures, religions, and affiliation.	☐	☐
2.11.2 The unit provides policies and procedures and staff training that emphasizes the understanding, inclusion, and validation all vulnerable or marginalized groups including young children, indigenous youth, youth with intellectual disability or autism, refugees, immigrants, LGBT2SQIA, and those in the juvenile justice and foster care systems.	☐	☐
2.11.3 The unit has access to consultation from supports who are familiar with how to best provide services to all vulnerable or marginalized groups including young children (e.g., pediatricians, developmental psychologists), indigenous youth, youth with intellectual disability or autism, refugees, immigrants, LGBT2SQIA, and those in the juvenile justice and foster care systems.	☐	☐
2.11.4 Assessments only use measures that have been validated for the culture and group being assessed.	☐	☐
2.11.5 The unit facilitates engagement of youth and families with hospital and community groups or cultural contacts (e.g., consultants, elders, culture-specific teams, support groups and organizations) that provide culturally informed and responsible mental health supports.	☐	☐
2.11.6 The unit provides youth with opportunities to continue their spiritual and religions practices.	☐	☐
2.11.7 The unit has processes and activities that help staff identify, monitor, and address their own cultural and group beliefs, prejudices, stereotypes, and preferences in healthy ways.	☐	☐
2.11.8 The unit identifies its own systemic biases and avoids promoting cultures and groups in ways may undermine other cultures and group identities.	☐	☐
2.11.9 The staff do not presume to know group identity and preferred affiliations and instead allow children and adolescents to express their preferences and conflicts.	☐	☐
2.11.10 The unit helps staff avoid taking sides in conflicts involving group identity and affiliation between youth and their parents/caregivers but does support discussion among them when helpful.	☐	☐
2.11.11 The unit protects patients, families, and health care providers from discrimination and bullying from co-patients, staff, and families.	☐	☐
2.11.12 The unit supports staff to feel safe about who they are (i.e., the unit does not encourage suppression or denial of culture or identity).	☐	☐
2.11.13 The unit celebrates the holidays and special days of all the different inpatient groups, but at the very least of those who are on the unit.	☐	☐
2.12 The unit provides patient centred care that engages children and adolescents as partners in planning, care decisions, and therapeutic alliances.	☐	☐

2.12.1	Staff recognize children and adolescents as persons with the right to participate in care decisions and to have their voice heard.	☐	☐
2.12.2	The unit encourages and provides opportunities for children and adolescents to express their views and to lead their recovery to the extent they can.	☐	☐
2.12.3	Staff take the time to find out what care goals and activities are important to each patient.	☐	☐
2.12.4	Young patients have regular contacts with staff to discuss costs and benefits of the current plan of care and its likely outcomes, concerns such as side effects and stigma, and plans for discharge	☐	☐
2.12.5	The unit invites children and adolescents to their case conferences and encourages participation in information exchanges and decisions.	☐	☐
2.12.6	Health care providers have the competence, and the unit provides time to answer all child and adolescent questions, to respond to their concerns, to attend to what they have to say, and to engage them as partners in care.	☐	☐
2.13	**The unit utilizes 'Safewards' or a similar integrated and structured approach to protect dignity, assure psychological safety, and optimally engage children and adolescents as partners in care.**	☐	☐
2.13.1	The unit emphasizes prevention that can help protect patient dignity more so than after the fact management of incidents.	☐	☐
2.13.2	The unit has mutually agreed publicised standards of behaviour developed by and for patients and health care providers which are displayed for all to see and that can help protect psychological and not only physical safety.	☐	☐
2.13.3	The unit has statements on how conflicts and flashpoints will be handled which are on display for all to see in the nursing office and are changed every few days.	☐	☐
2.13.4	The unit takes the time to process all stressful and frightening incidents with every patient.	☐	☐
2.13.5	The unit has a process that allows staff and patient to get to know each other and share personal information (e.g., music preferences, favourite films and sports) using a 'get to know each other' folder kept in by the patient.	☐	☐
2.13.6	The unit provides distraction and sensory modulation tools that can be used to prevent agitation and its escalation (e.g., stress toys, mp3 players with soothing music, light displays, textured or weighted blankets).	☐	☐
2.13.7	The unit uses a prevention and de-escalation model led by one or more of the staff who are most effective at prevention and de-escalation (as elected by the unit) and who can help support novice staff and expand the skills of the other staff,	☐	☐
2.13.8	The unit has a process that assures health care providers notice and express something good about each patient at nursing shift handover and case conferences (see also positive psychology)	☐	☐
2.13.9	The unit helps prevent escalation by being alert for rejection, loss and other bad news a patient might receive from friends, relatives or staff, and intervening promptly and compassionately in discussions,	☐	☐
2.13.10	The unit has a weekly meeting where children and adolescents are invited and encouraged to develop mutually supportive interactions with other patients.	☐	☐

