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Review Article

Why Residential Treatment Programs Will Never Be Able to Stop Restraining Children (and What to Do About It)

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ABSTRACT

The use of physical restraint in residential treatment programs for children remains highly controversial. Physically coercive techniques have the potential to worsen a child's mental health condition, cause psychological trauma, and result in physical injury or even death. Numerous attempts have been made to reduce the use of physical restraint in institutions when children are deemed "out of control", but no approach has eliminated its use altogether. In this review article, institutional incentives are discussed that make it difficult, if not impossible, for residential programs to stop restraining children. Staff are trained to respond to a dysregulated, aggressive child by staying actively engaged with them (interacting with them), a practice that runs counter to what is recommended by empirically supported treatments. The practice of disengagement, i.e., delaying interaction until the child has completely calmed down, combined with other clinical strategies described in this article, is a more effective alternative. There is no practical way to use disengagement in residential treatment, however, it is successfully used in family- and home-based treatment approaches. Family treatments have over 40 years of documented clinical efficacy with challenging youth and do not use physical restraint, but they are still relatively unknown to the public. The practice of restraining children must end, and family-based treatments offer an effective alternative to residential treatment. Children with serious mental health challenges deserve an opportunity to get better at home with the support of their own families before resorting to more invasive treatments that can harm them.

Keywords: Children and adolescents; Child and adolescent mental illness; Residential treatment; Restraints; Family-based treatment; Intensive family-focused therapy

INTRODUCTION

The use of physical restraint is a controversial practice in residential treatment programs that serve children and adolescents with serious mental health challenges. The use of physical restraint can lead to a worsening of a child's mental health condition and have lasting impacts on their physical and emotional well-being [1]. The United Nations Committee on the rights of persons with disabilities has adopted the position that the use of restraints on people with disabilities is a violation of their human rights [2].

Restraint is defined as any coercive measure that restricts the freedom of movement of a young person [3]. A seclusion is defined as escorting a child (typically by forcibly moving them) and involuntarily confining them to a specially designed safe room [4]. For the purposes of this article, restraint and seclusion are viewed as essentially the same experience in that both involve physical contact between the child and the staff. Typically, a child is physically restrained or taken to seclusion by one or more staff members when deemed necessary to maintain the child's safety, or the safety of the staff or other patients [5].

Prevalence of the use of physical interventions

Although physical restraint and seclusion are viewed as interventions of last resort, they are nonetheless quite common. There are approximately 700 residential treatment centers for children in the United States providing 24-hour care for more than 23,000 children and adolescents with many more throughout the world [6]. Most residential treatment programs physically restrain or seclude children. For example, one study found that 82% of child and adolescent residential treatment centers reported using restraint and seclusion in the prior year [7]. Estimates of the percentage of children in residential care who are subject to restraint range from 12.8% to 29% [8,9]. One study found that among a sample of just 798 youth, there were 13,339 restraint episodes over three years [5].

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What it is like for a child (and the staff) to experience physical restraint

Earlier in the author's career working in various residential treatment programs, he directly participated in hundreds of physical restraints. A typical situation in which a child gets restrained is as follows. Often when a child becomes frustrated and angry, usually in response to being told they need to do something or not do something, they can quickly escalate to the point where they are deemed "out of control". Typically, this includes yelling and cursing at the staff, hitting or kicking them or another patient, throwing chairs or other objects, trying to harm themselves (hitting their head, scratching or cutting themselves, or tying something around their neck), or extensively destroying property (breaking furniture, punching or kicking holes in the walls, or breaking windows). Depending on the size of the child, typically two, three, and sometimes four staff will restrain them, most commonly by holding them down on the ground until they are calm enough to be released. The restraint can often last an hour or longer, usually because the child will calm down somewhat while still being held down, but they repeatedly escalate, many times over and over until they fully calm down and can be released.

Restraining a child or adolescent is an ugly, messy process. The child screams and curses almost continuously and demands over and over to be let go. They thrash about and try very hard to get an arm or leg free, at which point they often attempt to hurt the staff until the limb is secured again. It is a physically exhausting process for both the staff conducting the restraint and the child in it, leaving everyone red-faced, sweating and fatigued. After the restraint is over, younger children will typically sob and stop speaking and teens will physically and emotionally pull away, left feeling angry, confused, and humiliated. Restraints are so loud and violent that other children anywhere in the vicinity will be exposed to it and thereby negatively affected.

