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Implementing evidence-supported methods in residential care and special education: A process-model

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ABSTRACT

This article presents the findings of a qualitative study in a Flemish centre for children and adolescents with emotional and behavioural disorders. The change in demand for care for this highly troubled population has created a need for intervention models that address students' socio-emotional needs. When preparing an organisation to implement such intervention models, it is critical to obtain a thorough needs assessment or pre-implementation evaluation of staff in the organisation. Fifty interviews with different staff members were performed, guided by three research questions: (1) How do staff perceive the children and youth cared for, including behaviour, needs and demands of these youths?; (2) How do staff attempt to translate this demand for care into treatment, and what obstacles could possibly stand in the way?; and (3) What are, according to staff, critical issues to take into account when implementing EBP, both on the individual and the organisational level? Using a grounded theory approach, the analysis resulted in a pre-implementation model. In the following article, this model will be discussed and illustrated with quotes from staff members.

1. Introduction

Children and adolescents with emotional and behavioural disorders (EBD) often require special treatment programmes to address their problems. Although the number of children who reside in substitute care is small in comparison to the total child population (less than 1%), they are increasingly troubled and present multiple problems at intake (Whittaker, 2004). These problems should be viewed as chronic conditions (Visser, van der Ende, Koot, & Verhulst, 2003) and seem to be almost as stable as personality traits (De Bolle et al., 2009). Research on youth in these settings, who are described as a highly vulnerable group with extensive mental health needs (Hukkanan, Sourander, Bergroth, & Piha, 1999), often describes their problems in terms of internalising and externalising behaviour. Connor, Doerfler, Toscano, Volungis, and Steingard (2004) for example, examined the characteristics of children and adolescents admitted to a residential treatment centre. The results of their study indicate high rates of internalising and externalising psychopathology, aggressive behaviour, and consistent gender differences, with girls having higher levels of internalising and externalising psychopathology and aggressive behaviour. In a comparative study between youth in residential treatment and youth in treatment foster care, Baker, Kurland, Curtis, Alexander, and Papa-Lentini (2007) found that the prevalence of disorders in the residential treatment centre population was substantially higher than in the treatment foster care population. Youth in residential care were more likely to be anxious/depressed, aggressive, and delinquent, and less likely to have attention problems than the youth in treatment foster care. Further, D'Oosterlinck, Broekaert, De Wilde, Bockaert, and Goethals (2006) gathered information about the characteristics of boys and girls with EBD placed in residential care and day treatment facilities in East Flanders. After data collection from a sample of 517 children, 83% were boys and 17% girls, a behavioural profile was created using CBCL (Child Behaviour Checklist) scores. Results of this study illustrated that children and adolescents in the sample showed a tendency towards externalising problems and portrayed themselves as aggressive and disruptive.

Several authors also indicate a change in characteristics of this population in time. In his article on future directions of residential treatment, Lieberman (2004) points out how an increasing rate of child abuse and neglect, along with the placement of greater numbers of children in less restrictive environments has resulted in programmes dealing with a higher amount of more seriously troubled youth than have been experienced in the past.

In a Flemish study on the evolution of the demand for care for children with emotional and behavioural problems and their parents, a group of children receiving therapy in the 1970s was compared with a group of children treated in the same programme in the 1990s. Results indicated that children from the 1990s group displayed more outward problematic behaviour — aggressive, impulsive and antisocial — compared to children from the first group. Further, in the 1990s group,

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parents tended to demand care at an earlier stage, more action points in relation to family dysfunction were formulated, and the care demand seemed to be more complex (D'Oosterlinck & Legiest, 2000).

Not surprisingly, the nature and the negative evolutions of the problems of these children and adolescents place the caregivers of these youth under enormous pressure, resulting in high turnover rates. The extensive literature on staff turnover has provided the field with consistent and meaningful insights into factors that could enhance the retention of professionals. Examples of influential factors on the individual level are low salaries (Colton & Roberts, 2004), the balance between work and personal life (Smith, 2005), job moral and job satisfaction (Colton, 2005), the perceptions of the children and youth cared for (Colton & Roberts), and behaviour management approach (Albrecht, Johns, Mounsteven, & Olorunda, 2009). Examples of influential factors on the organisational level are training (Colton, 2005; Colton & Roberts, 2004), administrative support and adequate time for paperwork (Albrecht et al., 2009), the implementation of evidence-based practices (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009), and supervision, both by supervisors (Cearly, 2004; Colton & Roberts, 2007; Gersten, Keating, Vovanoff, & Narniss, 2001; Smith, 2005) as well as by peers (Colton & Roberts, 2007; Gersten et al., 2001).

