Article

Pathways to Evidence-Based Practice in Therapeutic Residential Care: A Commentary

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What a pleasant surprise! Here assembled in a top rank journal is a collection of thoughtful, empirically oriented, and stimulating contributions. Together, they shine light on a far too long neglected area of child mental health (CMH) intervention: therapeutic residential care (TRC). Moreover, they accomplish this while avoiding the falsely dichotomous and divisive rhetoric that sometimes suffuses discussions of residential, family-based, and community-based service choices. These researchers present their findings and recommendations in a spirit that fully embraces the heart of progressive thinking in CMH: solid commitment to Systems of Care Principles (Stroul, Blau, & Friedman, 2010) and healthy respect and admiration for recent stellar achievements in family, foster-family, and community-based interventions work. I refer here to the impressive and growing corpus of research on child and family interventions, including the work of such pioneering investigators and program developers and their teams as Scott Henggeler—Multi-Systemic Therapy (MST)—and Patty Chamberlain—Treatment Foster Care Oregon-Adolescents (TFCO). Both interventions achieved the highest level of scientific rating from the California Evidence-Based Clearinghouse for Child Welfare (CEBC) as “Well Supported by Research Evidence.” In addition, Janet Walker and Eric Bruns, co-directors of the National Wraparound Initiative and their team have provided impressive leadership in raising Wraparound to the status of “Supported by Promising Research Evidence” as assessed by the CEBC. These three teams are exemplars of some of the best contemporary work underway in intervention research. For a summary of the status of evidence-based and evidence-informed alternatives to TRC, the interested reader is directed to the recent report from the Chadwick Center at Rady Children’s Hospital in San Diego and the Chapin Hall Center for Children at the University of Chicago (Chadwick Center & Chapin Hall, 2016) as well as to numerous citations from the three teams.

And no wonder, individually, these multi-disciplinary contributors bring a wealth of research experience to their task, as well as a variety of research leadership activities. These include decades of experience creating an active research presence in a youth services setting (Thompson and Daly), ongoing experience as research deans in two major national schools of social work committed to evidence-based practice (EBP; Farmer and Lee), pioneering bridge-building work between the worlds of service and university-based research (McMillen, Thompson, Huefner, Dupong Hurley, Lambert, and Bruce), iconic and longstanding leadership in CMH services research and policy (Burns), and, perhaps that rarest of achievements, directing National Institute of Mental Health (NIMH)-funded efforts designed to fathom the critical elements in TRC (Farmer, James, and Dupong Hurley). Collectively, this group represents the core of a national leadership team in TRC research—in my view, a necessary element—if the ideas and tantalizing findings from these individual efforts and those of others are to be carried forward in any meaningful way, a theme I’ll return to later in this commentary.

What Do These Five Papers Tell Us About the State of Research in TRC?

As the five papers in their rich detail are at hand, I offer here only the briefest selective summary of what they offer. Lee and McMillen (2017) offer a series of strategies for incorporating EBPs in therapeutic residential programs that “move beyond packaged programs.” These include (a) adopting the common elements approach as developed by Chorpita (Chorpita, Becker, and Daleiden, 2007) and others, (b) creating “home grown” interventions within the residential setting and working to establish their efficacy, (c) adapting existing EBPs for use in therapeutic residential settings, and (d) adapting the therapeutic residential setting