Negative consequences of the use of physical restraint

Trauma: A substantial percentage of children in residential care have experienced traumatic events prior to treatment, such as physical, sexual and/or emotional abuse. Estimates of the rates of trauma exposure among youth prior to placement into residential treatment range from 50% to over 70% [10-12]. Given the very nature of physical restraint, children who experience it are placed at greater risk of retraumatization and the development of comorbid psychopathology [13]. Children perceive being restrained as hostile and traumatizing and view the experience as detrimental to their relationships with staff [14,15].

Injuries: Due to a lack of sufficient research in this area, it is difficult to say with certainty how often children and adolescents are injured as a result of being restrained. However, one study, using the same data set previously cited provides a useful estimate [5]. Data were collected from six residential treatment facilities over a three-year period that included 794 youth representing 13,339 restraint episodes. The authors found that injuries associated with physical restraint are not rare, occurring on average 10.6% of the time. Therefore, within this one sample representing a small fraction of the 23,000 children in residential treatment at any given time, over 1,400 children sustained injuries.

Deaths: The use of physical restraints can be deadly. Nunno and colleagues conducted a 26-year study on restraint fatalities among children and adolescents in the United States [17]. The study found 79 restraint-related fatalities between 1993 and 2018. Using a different methodology, the Hartford Courant conducted its own investigation using a 50-state survey of mental health and children's residential treatment facilities and found that in the decade prior 142 children died shortly after being restrained or secluded [18]. It is difficult to know the precise number of children who die each year in the U.S. as a result of being restrained because there is no systematic documentation or examination of these incidents on the state or national level [17].

Asphyxia was the leading cause of death, followed by cardiac arrhythmia, suffocation, exertion, aspiration, cardiac arrest, internal bleeding, hyperthermia, strangulation, cardiac hypertrophy, blunt trauma, and dehydration [17]. The authors report that the children's deaths resulted not from the restraint position alone but from a combination of the staff's lack of competency in behavior management and support, their use of dangerous techniques, and the lack of organizational procedures to reduce safety risks [17]. In a review of 23 children who died during a restraint, the reviewers found that the deaths occurred in situations in which the child had not yet reached a point in which they were a danger to themselves or others [19].

Interventions and approaches to reduce the frequency of restraint and seclusion

Numerous attempts have been made to reduce or ideally eliminate the use of physical restraint and seclusion. Perers and colleagues summarize the various methods and strategies for reducing restraints in child and adolescent psychiatric inpatient (hospital) settings [20]. Two of the most promising approaches and their effectiveness are described here.

The Six Core Strategies: The Six Core Strategies were developed by the National Association of State Mental Health Program Directors (NASMHPD) through extensive literature reviews and discussions with experts who have successfully reduced the use of seclusion and restraint in a variety of mental health settings for children and adults [21]. The Six Core Strategies are based on child-centered, trauma-informed, and strength-based care and place an emphasis on prevention.

Various empirical studies have demonstrated the effectiveness of the Six Core Strategies in reducing restraint and seclusion. Azeem and colleagues found a downward trend in seclusions but not restraints among hospitalized youth [22]. Another study found that the implementation of the Six Core Strategies at a specialized mental health care facility resulted in a 19.7% decrease in restraint and seclusion incidents [23]. LeeAube and colleagues also examined the use of the Six Core Strategies and found a significant reduction in both restraints and seclusions [24]. Finally, Hale and Wendler report a 40% reduction in the use of restraints and seclusions at six months and reduced another 9% at 12 months [25].

Collaborative Problem Solving (CPS): CPS is a psychosocial treatment model for behaviorally challenging children and adolescents based on the assumption that children's problematic behaviors are attributed to expectations placed on them that are incompatible with their current neurocognitive skills [26,27].

Three empirical studies have shown that CPS reduces restraints in children placed in psychiatric inpatient units (hospital settings). In the first study, the developers of CPS report that in the nine

months prior to its implementation, there were 281 restraint episodes whereas in the 15 months after the implementation there was only one restraint. However, the authors state that this reduction only includes restraints lasting more than five minutes. Restraints lasting less than five minutes were also reduced but these data were not reported [26]. In a second study, restraints and seclusions were reduced from 148 per 1000 inpatient days prior to CPS to just 35 after its implementation [27]. A more recent third study found that restraints were reduced from 18.6% to 10.2% [28]. However, in a fourth study that specifically measured the effects of CPS in a residential treatment program, Pollastri and colleagues found no significant reduction in restraints per 1000 patient days (but a significant reduction in seclusions although these data were not fully reported) [29].