2.13.11 The unit displays inspirational and encouraging messages including positive and inspirational messages from previously discharged children and adolescents.	☐	☐
2.14 Staff assess what motivates children and adolescents and work in a way that reduces resistance and improves collaboration.	☐	☐
2.14.1 Inpatient providers do not presume children and adolescents should be highly motivated to follow treatment orders but instead take the time to know about what is important to youth and what barriers may stand in the way of collaboration with care.	☐	☐
2.14.2 The unit uses motivational interviewing approaches to provide youth with opportunities to explore their motivation and to consider from their own point of view what might be their best goals going forward.		
2.14.3 Inpatient staff separately assess and address motivation for a) making different changes related to the reason for admission, and b) working with inpatient and outpatient care providers.	☐	☐
2.14.4 The unit tracks both motivation for change and motivation for collaboration across the admission.	☐	☐
2.14.5 Staff are aware of practice inclinations to categorize patients as “motivated good patients” and “unmotivated bad patients” (resulting sometimes from frustrations in working with the latter).	☐	☐
2.14.6 Inpatient staff assess past confidence and self-efficacy and other potential barriers that can get in the way of healthy change.	☐	☐
2.14.7 The unit takes a history of past services with a specific understanding of how these past service experiences are affecting current commitment to change and openness to collaboration.	☐	☐
2.14.8 Staff identify resistance to change and collaboration as an opportunity rather than an obstacle.	☐	☐
2.14.9 Staff have the training, competence, and supervision in motivational interviewing and stages of change to effectively address the motivation for change and collaboration in all children and adolescents but particularly so in those who are in hospital against their will.	☐	☐
2.14.10 Staff do not confuse readiness to cooperate and improvements in compliance with improvements in health and well-being.	☐	☐
2.15 The unit respects the primary roles and responsibilities of parents/caregivers and engages them in planning, decisions, and care.	☐	☐
2.15.1 Health care providers on the unit engage parents/caregivers in collaboration from the beginning to the end of care (excepting atypical circumstances).	☐	☐
2.15.2 The unit notifies parents/caregivers of an emergency admission as soon as possible and no later than 3 hours after admission.	☐	☐
2.15.3 The unit routinely contacts parents/caregivers to arrange a formal assessment and information exchange interview within 24 hours of admission.	☐	☐
2.15.4 The inpatient team invites parents/caregivers and community mental health providers to attend and contribute to case conferences & meetings.	☐	☐
2.15.5 The unit plans meetings with a view to accommodating parent/caregiver work schedules and obligations and helping with transportation when needed.	☐	☐
2.15.6 Staff identify and address parent/caregiver complaints, expectations, and unhelpful blaming of children and others.	☐	☐

2.15.7	The unit assesses for isolation and alienation of parents/caregivers from community mental health services (including child welfare and protection services) and promotes collaboration and reconciliation.	☐	☐
2.16	**The unit engages community service providers as partners from the beginning to the end of care.**	☐	☐
2.16.1	The unit invites community partners to admission, care, and discharge planning meetings.	☐	☐
2.17	**The unit provides trauma informed care.**	☐	☐
2.17.1	All individuals are screened for history and current symptoms of chronic and acute stress, and trauma, at admission.	☐	☐
2.17.2	The unit monitors young people for trauma activation and trauma and stress related hyperarousal, agitation, and avoidance from admission to discharge.	☐	☐
2.17.3	All staff on the unit understand the traumatizing potential of mechanical restraint, seclusion, and other similar restrictive measures and strive to reduce these.	☐	☐
2.17.4	All staff on the unit understand that witnessing co-patient aggression, seclusion and restraints, and self-injurious behaviours, can be traumatizing.	☐	☐
2.17.5	The unit identifies and prevents bullying and intimidation that can cause the development of stress linked problems among co-patients, among staff, and among staff and co-patients.	☐	☐
2.17.6	Care providers utilize “here-and-now” grounding techniques to prevent and manage potential traumatic activation and crises (e.g., let’s do something else (distraction), take 3 breaths of calm, what are some things you are hearing now…. how about seeing?”)	☐	☐
2.17.7	Youth, parents/caregivers and staff on inpatient units are provided with the opportunity to discuss, debrief, and work through stressful incidents they have been exposed to.	☐	☐
2.17.8	Staff and youth work together to anticipate and prepare for future stressful and potentially traumatizing events (e.g., changing therapists, going to a new school, court cases, death of a loved one, painful medical procedure, rejection when visiting home, being unwanted at discharge).	☐	☐
2.17.9	Supervisors, consultants, and nurse educators provide training, monitoring and supervision specific to assuring all health care providers are competent to provide trauma informed care.	☐	☐
2.17.10	Care providers access regular peer supervision and consultation to manage stresses and to reduce likelihood of their own traumatization and re-traumatization.	☐	☐
2.1.1	The hospital supports trauma informed care and provides staff resources and supporting policies procedures.	☐	☐
2.18	**The unit provides attachment supportive care.**	☐	☐
2.18.1	The unit monitors and manages attachment distress that can result from separation from family and friends.	☐	☐
2.18.2	The unit has explicit processes and activities that accommodate the different developmental needs of very young children including optional “rooming in” for parents/caregivers, when required to protect and improve caregiver attachments.	☐	☐