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itself to facilitate the adoption and integration of EBPs into current practice. This thoughtful and provocative paper dovetails nicely with the contribution by James, Thompson, and Ringle (2017), which draws from survey data based on a sample of U.S. residential care providers on the integration of EBPs into the residential setting, including examination of the outcomes, processes, and barriers related to successful implementation. As the authors note, they collected descriptive data on 115 EBPs implemented in 66 residential care agencies, which were then analyzed with regard to multiple domains of implementation outcomes, such as the adoption, appropriateness, fidelity, and sustainability of EBPs (Proctor et al., 2011, cited in James, Thompson, and Ringle, 2017). Farmer, Murray, Ballentine, Rauktis, and Burns (2017) shed light on the elusive question of what constitutes “quality” in TRC and draw substantially on recent studies by Farmer et al. (2017) focused on a specific model of TRC: the Teaching Family Model. In reviewing prior work in this area, the authors underscore the oft-cited observation (Pecora & English, 2016) of the heterogeneity of settings typically included in surveys of group or residential care. The final two papers originate from studies on an adaptation of the Teaching Family Model (The Boys Town Family Home Model; Thompson & Daly, 2014) in what is likely its largest current application at Boys Town in Nebraska and related satellite programs. The first of these examines the role of “therapeutic alliance” along with youth ratings of implementation quality and ratios of positive to negative statements in relation to youth emotional and behavioral functioning at 6 months into therapeutic residential services (Dupppong Hurley, Lambert, Gross, Thompson, & Farmer, 2017). The second of these papers describes the pitfalls, promises, and organizational requisites for mounting an ongoing research partnership between a large TRC setting and a university-based research center: a structural innovation that is referenced in other papers as well (Lee & McMillen, 2017).

Viewed as a series, these five papers offer proof positive that quality research and critical thinking in TRC research are alive and well. Yet viewed in a wider context—which virtually all author teams acknowledge—the research base on TRC is limited and often lacking in rigor. Regrettably, this is particularly true with respect to research that provides solid empirical support for exemplary TRC “whole-cloth” program models, as well as studies that identify the critical—necessary and sufficient—elements in effective TRC programs. For example, although a research review by James identified several “promising” TRC models, there are none as of this writing that meet the highest levels of evidence as recognized by the CEBC, which provided the yardstick for this particular review (James, 2011). Although randomized controlled trials (RCTs) remain the elusive brass ring in TRC research, Lee and Barth (2014) offer some creative and useful strategies for TRC researchers desirous of improving the rigor of their research in situations where RCTs may not be presently feasible.

Suggestions for a Future TRC Research Agenda

What are the pathways forward for a more robust research effort to define and evaluate the proper place of TRC as one element in a suite of intensive interventions—including family, foster-family, and community-based alternatives—designed to meet the needs of high-resource using children, youth, and their families? Is TRC to be seen as a viable service alternative? If utilized, should it be seen solely as a last resort to be used only in acute situations, for limited periods of time? Are iatrogenic effects such as “deviancy training” a necessary outcome of group-based intervention approaches, or can these be avoided with careful attention to critical elements of successful program design? These are large and continuing questions and underscore the need for an enhanced and robust research effort moving forward.

To conclude this brief commentary, I offer three suggestions: (a) the need for a sharper and clearer definition of what is meant by “therapeutic residential care,” (b) a renewed effort to bring at least one exemplar of TRC to trials to determine its efficacy as an evidence-based intensive intervention, and (c) creation of a national leadership group to provide oversight and guidance to an expanded TRC research effort.

As previously noted, many reviewers have pointed out “therapeutic group residential care” as an umbrella term masks individual differences within and between program exemplars:

To say “residential care” or “residential services” communicates little beyond minimal setting information. The sheer range and variability of service components, change theories, frequency, intensity and duration of specific intervention strategies, organizational arrangements (size of living units, lengths of stay, staffing arrangements, for example) to say nothing of protocols for staff training and development and the integration of ongoing, systematic evaluation, all argue for increasing precision and specificity in both description and analysis. If residential services have fallen from favor as many of our contributors have noted, at least a partial reason must surely be that the term can mean so many different things in different contexts. This masking of differences in the use of umbrella terms such as “residential care” contrasts ever-more sharply with the conceptual and empirical precision that characterize many newer evidence-informed and evidence-based approaches to work with troubled youth such as Multi-Systemic Treatment (MST) and Multi-Dimensional Treatment Foster Care (MTFC) referenced in several earlier chapters. Proponents of these promising and innovative stratagems can speak with clarity and precision about intervention components, lengths of
service, costs and organizational characteristics in ways that are compelling to policymakers. In a head-to-head comparison with a largely unspecified and variable “residential” comparison, they will almost certainly win the rhetorical as well as the empirical battle. (Whittaker, del Valle, & Holmes, 2014, pp. 329-330)