It is worth noting that despite considerable time and effort devoted to addressing the problem of using physical restraints on children, no study to date has been able to eliminate its use completely. Not all residential programs restrain children, but the author suspects it is not because they have learned how to better respond to out-of-control behavior, but rather that they choose not to work with out-of-control children at all. Residential programs can and do "cherry-pick" clients at the time of referral, i.e., screen out more challenging youth based on their history, or simply discharge a child if their behavior is deemed too difficult to manage. Additionally, programs that work with youth on probation typically respond to out-of-control behavior by simply calling law enforcement.

In the remainder of this article, the author will propose an argument as to why it will likely be impossible for residential programs to avoid using physical restraint and seclusion, and propose an empirically-based alternative that in many cases can bypass residential treatment programs and in many cases eliminate restraints altogether.

Structural and situational variables that incentivize and maintain the use of physical restraint inherent within residential treatment programs

Incentives for the use of physical restraint: There are a number of institutional incentives operating on both the staff and the program that make it more likely they will physically restrain a child.

First, the staff are trained to do so. This ties into a concept known as "social proof," a term coined by social psychologist Robert Cialdini to describe the tendency for people to copy the actions of others when we are not sure of how to behave in novel situations [30]. Simply being taught how and when to physically restrain a child creates an expectation among the staff that physical restraint is the correct and acceptable course of action. Indeed, trainings for staff on restraint interventions result in spikes in the use of restraints [31].

Second, although there might be an institutional emphasis on not restraining a child unless it is absolutely necessary, the staff and program leadership risk substantial negative consequences should they not physically restrain a child who is out of control. If another child in the program gets assaulted or injured, the staff will likely experience criticism from their supervisor ("Why didn't you intervene sooner?") or other disciplinary action (e.g., a written reprimand or termination). Supervisors and other program leadership will also experience negative consequences in the form of parents and referral sources demanding that their own child be kept safe from other children (rightfully so). Other children might be removed from the facility, thereby creating financial incentives for the program to engage in restraints. Extensive property damage can result from an unrestrained child, and the associated costs also create monetary incentives to restrain. Last, if a co-worker initiates a restraint, there are strong interpersonal incentives for other coworkers to participate in the restraint out of a sense of loyalty or solidarity.

The problem? Engagement: Trainings for the staff on how to intervene with an angry and possibly violent child universally include various de-escalation techniques such as avoiding eye contact, using a matter-of-fact tone of voice, and validating the child's emotional experience ("I can see you're really mad right now and I get it"). However, these de-escalation techniques, plus the requirement that the staff remain in close physical proximity to the child, all have one common ingredient: engagement. An acting-out child gets the full attention of the staff, as well as the ability to engage the staff in prolonged back-and-forth verbal exchanges. Engagement is simply unavoidable due to the situational demands in residential treatment. However, the author will offer evidence that it is the very act of staying engaged that drives and often maintains out-ofcontrol behavior, both in residential treatment and elsewhere (the child's home, school, and so on).

As mentioned previously, when a child begins to escalate, it results in an increase in attention from staff, but it is more complicated than that. There is a longstanding, culturally held belief that misbehaving children do so for attention ("Any attention is better than no attention at all"). This is simply untrue. The author does not argue with his wife because he wants her attention, rather he argues because he wants things one way and she wants them another. This holds true for children as well.

In the vast majority of cases, children and teens do not act out to get their parents' or caregivers' attention, instead they do so because they want their way on something and aren't getting it. There can be other reasons, of course, but this seems to be the most common dynamic when there is conflict between children and adults. Additionally, acting out often has the effect of influencing the behavior of other people in desired ways. For example, becoming explosive often results in getting parents and other caregivers to back off on an expectation or setting a limit ("I don't talk to them about homework anymore because it just ends up in a fight"). Becoming highly dysregulated when asked to get off a screen or device results in parents sometimes acquiescing to the child's demands and giving more screen time, thereby reinforcing the dysregulated behavior. This pattern of intermittent reinforcement (sometimes giving in and sometimes not) has often been present for years in a family, resulting in the child's dysregulated responses becoming entrenched and habitual. Children and teens who are temperamentally more oppositional or prone to dysregulation have had many more opportunities to experience this unhelpful reinforcement pattern than their easier-to-parent siblings or peers.