Further, it is generally assumed that working with this highly troubled population and the change in regard to the demand for care has also created a need for intervention models that address students' socio-emotional needs (Baker et al., 2007; George & Fogt, 2005; Knorth, Harder, Zandberg, & Kendrick, 2008; Moses, 2000; Pazaratz, 2000; Tiesman, Konda, Hendricks, Mercer, & Amandus, 2013; White-McMahon, 2009), especially to cope with the high amount of conflict and crisis situations (D'Oosterlinck, Goethals, Spriet, Soenen, & Broekaert, 2009). Research has shown that staff members feel empowered when confronted with conflict and crisis if they are trained in conflict management methods, and have an insight in the specific behaviour of youths with EBD (Dawson, 2003; Lindsay, 1998).

At present, literature on the implementation of such methods is scarce. Starting from the debate between the psychoanalytically-oriented individual approach and the milieu therapy approach, the two dominant approaches that historically have shaped the standard treatment models used by most residential centres, the Sanctuary Model of residential care was developed (Abramovitz & Bloom, 2003; Bloom et al., 2003; Rivard et al., 2003). This model addresses trauma exposure as a central organizing life experience. The Sanctuary Model puts these fundamental attributes of healing into operation via a conceptual framework called "S.A.G.E.," an acronym that stands for Safety, Affect Management, Grieving, and Emancipation (Abramovitz & Bloom, 2003). Next to the S.A.G.E. framework, other important elements are: building a patient–staff treatment partnership; flattening the organisational hierarchy; integrating community and therapy education; promoting community building based on SAGE principles; and expecting patients and staff to share responsibility for maintaining a safe, nonviolent milieu. Research on the implementation of this model showed that successful implementation requires not only the implementation of new treatment protocols, but also change in the program philosophy and milieu toward a nonviolent and community-oriented paradigm, change in the organisational culture, and change in attitudes and behaviour of youth and staff as community members (Rivard et al., 2003).

Within the field of substance abuse treatment, Simpson developed a program change model, including four key elements that are typically involved in the process of change. The first stage is "exposure", usually involving training through lecture, self-study, workshops, or expert consultants. The second stage, "adoption", represents an explicit intention to try an innovation, including both formal decision made by program leaders and subtle levels of commitments made by individual staff. "Implementation" comes next, implying that there is a period of trial usage of the new innovation to allow testing of its feasibility and potential. The fourth and last stage moves to practice, reflecting the action of incorporating an innovation into regular use and sustaining it (Lehman, Simpson, Knight, & Flynn, 2011; Simpson, 2002; Simpson, 2004). Based on this model, Lehman, Greener, and Simpson (2002) developed a tool for the assessment of organisational functioning and readiness for change (ORC). Results of surveys of over 500 treatment personnel from more than 100 treatment units support its construct validity on the basis of agreement between management and staff on several ORC dimensions, indicating that the ORC can contribute to the study of organisational change by identifying functional barriers involved (Lehman et al., 2002).

Since implementation of such models is a complex process that is often fraught with unanticipated events, conflicts and resolutions (Aarons & Palinkas, 2007), several concerns should be taken into account to improve the probability that conditions are adequate to implement these practices (McLeskey & Billingsley, 2008).

Recently, Aarons and his colleagues have performed some studies on implementing evidence-based practices (EBP) in mental health care, supporting new optimism that successful implementation can lead to both positive organisational outcomes and ultimately to better client outcomes (Aarons et al., 2009). In an elaborate study, which included 301 mental health service providers from 49 different programmes, the association between attitudes towards adopting evidence-based practices and organisational culture and climate was examined. Correlation analyses showed that constructive culture was associated with more positive attitudes towards adoption of EBP and poor organisational climates were associated with more negative attitudes. The authors conclude that organisations may benefit from taking into consideration how culture and climate affect staff attitudes towards change in practice (Aarons & Sawitzky, 2006).

In an attempt to understand the implementation process in the child welfare system, Aarons and Palinkas (2007) interviewed case managers who were actively involved in implementing an EBP in order to reduce child neglect. The results of their study suggest that careful planning is but a part of the process of implementation, and that implementation is viewed as an adaptive undertaking. Further, it is deemed unrealistic to assume that implementation is a simple process, that one can identify all of the salient concerns, be completely prepared, and then implement effectively without adjustments. As a consequence, it has become clear that being prepared to implement EBP means being prepared to evaluate, adjust, and adapt in a continuous process that includes give and take between intervention developers, service system, organizations, providers, and consumers (Aarons & Palinkas, 2007).

When preparing an organisation to implement evidence based models as an answer to the evolving complex demands of its target population, it seems critical to obtain a thorough needs assessment or pre-implementation evaluation of staff in the organization. Currently, studies of this type are scarce. In an attempt to add to this small body of literature, we conducted a qualitative study — involving professionals in residential care and special education — guided by the following research questions:

- How do staff perceive the children and youth cared for, including the behaviour, needs and demands of these youths?
- How do staff attempt to translate this demand for care into treatment, and what obstacles could possibly stand in the way?
- What are, according to staff, critical issues to take into account when implementing EBP, both on the individual and on the organisational level?

2. Method

Youth care in Flanders, which is organised by the Flemish government, is divided into three main sections. The first is the youth protection service, which consists of a social branch and a legal branch for children and adolescents in problematic educational situations. The