To address the definitional question, as well as related issues, an international work group convened early in 2016 at the Centre for Child and Family Research (CCFR) at Loughborough University in the United Kingdom for a summit conference on TRC (the multi-disciplinary work group consisted of 32 participants including researchers and service providers from 11 countries including United Kingdom, Australia, Netherlands, Spain, United States, Italy, Israel, Ireland, Norway, Denmark, and Canada). Led by Lisa Holmes, director of CCFR at Loughborough University, Jorge Fernandez del Valle, professor of psychology and director of the Child and Family Research Group at the University of Oviedo, and myself, The Sir Halley Stewart Trust, United Kingdom, funded the summit. The resultant “Consensus Statement” on TRC was published in early September 2016 and simultaneously launched at the XIVth EUSARF (European Scientific Association for Residential and Family Care) Conference at the University of Oviedo, Spain, September 13 to 16, 2016 (Whittaker et al., 2016). The work group adopted the following working definition for its Consensus Statement as a beginning step toward delineating what “therapeutic residential care” represents:

Therapeutic residential care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources. (Whittaker et al., 2014, p. 24)

This nominal definition was not meant to be confined to a single model of TRC, any more than non-residential, family-based interventions are confined to a single model of service. We used this definition in our recent review as a means of establishing a beginning attempt at a common language (Whittaker et al., 2014). In substance, in values and means of establishing a beginning attempt at a common language (Whittaker et al., 2014, pp. 329-330)

In the U.S. context, this definitional issue takes on a particular sense of urgency just now. As of this writing, a bipartisan piece of congressional legislation—the Family First Act— presently on-hold at least until after the election portends significant changes in the delivery and funding of intensive out-of-home care services for vulnerable children and youth with far greater emphasizes on family-based services, permanency, and utilization of EBPs (Children’s Defense Fund, 2016). Although widely supported among child and family advocates, the bill in its present form offers many challenges to those who will implement its provisions. For example, although something called a “Quality Residential Treatment Program” (QRTP) is identified in the existing bill, its definition and key features—particularly with respect to critical service components and evidence base—remain tasks to be addressed. Even if this particular initiative fails to be enacted, the factors that propelled its genesis and legislative trajectory—particularly, the focus on family-centered care, permanency, and utilization of EBPs—are unlikely to recede. In my view, this gives added impetus to the need to provide increased attention to the definitional issue for “Quality Residential Treatment” referenced above: preferably, informed by prospective high-quality practice research, rather than discussions in a legislative conference room.

Moving now to the issue of identifying an evidence-based model for TRC, encouraging support for an RCT for one or more promising models of TRC seems to me a research and funding challenge that is both long overdue and well worth the effort. Lee and McMillen (2017) rightly note the “humble” origins for the whole-cloth TRC models identified by James (2011) as having some level of research evidence and, thus, showing promise. While this is true, it is also true that two of the five milieu models identified by James (2011) as showing “promise”—The Re-ED Model pioneered by Hobbs and colleagues in Tennessee and North Carolina (Hobbs, 1966, 1982) and The Teaching Family Model originated by Phillips, Phillips, Fiks, and Wolf (1971, 1973) and colleagues at the University of Kansas, in fact, received substantial multi-year awards from NIMH to refine, develop, codify, and disseminate their group-based approaches to work with troubled children and their families. These initiatives in the 1960s and 1970s were preceded by an even earlier NIMH-sponsored initiative in the mid-1950s to refine, develop, and replicate the innovative TRC model developed by Fritz Redl and David Wineman in their Pioneer House Project in Detroit (Redl, 1966; Redl & Wineman, 1957). James (2011) provides an excellent contemporary review on these models.