As mentioned previously, the developers of Collaborative Problem Solving (CPS) (and others) argue that when a child becomes out of control it is because they lack the cognitive skills to successfully meet the demands of the situation. The author does not believe this is the case with most explosive, dysregulated children. Evidence against this hypothesis comes from the fact

that many children and teens who have out-ofcontrol behavior in the home do not behave like this in other environments. If this was simply a neurocognitive deficit, one would expect the child to behave in a similar fashion in other environments that also place similar demands on them (e.g., school). Obviously, some children do have explosive episodes in more than one environment, but many do not. Furthermore, with proper treatment, explosive episodes begin to subside relatively quickly with no observable acquisition or routine use of emotional regulation skills on the part of the child or teen.

The author will offer a competing hypothesis: much of the out-of-control behavior that leads to physical restraint is actually a naturally occurring by product of unhelpful bidirectional influences between a child and their parents or other caregivers that arise during engagement rather than the child having a skills deficit issue.

It is a natural human tendency for adults to stay fully engaged with an out-of-control child and for the out-of-control child to stay fully engaged with the adult. Typically, this is in the form of a back-and-forth argument, a tug-of-war if you will, about whatever made the child upset in the first place, often compounded further by a series of unhelpful adult commands ("You need to calm down," "Put the chair down," "You can't talk to me that way," etc.). Typically, commands such as these result in the child getting even more angry and dysregulated.

The author will now discuss a highly effective alternative to engagement, one that is supported by empirical evidence.

Alternatives to residential treatment that do not physically restrain children: Family- and home-based treatment models

It is a common argument to hear that children must be placed into residential treatment because there is no other alternative.

The author and his colleagues deliver intensive family-focused therapy (IFFT), a form of family and home-based mental health care. It is one of several such outpatient models that treat children and adolescents with treatmentresistant mental health conditions and severe behavioral challenges [32]. Significant empirical support exists spanning the past 40 years for the efficacy of familybased treatments for serious mental health conditions that include oppositional behavior. Several of these models were developed specifically to be an alternative to residential treatment [33]. These include functional family therapy, multidimensional family therapy, and multisystemic therapy [34-36]. Carr et al. provides an excellent comprehensive review of these and other family-based models, their empirical support, as well as their strengths and limitations [37].

It is important to note that many family-based, outpatient treatment models work with children and adolescents who often have the same degree of psychological and behavioral challenges as children served in residential treatment programs. Three of the four models above (functional family therapy, multidimensional family therapy, and multisystemic therapy) were developed to treat substance-abusing adolescents involved in the juvenile justice (probation) system, a notoriously difficultto-treat population. In intensive family-focused therapy, almost half of the children treated have problematic behavioral scores as high or higher than children in residential programs and psychiatric inpatient units as measured by the Youth Outcomes Questionnaire v.2.01 (a total score of ≥ 115 and 110 respectively) [38]. Many of these patients also have an extensive history of prior psychiatric hospitalizations and failed residential placements.

It is important to note that neither IFFT nor any of the other family-based models cited here include parents physically restraining their children. However, many of these children can be successfully treated on an outpatient basis and kept out of residential care. Each of the models likely approaches unsafe, out-of-control behavior somewhat differently but the author will describe how this is achieved in IFFT.

Disengagement (active ignoring)

It is not at all uncommon for the parents of children and adolescents prior to the start of IFFT to have experienced numerous out-of-control episodes in the home, often resulting in the parent physically restraining their child. Parents' motivations for doing so are often the same as that of the staff in residential treatment: they believe that their child is so out of control that they simply have no idea what else to do.

As mentioned previously, a history of unhelpful bidirectional influences typically exists in the home. The child will begin to escalate and the parents will try to do something about it, which typically includes telling the child repeatedly to stop or threatening them with consequences. In the author's 40-plus years of clinical experience, he has never met a parent who does not stay fully engaged with their angry, out-of-control child. It is what people do in that situation, and from the parent's perspective it makes sense: "I need to do something to stop them."

There is just something about human nature that keeps people in heated arguments despite no one liking them. We all know the feeling–it's just very hard to stop talking and walk away from someone when angry. Parents are likely wanting to exert their parental authority and get their way ("I need to show them that I'm the parent"), and conversely, the child is also trying to get their way ("Let me do what I want"). These needs are often incompatible and therefore cannot easily reconciled. And there's something as well about arguing with family. As human beings, we often save our worst behavior for the people we care about the most. Nobody fights better than family.

As the author has stated, it is the process of staying engaged that results in mutual, unhelpful reinforcement, which escalates the child's behavior to the point in which they become physical. Parents then respond by becoming physical themselves (restraining the child) and thus the pattern of engagement leading to escalation and then restraint gets repeated over and over across time, resulting in trauma and ruptured attachments that fuel even more resentment and problematic behavior.

