



Redefining Residential: Integrating Evidence Based Practices

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This is the fifth in a series of papers being issued by the Association of Children's Residential Centers (ACRC) regarding key program and policy issues facing the field of residential treatment. ACRC is the longest standing national association focused exclusively on the needs of children who require residential treatment and their families. Over the past several years ACRC has engaged with national policy makers, family members, youth, and its membership in an effort to redefine the shape and scope of residential treatment as an intervention for youth with serious emotional and behavioral disorders and their families.

This paper addresses issues related to the use of evidence based practices in residential treatment. It will address the national context, issues specific to residential treatment, and ideas that organizations can consider as they encounter policy and program challenges.

Current Context

There is increasing demand at the national and state levels to address the effectiveness of services provided to children and families. At the national level major reports from the Surgeon General (1999), the Institutes of Medicine (2001) and the President's New Freedom Commission (2003) have identified the gap between research and service delivery, and have recommended closing it through timelier implementation of practices supported by research-based evidence. Federal agencies have responded with the development of a "tool kit" regarding specific practices found to be advantageous in working with children with disruptive behavior disorders as well as a resource guide for establishing evidence based cultures in the child serving system. Several states have passed laws or implemented policies fostering the introduction and implementation of evidence based practices (EBP).

However, many competing definitions of EBP are offered by clinicians, researchers, and constituencies. The most scientifically rigorous of these is:

"...identified through at least two control group design studies, with a minimum of two investigators, employing a treatment manual, with uniform therapist training and inheritance..."

Other definitions take a broader view. The Federation of Families for Children's Mental Health (FFCMH) has defined evidence based practice as:

"child and family history and experience of what works and what does not."

A definition that incorporates these and others has been advanced by the American Psychological Association (2006):

"the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."

Additionally key constituencies have raised concerns about emerging EBP policy and practice-

-Family members express apprehension that EBP have been developed in controlled settings with specific populations and/ or in specific locations, and may not be sufficiently individualized or culturally appropriate. They assert the importance of practice based and community defined evidence, bottom up approaches that incorporate knowledge of what has worked or might work in their families in real clinical and community settings.

-Cultural and ethnic groups are concerned about the lack of EBP for ethnic/racial populations as well as the lack of inclusion of these populations in current development or replication studies. They assert the need for more effort focused specifically on discovering information that already exists in cultural communities about what has worked over the course of time.

-Practitioners, whether working in individual practice or within an organization, find adherence to manualized interventions problematic. They express concerns about the replacement of clinical judgment with approaches that have fixed content, fixed intensity, and fixed duration requirements. Some practitioners have argued that the exclusion criteria employed by EBP limit the ability to use the intervention for children who do not neatly fit into a specific diagnosis, or who meet criteria for multiple diagnoses.

-Researchers have reached varied findings regarding the variables affecting outcome. While the clear demonstrated effectiveness of interventions tested and twice replicated in randomly controlled trials is compelling, there is also extensive research that client factors, the alliance between the clinician and the client, and the impact of perceived hope account for a greater degree of the change than the specific model or technique used.

-Organizations face multiple challenges in implementing EBP. Although research has identified a number of organizational variables that affect the degree to which an EBP will be effective, the relationship between organizational characteristics and implementation is typically not addressed in the studies. Administrators point to these issues as well as to the costs of implementing EBP, maintaining fidelity, training, and retraining.

Important efforts are occurring to address these challenges. The APA and others speak to the importance of “practice based evidence”, defined as:

“...a range of treatment approaches and supports that are derived from and supportive of the positive culture of the local society and traditions...and accepted as effective by the local community, through community consensus...and (that) address the therapeutic and healing needs of individuals and families from a culturally specific framework..” (Isaacs, Huang, & Echo-Hawk, (2005)

Similarly, increased attention is being focused on evidence based thinking, a process through which decisions are made in collaboration with the child and family based on what is known about the best available clinical practices, informed by data regarding client progress and outcomes.

Recent research has highlighted the “common elements” approach, in which specific techniques and procedures that are common to evidence based treatment protocols are identified and distilled into smaller practice elements, allowing practitioners the choice to either use the protocol in full or use the discrete practice elements (Chorpita, Becker, and Daleiden, 2007). This approach enables treatment plans to be built based on the correlation between specific practitioner-child interactions (time-out, cognitive, etc.) and broad diagnostic problem areas (e.g. anxiety, depression, attention, conduct).

New models are being developed to synthesize these various approaches to EBP, by designing treatment plans (following a comprehensive assessment) that integrate information from:

- evidence based practice research (*i.e. which models have been shown to work*),
- common elements research (*i.e. what specific intervention elements have proven effective*),
- practice-based evidence (*i.e. what has worked in this community, with this culture, and/or in this organization*), and

-case specific evidence (*i.e. what has worked or is working with this child and family*).