So what have we learned from these pioneering efforts in TRC—including some from “ancient” history? From Redl and Wineman (1957), we learned the importance of bringing therapy from the consulting room to the life-space and involving those closest to the children—the youth care workers, the house parents—directly in its delivery.
We learned that the “whole is greater than the sum of the parts” and that constructing a therapeutic milieu is not simply an additive process, but an integrative one: a take-away message that should resonate with proponents of constructing therapeutic environments simply by adding more individual EBP’s to a treatment regime. Finally, we learned that relationship matters: a theme echoed in several of the contributions at hand (Duppong Hurley et al., 2017; Farmer et al., 2017). From Hobbs and colleagues in Project Re-ED, we see the beginnings of what we call today a “strengths perspective” oriented to competency acquisition. We see an interesting attempt to blend teaching/therapy roles in a psycho-educational approach. We see the outlines of an ecological approach to treatment planning with strong emphases on engaging families and limiting residential stays to 5 days with weekends at home. Finally, from Phillips et al. (1971, 1973), we learn that applied behavior analysis can work in a group setting and that the ratio of positive reinforcement to corrective feedback is critical. All of this is accomplished in a family-like setting with a well-trained couple as primary service deliverers. We learn something of the importance of maintaining and monitoring change across settings—home and school, for example—and we learn something of how a model can be refined and modified through continuous evaluation and then replicated (Thompson & Daly, 2014). I submit that this is a pretty impressive return on what were rather modest investments in earlier decades: But, it is critical that this work continue. By my count, it is now slightly more than 40 years since the last significant infusion of developmental support from either a government or private foundation was specifically designated for TRC.

In my judgment, the leading candidate for an RCT among the promising models identified by James (2011) is The Teaching Family Model: specifically, in the adaptation presently in use at Boys Town in Nebraska and in a number of communities around the United States (Thompson & Daly, 2014). I base this recommendation on the corpus of research on this model since its inception in the 1960s, the present infra-structure to support training and evaluation, and the fact that the Boys Town National Research Institute and its university partners have a proven track record of carrying out high-quality studies from funders with exceedingly high standards such as NIMH. Although one hopes that alternate models of TRC will one day be brought to trials, this would be an excellent beginning.

Finally, with respect to my third suggestion, I believe there is little likelihood that meaningful progress will be made on defining and empirically validating a high-quality TRC presence in the existing service array without strong and consistent national leadership that bridges the research–practice gap. A good starting point would be to identify a prioritized national research agenda for TRC and then actively seek public and philanthropic sources for funding. Lee and McMillen (2017) offer some useful suggestions for linking the research community with existing service associations such as the Association for Children’s Residential Centers and the paper by James, Thompson, and Ringle (2017) illustrates the fruits of such linkages in its exploration of EBP integration into existing TRC settings. I believe there is much to be learned from the experience of other national service improvement efforts, such as the previously cited exemplary work accomplished over the last dozen or so years by those working to improve both the efficacy and implementation of the Wraparound approach. Although as Eric Bruns, co-director of the National Wraparound Initiative, was kind enough to point out, the success of that effort had less to do with the receipt of specially designated funding for model development and dissemination—of which there was precious little. Rather, as he stated, “it was an effort borne of and fueled by dozens of collaborators who were invested in achieving the goals” (of Wraparound; E. Bruns, personal communication, August 1, 2016). This is a point well taken as one considers what will be involved in launching a comparable national effort for TRC. Personal experience convinces me that simply enumerating a set of research priorities for TRC offers no guarantee that these will be implemented (Whittaker & Pfeiffer, 1994).

One final point: The five papers referenced here represent thoughtful and creative contributions to the TRC research literature. One hopes that this work continues and will be expanded. Ultimately, closer links between the research and practice communities will result in more effective and humane service stratagems for children, youth, and families. To the extent that we will continue to need some high-quality TRC capacity in our service array, albeit with a reduced profile, let us commit to making it the very best we know how to offer. To me that means moving TRC into full harmony with systems-of-care and full accordance with EBPs. The author teams here have shined the light on some intriguing pathways toward both these goals. As Lee and McMillen (2017) point out “small steps” are important.

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