For the reasons stated previously, staff in residential programs must respond by staying engaged with the child. They really have no choice because of the structural and institutional demands placed upon them, thereby repeating the same patterns of reinforcement that occurred in prior settings (home, school, hospitals, etc.), but staying engaged is simply the wrong clinical intervention.

Parents, however, do not have the same structural or institutional constraints and are therefore free to respond to an out-of-control child very differently. If we know that fully attending to an angry,

dysregulated child or teen (talking to or otherwise interacting with them) plays a significant role in reinforcing the pattern of out-of-control behavior, an important component of treatment involves changing this reinforcement pattern. This is typically best accomplished using a three-pronged approach, one focusing on what the parent can do differently, one focusing on what the child can do differently, and the design and implementation of various behavioral incentives for the child to manage their strong negative emotions in a more effective way. Again, this has nothing to do with children seeking attention, it is about how to break the pattern of mutual engagement that results in inadvertently reinforcing the very behavior we are trying to change.

IFFT begins by providing psychoeducation to the parent on the nature of this mutual engagement-reinforcement pattern. It is important to talk with parents about the rationale for adopting a different course of action when the child becomes escalated so that they are fully on board and committed to the idea. The strategy of disengagement is often quite foreign to parents and counter-intuitive. We also forewarn parents that the strategy can be difficult to implement, especially at first and it will likely result in an extinction burst (a temporary worsening of behavior) [39].

Disengagement is implemented as follows. Parents are advised to remain engaged (interact) with the child or teen early in the escalation cycle while the child is still reasonably calm. At this stage, it is often possible to problem-solve or collaborate with the child to arrive at a mutually agreeable solution. However, if the child begins to lose their temper and becomes disrespectful, parents are instructed to say, "Look, I can't have a conversation or help you with this as long as you're yelling." If the child calms down, the conversation can proceed but if the child does not stop yelling or continues to make disrespectful comments, we ask the parents to say, "Happy to talk again once you've calmed down" and then walk away from the child.

This is obviously very different from what most parents have done before, and this is the first moment in the family in which the historical pattern of engagement-reinforcement starts to be disrupted. Most often, the child will try to draw the parent back into an argument through various means because this is what the child is familiar with and has been inadvertently reinforced for doing many times. Parents must stay true to the strategy and not interact with the child again until they have fully calmed down, no matter how long that takes (which is typically under an hour but sometimes longer). However, most children will not allow their parents to disengage and will follow them around the house, still making attempts to say or do something to draw them back into conflict. It takes time and effort on the part of the parents to learn and maintain this strategy.

And this does mean never engaging when their child is escalated and/or disrespectful. It is the perspective of IFFT that holes in the wall or broken furniture can be fixed but a violent solution (restraint) can damage relationships in ways that are far more difficult to repair. Sometimes, if the child doesn't allow their parent to disengage, this strategy requires the parent to go to their bedroom or a bathroom and lock the door or even or leave the house (and take siblings with them if they become a target). Families have access to their IFFT therapists almost around the clock, so the treatment team can stay in contact during an escalation and advise the parent on exactly what to do to keep everyone safe until the situation has been fully resolved.

The best real-world example that illustrates the idea of how difficult (yet effective) it can be to disengage is as follows. The patient was an adolescent who would go to great lengths to engage their parents when dysregulated. On one occasion, they took a knife and started cutting up a sofa. While understandably difficult for the parents, it was important that they remain disengaged or their teen would do this every time because they would learn that's what it took to get the parents to engage again. The parents were advised to leave the house and not comment on the sofa (not then anyway), and, not surprisingly, the patient immediately calmed down as soon as the parents left (this was ascertained because the patient's brother was at home). Obviously, there must be a careful assessment of possible self-harm or other safety issues in situations such as this and take steps to mitigate these risks if necessary.

Occasionally, a parent or therapist will make the comment that disengaging from an angry child seems like "abandonment." The author does not believe this is the case at all. Parents might give the appearance of ignoring the child, but in reality the process is actually quite active in that they still quietly monitor the child to ensure their safety. There are many real-world precedents for disengagement as well. An adult would never think of remaining in a conversation with another adult who was screaming and cursing at them (hopefully). We are much better at maintaining boundaries with other adults who mistreat us, yet for many reasons, parents are often reluctant to set similar boundaries with their children.

