

Considering Evidence-based Practice in Treatment Foster Care

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Like most professionals, you have probably heard the term “Evidence-based Practice.” The frequency of conversations about Evidence-based Practices (EBP) does not necessarily make the successful use of EBP more likely to occur. Providers, developers and administrators of Treatment Foster Care services, like their colleagues in medicine, child mental health, education, and child welfare, are talking more and more about the merits and limitations of EBP. To increase the likelihood that these exchanges do contribute to improved care for children and families, the conversation needs to clearly address confusion around definitions and evidence in light of the EBP critique, limitations in the inventory of EBP, and the integral challenges to integrating EBP in our agencies.

DEFINING EBP

Evidence-based practices are programs, procedures or tools that have proven effective in addressing a particular problem or condition. EBP are often developed in academic or other controlled service environments, due in part to needed constraints imposed by research design and measurement protocols on referral criteria and concurrent interventions. Nonetheless, most practitioners are interested in evidence that a particular EBP is efficacious in the real world settings in which they work.

All evidence is not weighed equally. A variety of criteria have been described for evaluating potential EBP, including rigor of experimental design, level of practice articulation, and other factors (e.g., www.cwla.org/programs/r2p/default.htm). Most reviewers of EBP recognize effectiveness under conditions of random assignment experimental control as the highest level of evidence. When it is inappropriate to use random assignment, researchers often compare the results from different approaches used among large numbers of participants.

Some lists of ‘Best Practices’ rely not upon systematically demonstrated effectiveness, but on consensus among experts. In general, the convincing power of evidence of positive effects suffers with the study design’s inability to rule out confounding or other causes for the observed improvement, reduced measurement rigor, and more obstacles to methodological replicability (e.g., less conveniently described practice). For example, would the youth have gotten better because of maturity? Is there something “outside” that had a positive impact? The research design used in EBP addresses these and other threats.

A number of limitations deserve caution when considering implementing EBP. First, EBP typically are validated in a relatively narrow population and under a narrow set of conditions. Other critiques spotlight the potential that the EBP inventory can be shaped to include only those practices that are conveniently studied, and that EBP discourage innovation and development of nontraditional methods. To reduce the risk of over-generalizing from the available evidence, EBP under consideration should always be assessed in context of the population and conditions in which they will be applied. Expanding research using multiple and flexible methodologies to study evolving programs in applied settings can help balance the damping effect on creativity and innovation.

THE INVENTORY OF EBP

Mindful of these concerns, one can still find useful guidance in the available repertoire of articulated model practices. While consulting Standards of Care is a useful first step, EBP go beyond Standards of Care, which are typically limited to describing essential and nonspecific programmatic and procedural features supported by an amalgam of universal experience, professional ethics, expert consensus, risk management and truism. Given the often mentioned shortage of EBP in child welfare, it is necessary to scan allied fields to identify prospective EBP (e.g., children's psychiatric treatments, psychological assessment, educational strategies, community-based programming and organizational development). Similarly, we may have to consider a broader definition of "practice" that recognizes that programs may be improved through the adoption of intervention *program components* and discrete *practice tools*, as well as the prototypical comprehensive *program models*.

Program Models represent the most comprehensive yet uncommon EBP. These models typically specify both a program model (overall framework of services, logistic and staffing outline, quality monitoring component) and a clinical model (conceptual framework linking specific conditions and needs to corresponding change promoting activities).

e.g., Multi-dimensional Treatment Foster Care (Fisher et al, 2000) is the best described, studied and validated approach. The intervention centers on parent management training using social learning principles, provided by foster parents with training and support from clinical staff. Developed as an alternative to youth incarceration, the model has been expanded to younger and more child welfare populations.

e.g., Wraparound is another relevant program model for family-based treatment (Burns et al, 1999) as it emphasizes surrounding the child and family with mental health and social services, inclusive teaming, involving family members as partners, mixing formal and informal services and assembling flexible services and corresponding flexible funding. Wraparound services have been used with a variety of youth populations.

Program Components represent a broader domain of discrete therapeutic interventions that can be integrated within a broader child welfare service framework. Effective interventions can be identified in numerous fields.

e.g., Individually focused interventions include several cognitive behavioral treatments for a variety of children's anxiety problems (Ollendick & King, 1998).

e.g., Parent management training in which parents are taught behavioral principles and participate in group sessions focusing on behavioral management (Pelham et al, 1998).

e.g., Family focused approaches that have demonstrated effectiveness include Multisystemic therapy (Henggeler et al, 1998) and Functional Family therapy (Alexander et al, 1998)

Program Tools are decision making aides that have demonstrated validity in making decisions and measuring specific concerns. They can be incorporated into other approaches to improve comprehensive assessment, service planning, and ongoing monitoring.

e.g., North Carolina Family Assessment Scale (NCFAS) assesses environment, parental abilities, family interactions (Kirk, 1998)

e.g., Child and Adolescent Functional Assessment Scale (CAFAS) measures well-being, and behavioral–emotional functioning (Hodges, 2000).

CHALLENGES TO IMPLEMENTATION

After identifying the EBP that fits an identified clinical need and is appropriate to the service population, the implementation challenges are nothing less than managing individual and organizational change. In fact, research on dissemination of EBP reveals that many efficacious services have not achieved the same results when applied in natural settings. However, treatment integrity (providing services as designed) has often been related to better outcomes.

While there are few EBP to guide implementation of EBP, a number of factors appear to impact success and should be considered when promoting integration of EBP (Rogers, 1995). For instance, the relative advantages of the innovation should be clear, and the costs of maintaining the current approach should be salient. The new practices will be better integrated if they are compatible with current models, philosophy and staff training. Organizations that have formal structures and routines to help address practice standards and concerns have an advantage, as do settings with clear and supportive hierarchical communication that provide reinforcement to help shape change. Other characteristics that may promote coordinated change include organizational stability and maturity, a history of successful innovation, and centralized decision making. In fact, if these factors appear insurmountable, it may be better to identify another more promising EBP that is more likely to be integrated successfully.

CONCLUSION

There is ample support for a variety of EBP relevant to foster family-based treatment. Whether evaluating the merits of comprehensive models, discrete interventions or practice tools, it is essential to consider the strength of the evidence and the likelihood that the practice will fit with the immediate and specific needs and context. EBP implementation requires planned individual and organizational change and thus presents challenges to managing transformation beyond the specific requirements of the individual EBP.

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