Implications for Residential Treatment

Regardless of the varying definitions of EBP, the “gold standard” that needs to be met for an intervention or model to be formally accepted as an EBP is the most rigorous of those referenced above (e.g. twice replicated controlled studies, treatment manual, etc.). Given the nature of residential- the exponential number of interactions that occur within milieu settings that contain a significant number of children for varying lengths of stay and adults that vary by shift- along with the variability between programs, it would be a research challenge of monumental proportions to establish the controls necessary to prove the evidential basis for residential treatment per se to be recognized in the scientific and policymaking communities as an EBP. The challenge for the field thus becomes how to engage the current and upcoming EBP mandates productively, redefining residential as a multimodal intervention, invaluable for specific children and families at specific times, which incorporates specific evidence based practices as well as practice based evidence in the interactions that occur between staff, children, and families.

Doing so is not easy. Residential treatment programs are more than mere places; they are settings that contain and sustain unique cultures. As such, implementation of some evidence based practices as part of ongoing programming may not fit within the existing culture of the organization. The multi-variant human interactions in an environment as complex as a residential treatment milieu have the potential to confound implementation of EBP. Additional challenges are created by the costs of EBP. Some models have significant upfront and ongoing training costs that are compounded by costs associated with training and retraining of staff, turnover, and administrative overhead.

These challenges notwithstanding residential agencies across the country are making efforts to implement EBP. These include: adding client-specific models (such as dialectal behavioral therapy and trauma informed cognitive behavioral therapy) into their programming; introducing milieu-wide interactive approaches (such as motivational interviewing and collaborative problem solving); and working with community partners to send youth to evidence based treatments offered in community settings. However, the degree to which any or all of these approaches are integrated into a residential treatment intervention that remains coherent to the youth and family, and that honors youth and family choice, varies and there are not currently studies that compare their effectiveness and outcomes.

Embracing the Challenge

Although it may seem inarguable that basing our work on what has shown to be effective is obvious, many residential treatment organizations find the challenge of implementing evidence based practices daunting, even (for some) overwhelming, related to the multiplicity of factors noted above. The emerging consensus among professionals, parents, and policy makers alike suggests that the development of cultures within residential treatment organizations that embrace evidence based practice and practice based evidence, will do much to achieve the ultimate goal of improved outcomes as a result of services.

Such cultures would support and encourage evidence based thinking as defined above- collaborative decision making based on what is known about best practices, informed by data about individual client progress. As a foundation they would implement and/or sustain the critical elements that have been shown to produce positive impact in residential treatment, in particular a healthy, safe environment with informed and knowledgeable staff who know how to interpret and respond to language and behavior in such a way as to develop therapeutic relationships that offer hope and recovery.

Organizations can take (or sustain) several actions that will facilitate the establishment of an evidence based culture and enable them to respond to the EBP challenge while promoting improved performance and outcomes. A few are noted below-

- Create an organizational climate that nurtures and sustains a positive perception of the workplace and the importance of evidence based thinking among all staff.
- Ensure that service plans are based on: a high quality assessment; a reasonable belief derived from research or quality improvement data that the services will be likely to succeed;

the preferences of the family and youth—and objective monitoring of progress with revision of services and approaches based upon results.

- Utilize information available on the internet and the variety of other sources to identify approaches that have been shown to be successful with the individuals the organization serves based on gender, race, age, problem areas, etc.
- Require individual and group treatment planning and programming to be purposeful and informed, with decisions based on objective evidence.
- Routinely review clinical and organizational practices to determine current effectiveness.
- Work with staff and clients to meaningfully integrate specific evidence based models for specific populations that the agency serves while simultaneously being careful to not provide such EBP to individuals where there is not a service fit.
- Identify key practices within manualized approaches that may be effective for specific individuals or populations served, while also assessing the effectiveness of the practice if delivered separate from the rest of the model.
- Implement common elements research to help precisely tailor individualized plans.

Conclusion

ACRC urges the field of residential treatment to embrace the EBP challenge and to develop evidence based cultures. Doing so will strengthen the emerging emphasis to redefine residential as an evidence based ecology within which careful multimodal work is being done to effectively meet the needs of the children and families being served. ACRC also urges funders and policy makers to identify and support such efforts in the financial and regulatory environments. Doing so would not only be sound from a policy and business perspective, the needs of children and families in our country demand no less.

Please feel free to call ACRC should you have any questions at www.togetherthevoice.org