Typically, disengagement works best when it is paired with some sort of mild penalty for episodes of severe dysregulation, such as a brief period (a day or two at the most) of a child or teen not having access to privileges, most commonly a screen of some sort (phone, gaming system, etc.). IFFT favors the use of negative reinforcement ("You'll need to earn your phone back by not having another upset for a while") vs. punishment ("You've lost your phone for a week"). On the positive reinforcement side of things, privileges can be accessed on any day when there is no out-of-control behavior.

As mentioned previously, IFFT does not necessarily see severe dysregulation as a skills deficit. In IFFT, children are taught emotion regulation and other skills, but they are often very reluctant to use them when angry. The interventions described here are also paired with many discussions in individual and family therapy sessions about whether out-of-control episodes get the child what they want and what other strategies they might use to get more of what they want (e.g., more regular access to privileges), such as walking away, taking time to calm down, accepting no, negotiating with their parents respectfully, and so on. IFFT teaches children that it is okay to be angry, but it is not okay to take that anger out on anyone, especially family ("You can be mad, but you can't be mean"), nor is an out-of-control episode an inevitability of getting angry.

Episodes of dysregulation typically begin to subside within the first two or three months of treatment and in most cases are reduced to zero by the conclusion of treatment, all without parents ever becoming physical with their child.

Other family-based treatments that also include disengaging: Disengaging, i.e., actively ignoring tantrums and severe emotion dysregulation, has considerable empirical support and is also recommended by other evidencebased family treatments for

children with oppositional, aggressive, and out-of-control behavior. These include Parent management training [40,41], parent-child interaction therapy [42-43], and the incredible years [44,45]. In addition, the Centers for Disease Control and Prevention also recommends that parents actively ignore children who are dysregulated [46].

CONCLUSION

The use of physical restraint or seclusion in residential treatment remains highly controversial and for good reason. Research indicates that these interventions can worsen a child's mental health condition, traumatize or re-traumatize them, cause physical injuries, and even result in the child's death.

The author has argued that there exist institutional and contextual incentives in residential treatment programs that will likely make it difficult if not impossible to discontinue the use of physical restraint and seclusion. Staff are taught how and when to restrain a child and therefore expect to do so (social proof). By not restraining, staff open themselves up to negative employment consequences if another child gets injured, or if property damage results in significant financial expense for the organization. Most importantly, staff are trained to stay continuously and fully engaged with an out-of-control child, a response that runs counter what has been found to be effective in empirically supported treatments.

The author has argued that it is this process of bidirectional engagement-reinforcement that sustains a child's out-of-control behavior. This pattern of reinforcement, rather than some sort of neurocognitive skills deficit on the part of the child, typically becomes entrenched in families over time, thus the severe actingout behavior becomes chronic and habitual, as does the parent's or caregiver's less-than-ideal response to it.

This article describes the empirically supported process of disengagement, i.e., not speaking to or otherwise interacting with an out-of-control child until they have fully calmed down. Disengagement, when combined with other clinical strategies and incentives, is an effective intervention that can be used by parents in the home to avoid having to physically restrain their child or put them in institutions where someone else does. Although disengagement has been found to be effective in IFFT and in other treatments, more empirical study on its use is recommended.

Residential treatment is not the only option. Family- and home-based treatments have over 40 years of documented clinical efficacy and are a viable alternative. Obviously, not all children can be treated at home (and not all children have families to take care of them), so residential treatment will remain an important part of the mental health continuum. However, family-based treatments are still largely unknown to most parents. Despite their clinical efficacy, the reach of family- and home-based treatments is still limited and the mental health community must be better at educating parents about their existence.

Paris Hilton's story of her abuse as a teenager in a residential treatment program has become quite well-known. In 2024 she testified before the United States Congress describing her experiences and she has become a powerful advocate for treatment alternatives that keep children with their families [47]. Obviously, the author does not have access to all of the information that led to her placement in residential treatment, but her public account of her struggles at the time sound very much like just a rebellious teenager. The author would be curious to know if Ms. Hilton's story would had turned out differently had her parents been made aware of family-based treatment options.

Health insurance companies in the U.S. also seem largely unaware of family-based therapies. The author has yet to meet a young person referred to family treatment by their insurance company despite research showing that family and home-based treatments result in a significant reduction in healthcare costs relative to individual therapy alone [48].

The practice of physically restraining children must stop. Familyand home-based treatments that do not restrain children are a viable and effective alternative to residential treatment. Children and adolescents with serious mental health challenges deserve the opportunity to get well at home with the support of their own families before experiencing far more intrusive, invasive, and sometimes dangerous alternatives.

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