2.18.3	The unit provides appropriate enhanced attachment opportunities for youth whose parents/caregivers may be unable to visit, who are in foster care, who have communication difficulties, or who are isolated or alienated from attachment figures.	☐	☐
2.18.4	Staff individualize attachment supports for each patient and for parents/caregivers (rather than providing similar level and type of attachment support to all youth and all families).	☐	☐
2.18.5	Health care providers match interventions to style of attachment in ways that meet the different issues that arise from secure, insecure-ambivalent (anxious-preoccupied), anxious-avoidant (dismissive-avoidant), and disorganized/disoriented (fearful-avoidant) attachment patterns.	☐	☐
2.18.6	All inpatient care providers align their attachment behaviours in ways that best promote healthy attachments for each patient on the unit.	☐	☐
2.18.7	Inpatient care providers are aware of the problems that can arise if they act in ways that undermine, replace, or displace rather than supplement attachments to parent/caregiver, family, and friends.	☐	☐
2.18.8	Supervisors, consultants, and nurse educators provide training specific to understanding and providing attachment supportive care.	☐	☐
2.18.9	Care providers are aware of their own attachment needs and styles and how these can impact on the relationships they have with each other and with patients and their families.	☐	☐
2.18.10	The unit schedules staff rotations in ways that allow children and adolescents to have continued contact with staff they are most comfortable and familiar with.	☐	☐

BENCHMARKS: Supporting Attachment Self-Report Checklist ***Children and adolescents would likely report that I ….***	
a. Am calm, warm, patient, and safe.	☐
b. Show an interest in them as persons and not just as patients.	
c. Aware of their own attachment difficulties and how these affect them.	☐
d. Support keeping parents/caregivers support the them at admission.	☐
e. Encourage bringing photographs, stuffed toys, music, or other familiar things that can help provide attachment security.	☐
f. Encourage and provide opportunities to maintain attachment and contacts with family and friends after admission.	☐
g. Help develop children's capacity to be their own attachment supports (e.g., "Give yourself a mental hug, a 'high five,' a 'wayda go', and tell yourself you did a good job")	☐
h. Counter insecure, abusive, and overly dependent disempowering self-rejecting statements (e.g., "Nobody cares about me. Nobody would miss me if I wasn't here.")	☐
i. Make relationships with them as important as rules, diagnosis, and medication.	☐
j. Make some quality time for work and play and to be together with them on the unit (e.g., cook & eat together, do makeup or hair, go for a walk, play a game) instead of just monitoring, supervising and watching.	☐
k. Make the time to actively and nonjudgmentally listen to what they have to say.	☐
l. Do not make unrealistic attachment promises to be friends and keep in touch after the admission.	☐
m. Help patients consider the potential harms and benefits of romantic attachments and sexualized behaviours involving co-patients and help coach them through some of these difficult situations.	☐
n. Provide opportunities to repair and improve damaged attachments with parents/caregivers, staff, and co-patients.	☐

o. Reward secure exploration and reasonable risk taking.	☐	
p. Know about losses or rejection and provide supports that can help prevent stress-related harm (e.g., break ups, deaths, divorce or separation of parents, serious illness).	☐	
q. Help youth plan and rehearse how to cope with transitions and possible attachment threats and loss (e.g., going to a new group home or entering foster care, leaving the unit, trying to date someone, discharge back home to parents who may be ambivalent about the youth's return).	☐	
2.19 The unit monitors, reports, and utilizes youth and parents/caregiver satisfaction, feedback, and complaints to assure good services and advocate for improvements.	☐	☐
2.19.1 The unit collects, reports, and utilizes youth, and parents/caregiver satisfaction ratings.	☐	☐

BENCHMARKS: Satisfaction

Number of Youth Responding _____ #

Satisfied _____%
Dissatisfied _____%

Number of of Parents Responding _____#

Satisfied _____%
Dissatisfied _____%

2.19.2 The unit collects, reports, and utilizes youth, and parents/caregiver feedback.	☐	☐

BENCHMARKS: Themes

The most important themes recorded from surveys and feedback are:

2.19.3 All inpatients and parents/caregivers are aware of the unit complaints process which allows them to address problems as soon as they occur.	☐	☐
2.19.4 The unit collaborates with youth, parents/caregivers and community partners to identify unmet needs and advocate for service improvements	☐	☐
2.19.5 The unit has a patient advocate that children and adolescents, and their parents/caregivers can access	☐	☐

BENCHMARKS: Patient Advocate

Percent of children and adolescents which made use of the unit patient advocate _____%

Percent of parents/caregivers which made use of the patient advocate _____%

DETAILS, NOTES, & FEEDBACK: