

Collaborating With Clients and Improving Outcomes: The Relational Re-enactment Systems Approach to Treatment Model

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The Relational Re-enactment Systems Approach to Treatment model is a coherent and comprehensive approach to residential treatment that increases family involvement through system-wide clinical consultation. The therapeutic alliance with youth and their families is emphasized as the key to creating client-centered goals for discharge to a less restrictive environment. The current study examined outcomes from four years of the model's implementation. Results indicated a significant increase in the proportion of youth discharged to a family home. Additionally, the proportion of discharges that were the result of youth running away from treatment was reduced by half.

KEYWORDS *residential treatment, therapeutic alliance, family involvement, clinical consultation, residential outcomes*

Residential treatment for children and adolescents remains an important treatment option, despite its cost and debate about its effectiveness. Barriers to successfully examining residential treatment have been explicated elsewhere (Burns, Hoagwood, & Mrazek, 1999; Frensch & Cameron, 2002). One particularly salient aspect of the challenge to looking at evidence-based practice in residential care is the large-scale nature of treatment in such settings which does not lend itself to approaches that depend on manuals and techniques. Additionally, residential programs have the challenge of treatment being provided through many practitioners in many settings to clients with behavior disorders who are often the most difficult to treat (cf. Frensch & Cameron, 2002). Nonetheless, there is evidence that residential

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treatment—although varied in program model and client characteristics—can be effective in returning youth to less restrictive environments and reducing symptom severity (e.g., Behrens & Satterfield, 2006; Lyons, Woltman, Martinovich, & Hancock, 2009; Nofhle et al., 2011; Preyde et al., 2011).

Despite the challenge of critically examining through research the impact of residential treatment on its clients, there is a continued need to do so. Researchers have been encouraged to generate and examine data in ways that take into account some of these challenges (Curry, 2004; Landsman, Groza, Tyler, & Malone, 2001). Curry (1991), for example, suggested that cross-sectional data would address the challenges inherent in attempting to compare treatment approaches. Additionally, the quality improvement process can be used to create “practice-based evidence” (Lyons & McCulloch, 2006) in which treatment outcomes provide feedback about effective—or ineffective—practice. The need for objective data to support conclusions about the success of treatment outcomes has been emphasized (Behrens & Satterfield, 2006). It makes intuitive sense that successful residential treatment is one in which the model of treatment being used is effective to such an extent that the level of acting-out that required such treatment is eliminated. The call for objective data in future residential research, then, would suggest that outcomes be assessed based on the extent to which this goal was met at and after discharge.

Positive or successful discharges, regardless of the measure used to assess this construct, have been linked repeatedly in the literature to the following three factors: family involvement prior to discharge, stability in the post-discharge resource, and availability of after-care support (Burns et al., 1999; Frensch & Cameron, 2002; Hair, 2005; Walter & Petr, 2008). Family involvement, in particular, has been stressed (cf. Curry, 1991, 2004) with practitioners urged to view families as “partners” and treatment as a “family support system.” Although particular family engagement strategies or family-centered models of care have not emerged as evidence-based, research repeatedly supports the significant impact of family-centered treatment (Affronti & Levison-Johnson, 2009). Based on both research and parent advocacy, the American Association of Children’s Residential Centers (AACRC, 2009) has issued a position paper promoting family members as the “primary decision maker” in their youth’s treatment. In order to assist family members to take on the role of primary decision maker in their children’s treatment, family-centered approaches likely need to provide training, focus on reducing barriers to engagement, and offer a range of treatment options (Affronti & Levison-Johnson). It is important to note, however, that a national survey of treatment facilities suggested that, while providers were increasing the role of families in the treatment process, many acknowledged that staff had not had training in family-driven principles and many recommendations of the AACRC remain unimplemented (Brown et al., 2010).

In concert with research support for the necessity of family involvement specifically in residential treatment, the American Psychological Association defines evidence-based treatment as not simply derived from research, but also dependent on client collaboration (APA Presidential Task Force on Evidence-Based Practice, 2006). Additionally, meta-analyses about effective treatment more generally suggest that the alliance between therapist and client—that is, the extent to which there is agreement on the tasks and goals of treatment—is related to positive treatment outcomes (Wampold, 2010). Together, these factors suggest that an evidence-based residential program is one that involves clients and families in treatment throughout the process of treatment and post-discharge, with the results being evident in clients needing less structure at and in the time after discharge.

An additional factor emerging in evidence-based treatment literature—a coherent treatment model—is not specific to residential treatment. Nonetheless, there is some evidence that adherence to a coherent model—one that is theoretically-grounded and guides treatment implementation—improves effectiveness of treatment in general, making it a salient factor in assessing outcomes in residential treatment in particular (Wampold & Malterer, 2007). In a study of treatment fidelity with Multisystemic Therapy (MST), the effectiveness of treatment was more modest when therapists were not receiving weekly feedback regarding their adherence to the model and were, as a result, less closely following its tenets and process (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). In the implementation of the Sanctuary Model (Bloom, 2005), units that had “greater enthusiasm and commitment to the model” had improved community characteristics and positive youth changes (Rivard, Bloom, McCorkle, & Abramovitz, 2005). An effective residential treatment program, then, may be one in which the fundamental components of family involvement, after-care support and placement stability happen within a coherent treatment framework that is accepted by the agency’s staff and supervised with ongoing feedback.

Relational Re-enactment Systems Approach to Treatment

The Allendale Association, a residential treatment facility in Northern Illinois, developed a holistic and systems-based model for treatment based on an understanding of evidenced-based practice both in general and as guided by the existing literature at the time of the model’s development. Additionally, the model arose from the agency’s quality improvement process in which treatment outcomes, particularly those related to family involvement, were used to make changes to practice. The resulting model, the Relational Re-Enactment Systems Approach to Treatment (REStArT),¹ emphasizes family-centered consultation, therapeutic alliance, and understanding and working with ambivalence, especially as it relates to discharge

planning. The agency formalized the current model in 2007. Since that time, its method and implementation have undergone a continual process of development based on feedback from outcomes within the agency and response of staff and clients to the program.

The model has 13 principles (see Appendix) that capture the philosophy, theory, and practice behind the approach. The first principle refers to the development of therapeutic alliance. Although this represents just one of the 13 principles, in reality, the construct of therapeutic alliance is fundamental to both the philosophy and practice of the model, and as such, runs throughout the principles. In fact, the remaining principles are designed to build and maintain an alliance with the client and their families that puts their goals and choices at the center of treatment. More than just the quality of the relationship between caregivers, service providers and client, the therapeutic alliance is one in which all parties agree on the tasks and goals of treatment (Wampold, 2010). Because treatment is dependent on working toward specific outcomes, treatment truly begins when this alliance is developed. The implication of this is that the quality of the therapeutic alliance between agency staff and youth and their families must constantly be assessed. The model offers staff methods for examining whether treatment is perhaps stalled because there have been disruptions in this alliance. For example, sometimes a family indicates that they are working toward reunification, but then do not follow through on tasks related to this goal. Historically, these families may be viewed as resistant (AACRC, 2009). The REStArT model guidelines provide ways for staff to evaluate whether they are prematurely foreclosing on a discharge plan that either differs from the family's or about which the family has ambivalence that needs to be addressed before treatment and discharge planning can continue.

Treatment is based on youths' "conflict cycles," which are defined by their re-enactments of their attachment experiences in the present and the response of adults to these re-enactments. The "conflict cycle" construct originated in the work of Wood and Long (1991) as a way of understanding a youth's problematic interactions with adults. The cycles are initiated when a stressful situation triggers feelings in the youth that the youth responds to with inappropriate behaviors. The youth's behaviors then generate an affective and behavioral response from adults. The adult's response often perpetuates the cycle of conflict, either through escalation when the adult's response is "counter-aggressive," which initiates a new stressor for the youth or through avoidance when the response is "counter-indulgent," which interferes with the youth learning new and more appropriate responses. The REStArT model extends the concept of conflict cycles from one-time occurrences to predictable patterns that tend to be repeated by youth based on their previous experiences with attachment figures. This forms the "relational re-enactment" component of the model and is based on attachment theory (Bowlby, 1980), object relations theory (Masterson, 1976), an understanding

of the impact of trauma, and neurobiological underpinnings (Siegel, 1999) in order to organize the youth's patterns into diagnostic categories. In addition to developing goals with families and youth, treatment planning is driven by this conceptualization of the youth's conflict cycle and designed to interrupt this cycle, which gives youth a chance to find new ways of relating and responding.

The model is systems-based and structures treatment activities in order to engage all systems involved with a youth and the experiences the members of those systems have with the youth. In this way, the treatment team can develop an understanding of how the youth sees themselves, others, and their relationships. One critical function of working as a whole system within this model is to see the "whole child." Youth's internal conflicts often become visible in the form of a dis-integrated or split pattern of interacting with the people in their world. When all members of the youth's system bring their views of the youth together, a unified picture of that youth can be created. This complete picture allows treatment providers and others invested in the youth to have both empathy for and expectations of the youth, while also giving the youth an opportunity to consolidate their conflicted feelings and experiences.

"Clinical consultation" is a critical component of the REStArT model and perhaps the practice that most reflects the model's emphasis on therapeutic alliance and understanding and working with the client from within the broadest system possible. Clinical consultation is the family engagement practice that carries out the family-centered philosophy of the model. Consultation involves ongoing, frequent, and purposeful collaboration with all members of the youth's treatment team, which includes the youth's family as equal contributors. It is not, as the term consultation sometimes implies, an opportunity for clinical staff to impart knowledge of the client to other staff and to family members. Rather, it is a time for all participants, often headed by key players such as the youth's therapist, case specialist, unit coordinator, teacher and family to discuss their understanding of the youth's dynamics and functioning and their ideas, based on this understanding, for moving forward toward the youth's ultimate goal: discharge.

These consultation opportunities occur as a scheduled activity, much as family therapy would occur. In other words, they are not scheduled only as the result of crises or at times of staffings. Often they occur twice a month, with families sometimes "present" by phone so that travel does not create a barrier to regular contact. These meetings may focus on discharge planning from the beginning of a youth's time in treatment, so that family concerns and wishes are addressed on an ongoing basis. One crucial function of the frequency and consistency of the clinical consultation is to recognize a family or individual youth's ambivalence about discharge as it emerges in treatment rather than only as an obstacle to discharge when a discharge date is approaching. Current best practice (AACRC, 2009) asks that

residential treatment centers allow families to be primary decision makers; however, families may not have the training or resources to fully engage in the decision making process. The clinical consultation provides ongoing opportunities for families to make decisions about their youth's care while working with the treatment team as a whole, rather than perhaps only meeting with the family therapist. Additionally, research suggests that barriers to family engagement be addressed (Affronti & Levison-Johnson, 2009) and the consultation process allow staff to identify ways in which the youth and family's ambivalence about discharge goals could potentially interfere with treatment and assist the family in addressing that ambivalence.

A case example illustrates the features of therapeutic alliance, ambivalence, and the use of consultation. "Barry" was an adolescent male who had a discharge goal of returning home to his mother's care. Like many youth in residential treatment, Barry had a history of physically aggressive and destructive behaviors with his family. As treatment progressed and Barry's behaviors were contained, the treatment team focused more strongly on setting a date for Barry to return home. Barry's mother had stated that she was in agreement about this discharge goal, but in consultation, often referred back to Barry's previous dangerous behaviors. The treatment team found themselves trying to convince Barry's mother that his behavior had improved and he was ready to return home, but discharge dates went unmet. In using the model to assess why the discrepancy existed between Barry's mother's stated goal and her behavior, the team realized that they had not sufficiently taken into account her ambivalence about having him home. While she missed him and wanted them to ultimately be reunited, she continued to fear for the safety of the other children in her home. By recognizing this fissure in the therapeutic alliance, the team was then able to use clinical consultation time to address her conflicted feelings about discharge, work more openly with her and Barry about discharge plan obstacles, and return him to his family home.

Method of Assessing Outcomes

This article presents a preliminary evaluation of Allendale's outcomes with the REStArT model over the last four years. Residential outcomes research is replete with multiple outcome measures meant to assess multiple constructs. And Allendale, like many residential programs, has collected an abundance of data which address a myriad of outcomes constructs. For the sake of this initial "snap-shot" of the REStArT model's impact on Allendale's program, fundamental definitions of key constructs were the focus.

Because youth are admitted to Allendale's programs when their behavior precludes them from functioning safely in a less restrictive environment, the construct of "successful discharge" was measured by looking at whether youth were discharged to a less restrictive environment. This included: home

(family), non-Allendale group home, foster care, transitional living program, self-selected independence, or an adult mental health facility (provided this facility was less restrictive than a residential program). “Negative discharges” were those for which the youth either required a greater level of restriction or had left treatment prematurely: jail, psychiatric hospitalization, runaway, and shelter. Transfers to other residential programs were considered “neutral” but were combined with negative discharges when comparing the number of positive discharges to all other discharges.

Within the category of “successful discharges,” the agency was particularly interested in those that indicated what could be considered evidence of the construct “therapeutic alliance.” Certainly, not all youth can return home to their family of origin regardless of the quality of the agency’s alliance with them. At times, a youth has “aged out” of a return-home goal or the youth has no family to whom they can return. However, sometimes the failure of a youth to return to an available home is the result of a poor alliance between the agency and the family in that they are not working toward the same goal. The focus was, therefore, on assessing the extent to which return-home discharges increased over the years that the REStArT model was being implemented and refined.

Conversely, discharges that were the result of a youth running away from treatment were considered evidence of a poor client-agency alignment in that those youth who run away ostensibly have selected a discharge time and type of their own. Previous research on factors related to youth running away from treatment have suggested that both youth characteristics and program characteristics account for an almost equal proportion of the variance in this outcome (Eisengart, Martinovich, & Lyons, 2007; McIntosh, Lyons, Weiner, & Jordan, 2010). The implication for this study is that, although runaway behavior was not particularly targeted in the treatment model, changes to the program itself could potentially result in changes to the frequency of discharges based on youth running away.

Many authors have noted that a study that simply examines and makes conclusions based on the discharges within a single program does not account for threats to the internal validity of that study. In other words, it is almost impossible to say with certainty that the program itself is responsible for the quality of those discharges. In this current, albeit preliminary study, the agency used a variant of a model suggested by Curry (2004) in which the same program uses different models and compares the results obtained by those models. The review of four years of data provides a cross-sectional design in that the clinical consultation component of the model had not yet been implemented in the first year of study and the REStArT model itself has been refined over the years that data have been collected. As such, the study examined the extent to which positive discharges and evidence of therapeutic alliance have increased over the initial life-span of this model while negative events have decreased. Although the current study

did not explicitly control for variables that may impact outcomes, changes to agency client population were examined in order to develop hypotheses about whether these changes may have affected outcomes. In particular, the average age of clients and clients' funding source was assessed for potential impact on client discharge type.

RESULTS AND DISCUSSION

The Allendale Association provided treatment to over 150 clients at any given time in high-end residential (on-campus) and group home settings during the four years of this study. Between 2007 and 2010, when intakes and discharges were taken into account, 233 clients, on average, were served each year. Allendale's clients are females and males (on average, 37% and 63% respectively between 2007 and 2010) primarily from northern Illinois, including Chicago. Over the four year period in this study, approximately 56% of clients were African American, 33% were white, 6% were Hispanic, and 5% were identified as bi-racial. At admission, most clients were between 13 and 16 years of age (approximately 63%), with another 24% between 17 and 18, 11% under 12, and 2% over 19. The average age at discharge between 2007 and 2010 was 17 years old. Clients in treatment at Allendale may have many diagnoses but are likely to have a diagnosis of Conduct Disorder with a severity that warrants a highly-structured level of care.

The proportion of positive discharges from Allendale's on-campus units and group homes has been steadily increasing over the four years since the implementation of the REStArT model (see Table 1). Although the increase in proportion of positive discharges overall compared to the proportion of all other discharges did not change significantly, $X^2(3, N = 435) = 4.79, p = .19$, the proportion of positive discharges was already substantial (69.9% in FY07) and did increase without any downturns (81.7% in FY10). This suggests that, while Allendale's clients were already being discharged with

TABLE 1 Proportion of Positive Discharges vs. All Other Discharges

Fiscal year	<i>N</i>	Positive discharges	<i>N</i>	All other discharges	Total
FY07	58	69.9%	25	30.1%	83
FY08	91	78.4%	25	21.6%	116
FY09	103	81.1%	24	18.9%	127
FY10	89	81.7%	20	18.3%	109

Note. Totals include all clients discharged during the fiscal year. "Positive discharges" include discharges to home (family), non-Allendale group home, foster care, transitional living program, self-selected independence, or an adult mental health facility, provided this facility was less restrictive than a residential program. "All other discharges" include discharges to jail, psychiatric hospitalization, runaway, shelter, and transfer to another residential program.

$X^2(3, N = 435) = 4.79, p = .19$.

positive outcomes, clients who were discharged after the inception of the REStArT model were more likely to have a positive (that is, less restrictive) post-discharge placement.

Client discharges to family offer a barometer of the extent to which the agency has been successful at not only releasing a youth to a less restrictive environment, but also developing an alliance with youth and family that prepares them to reunite. Allendale's proportion of discharges to the client's home compared to other positive discharges increased significantly over the four years (see Table 2). Discharges to home were 29.3% of all positive discharges in FY07 and were 44.9% in FY10, $X^2(3, N = 341) = 9.92$, $p = .02$.

This significant change remained when comparing the proportion of discharges to home to all other discharges, both positive and negative (see Table 3). Discharges to home were 20.5% of the overall discharges in FY07 and 36.7% of discharges by FY10, $X^2(3, N = 435) = 12.26$, $p = .007$. One of the explicit goals of the Allendale REStArT model is to develop an alliance with clients and their families as the foundation of treatment and these results suggest that the model may have contributed to that process.

TABLE 2 Proportion of Discharges to Family vs. All Other Positive Discharges

Fiscal year	<i>N</i>	Discharges to home (family)	<i>N</i>	Other positive discharges	Total
FY07	17	29.3%	41	70.7%	58
FY08	25	27.5%	66	72.5%	91
FY09	46	44.7%	57	55.3%	103
FY10	40	44.9%	49	55.1%	89

Note. Totals include only clients with positive discharges during the fiscal year. "Other positive discharges" include discharges to non-Allendale group home, foster care, transitional living program, self-selected independence, or an adult mental health facility, provided this facility was less restrictive than a residential program.

$X^2(3, N = 341) = 9.92$, $p = .02$.

TABLE 3 Proportion of Discharges to Family vs. All Other Discharges

Fiscal year	<i>N</i>	Discharges to home (family)	<i>N</i>	All other discharges	Total
FY07	17	20.5%	66	79.5%	83
FY08	25	21.6%	91	78.4%	116
FY09	46	36.2%	81	63.8%	127
FY10	40	36.7%	69	63.3%	109

Note. Totals include all clients discharged during the fiscal year. "All other discharges" include discharges to non-Allendale group home, foster care, transitional living program, self-selected independence, an adult mental health facility (provided this facility was less restrictive than a residential program), jail, psychiatric hospitalization, runaway, shelter, and transfer to another residential program.

$X^2(3, N = 435) = 12.26$, $p = .007$.

TABLE 4 Proportion of Runaway Discharges vs. All Other Discharges

Fiscal year	<i>N</i>	Runaway discharges	<i>N</i>	All other discharges	Total
FY07	14	16.9%	69	83.1%	83
FY08	13	11.2%	103	88.8%	116
FY09	7	5.5%	120	94.5%	127
FY10	9	8.3%	100	91.7%	109

Note. Totals include all clients discharged during the fiscal year. "All other discharges" include discharges to home (family), non-Allendale group home, foster care, transitional living program, self-selected independence, an adult mental health facility (provided this facility was less restrictive than a residential program), jail, psychiatric hospitalization, shelter, and transfer to another residential program.

$X^2(3, N = 435) = 7.82, p = .05$.

The proportion of runaway discharges compared to all other discharges decreased significantly during the period of study (see Table 4). Runaway discharges accounted for 16.9% of discharges in FY07 and 8.3% of discharges in FY10, $X^2(3, N = 435) = 7.82, p = .05$. Since the introduction of the REStArT model, the proportion of discharges that were runaways was cut in half, suggesting that the model may have been a factor in clients being less likely to discharge themselves rather than working together with the agency toward a planned discharge.

Although an analysis of proportions does not indicate whether particular variables predict particular outcomes, a preliminary examination of demographic data suggests that changes to the demographic data over the last four years do not play a significant role in the move toward more positive, planned, and home-based discharges. Clients with funding through the Illinois Department of Children and Family Services (DCFS) are less likely to have a family home to return to, whereas clients with Department of Human Services funding (DHS) or Illinois Board of Education (ISBE) funding are likely to have been placed in residential/ group home treatment directly from their family home. When comparing funding sources over the four years of the study, the proportion of clients being discharged with DCFS funding has decreased significantly in relation to other funding sources, $X^2(3, N = 435) = 18.08, p < .001$ (see Table 5).

While it could appear then that any improvement in Allendale's home/family discharge rates may be accounted for by this decrease in DCFS funding, there is some evidence to suggest that this is not the case. The proportion of DCFS clients being discharged to home compared to all other DCFS discharge types increased, $X^2(3, N = 196) = 7.10, p = .07$ (See Table 6). In FY07, 4.2% of DCFS discharges were to home and in FY09, the proportion was 22.2%. The rate fell again in FY10 (12.1%), perhaps accounting for the less than statistically significant increase. While this decrease in FY10 needs further study, the overall improvement in DCFS discharges to home seems to support the REStArT model's approach to returning clients home regardless of the client's funding. In fact, clients with DCFS funding

TABLE 5 Proportion of DCFS Funding vs. All Other Funding

Fiscal year	<i>N</i>	DCFS funding	<i>N</i>	All other funding	Total
FY07	48	57.8%	35	42.2%	83
FY08	61	52.6%	55	47.4%	116
FY09	54	42.5%	73	57.5%	127
FY10	33	30.3%	76	69.7%	109

Note. Totals include all clients discharged during the fiscal year. “DCFS funding” refers to youth funded by the Illinois Department of Children and Family Services. “All other funding” includes youth funded by the Department of Human Services, the Illinois School Board of Education, the Department of Corrections, and private funding.

$X^2(3, N = 435) = 18.08, p < .001.$

TABLE 6 Proportion of DCFS Discharges to Home vs. Other DCFS Discharges

Fiscal year	<i>N</i>	DCFS discharges to home	<i>N</i>	All other DCFS discharges	Total
FY07	2	4.2%	46	95.8%	48
FY08	9	14.8%	52	85.2%	61
FY09	12	22.2%	42	77.8%	54
FY10	4	12.1%	29	87.9%	33

Note. Totals include clients who had DCFS funding at the time of their discharge. “DCFS” refers to the Department of Children and Family Services. “Other positive discharges” include discharges to non-Allendale group home, foster care, transitional living program, self-selected independence, or an adult mental health facility, provided this facility was less restrictive than a residential program.

$X^2(3, N = 196) = 7.10, p = .07.$

TABLE 7 Age Distribution FY07– FY10

Fiscal year	<i>N</i>	<12	<i>N</i>	13–16	<i>N</i>	17–18	<i>N</i>	19+	Total
FY07	9	10.8%	42	50.6%	31	37.3%	1	1.2%	83
FY08	11	9.5%	69	59.5%	33	28.4%	3	2.6%	116
FY09	10	7.9%	81	63.8%	36	28.3%	0	0.0%	127
FY10	7	6.4%	54	49.5%	41	37.6%	7	6.4%	109

Note. Ages are in years at the time of the client’s discharge. All clients discharged during the fiscal year are included in the total.

are often less likely to have ready access to a home discharge, making the program’s rate of discharges to home for DCFS clients a particularly salient result.

The data on the ages of clients over the last four fiscal years were not statistically appropriate for a chi-square analysis. The proportions in four primary age groupings show few trends; one notable trend was an increase in the proportion of clients in the oldest grouping and a decrease in the proportion of clients in the youngest grouping (see Table 7). This finding then would seem to suggest that return-home goals would be harder to attain as older youth often find independent placements. Such a trend, then, does not offer an alternative to the hypothesis that the REStArT model appears to have contributed to an increase in youth returning to the homes of their families.

IMPLICATIONS AND LIMITATIONS

Allendale's REStArT model is a coherent approach (Wampold & Malterer, 2007) that emphasizes family involvement through a structured clinical consultation process and the development of a strong therapeutic alliance with youth and their families. This initial study of four years of the model's implementation suggests through cross-sectional discharge data that the model may be instrumental in improving outcomes that are generally positive and specifically focused on returning youth to family homes. While a single study still does not answer the question of which particular family engagement practices can be more broadly termed "evidence-based," it does suggest that a family consultation strategy that targets therapeutic alliance and client ambivalence may be worthwhile.

The initial examination of outcomes is promising; nonetheless, the results create additional questions. As suggested by Lyons and McCulloch (2006), for example, research on evidence-based practice needs to distinguish client characteristics from the impact of particular treatment center characteristics. Like many outcomes studies in residential treatment, these outcomes reflect only those in the REStArT program and are limited then by a lack of comparison to either another program entirely or even to another agency implementing a similar program. In terms of client characteristics, an analysis of those factors that predict positive, planned, and family-based outcomes in response to the REStArT program would be beneficial toward both understanding the differential impact the treatment may have on varying clients as well as strengthening the model's treatment in those cases which were not successful. Additionally, while the model appears influential in promoting discharges to less restrictive environments, future study will need to examine the stability of these outcomes to know whether the results endure over time.

NOTE

1. The full text of the principles and training materials related to the REStArT model can be obtained without cost by contacting the authors.

REFERENCES

- Affronti, M. L., & Levison-Johnson, L. (2009). The future of family engagement in residential care settings. *Residential Treatment for Children & Youth, 26*, 257-304.
- American Association of Children's Residential Centers (AACRC). (2009). Redefining residential: Becoming family-driven. *Residential Treatment for Children & Youth, 26*, 230-326.

- American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285.
- Behrens, E., & Satterfield, K. (2006). *Report of Findings from a Multi-Center Study of Youth Outcomes in Private Residential Treatment*. Presented at the 114th Annual Convention of the American Psychological Association at New Orleans, Louisiana. Retrieved from http://www.aspenassessment.com/Residential_Treatment_Outcomes_Study.pdf.
- Bloom, S. L. (2005). The sanctuary model of organizational change for children's residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations*, *26*, 65–81.
- Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss*. New York: Basic Books.
- Brown, J. D., Barrett, K., Ireys, H. T., Allen, K., Pires, S. A., & Blau, G. (2010). Family-driven youth-guided practices in residential treatment: Findings from a national survey of residential treatment facilities. *Residential Treatment for Children & Youth*, *27*, 149–159.
- Burns, B. J., Hoagwood, K., & Mrazek, P. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review*, *2*, 199–254.
- Curry, J. F. (1991). Outcome research on residential treatment: Implications and suggested directions. *American Journal of Orthopsychiatry*, *61*, 348–357.
- Curry, J. F. (2004). Future directions in residential treatment outcome research. *Child and Adolescent Psychiatric Clinics of North America*, *13*, 429–440.
- Eisengart, J., Martinovich, Z., & Lyons, J. S. (2007). Discharge due to running away from residential treatment: Youth and setting effects. *Residential Treatment for Children & Youth*, *24*, 327–343.
- Frensch, K. M., & Cameron, G. (2002). Treatment of choice or a last resort? A review of residential mental health placement for children and youth. *Child and Youth Care Forum*, *31*, 307–339.
- Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child and Family Studies*, *14*, 551–575.
- Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, *65*, 821–833.
- Landsman, M. J., Groza, V., Tyler, M., & Malone, K. (2001). Outcomes of family-centered residential treatment. *Child Welfare*, *8*, 351–380.
- Lyons, J. S., & McCulloch, J. R. (2006). Monitoring and managing outcomes in residential treatment: Practice-based evidence in search of evidence-based practice. *Journal of the American Academy of Child and Adolescent Psychiatry*, *45*, 247–252.
- Lyons, J. S., Woltman, H., Martinovich, Z., & Hancock, B. (2009). An outcomes perspective of the role of residential treatment in the system of care. *Residential Treatment for Children & Youth*, *26*, 71–91.
- Masterson, J. (1976). *Psychotherapy of the borderline adult: A developmental approach*. New York: Brunner/Mazel.

- McIntosh, A., Lyons, J. S., Weiner, D. A., & Jordan, N. (2010). Development of a model for predicting running away from residential treatment among children and adolescents. *Residential Treatment for Children & Youth, 27*, 264–276.
- Noftle, J. W., Cook, S., Leschied, A., St. Pierre, J., Stewart, S. L., & Johnson, A. M. (2011). The trajectory of change for children and youth in residential treatment. *Child Psychiatry and Human Development, 42*, 65–77.
- Preyde, M., Cameron, G., Frensch, K., White, S., Penney, R., & Lazure, K. (2011). Long-term outcomes of children and youth accessing residential or intensive home-based treatment: Three year follow up. *Journal of Child and Family Studies, 20*, 660–668.
- Rivard, J. C., Bloom, S. L., McCorkle, D., & Abramovitz, R. (2005). Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 26*, 83–96.
- Siegel, D. J. (1999). *The developing mind*. New York: The Guilford Press.
- Walter, U. M., & Petr, C. G. (2008). Family-centered residential treatment: Knowledge, research, and values converge. *Residential Treatment for Children & Youth, 25*, 1–16.
- Wampold, B. E. (2010). *The basics of psychotherapy: An introduction to theory and practice*. Washington, DC: American Psychological Association.
- Wampold, B. E., & Malterer, M. B. (2007). *A critical evaluation of the evidence-base for the effectiveness of residential treatment centers: How does Allendale compare?* Unpublished manuscript, University of Wisconsin at Madison.
- Wood, M. M., & Long, N. J. (1991). *Life space intervention*. Austin, TX: Pro-Ed.

APPENDIX

Principles: The Relational Re-enactment Systems Approach to Treatment (REStArT)

- I. Developing a Working Therapeutic Alliance: *Client, family, and service providers agree on the goals and tasks of treatment. These goals and tasks need to be youth and family driven.*
- II. Relational Re-Enactment: *Identify youth's attachment style through the ways in which the youth re-enacts it in his/her behavior with others (i.e., identify the conflict cycle).*
- III. Managing "Counter-Response": *Identify the adult counter-response (feelings and subsequent behavior) within that youth's particular conflict cycle; identify the adult's unpleasant reality (related to the youth's conflict cycle) that is being avoided by the adult; face the adult's unpleasant reality and the adult's feelings so that they are not driving the adult's behavior (counter-response).*

- IV. Systems-Oriented: *Identify all the systems involved with the youth and have them come together to develop a shared understanding of and way of approaching the youth and to identify a common interest or goal.*
- V. Finding the Imbalance in the System: *Identify polarities in youth's behavior and subsequent polarities in adults' counter-response (i.e., splits/divisions within the system).*
- VI. Seeing the Whole Youth: *Identify ways in which our view of the youth has been compartmentalized (i.e., sees the youth in a particular way). Work together and dialogue so that all parties see both sides of the youth—the adaptive side and the maladaptive side.*
- VII. Working with Ambivalence: *Be aware of and identify examples of ambivalence in the family and the youth so that this can be verbalized instead of expressed through their behavior.*
- VIII. Restoring the Balance: *Use dialogue and consensus to restore balance in developing a plan to interrupt the youth's conflict cycle (integrate both extremes of the adults' counter-response reactions in order to arrive at a more balanced response).*
- IX. Interrupting the Conflict Cycle: *Implement a plan that interrupts the way the youth typically responds to stressors which provides an opportunity for the youth to respond in a new more adaptive way.*
- X. Expecting Health: *Trust the youth's ability to determine their own goals, tolerate disappointments, and repair relational disruptions.*
- XI. Ownership at Every Part of the System: *Create investment in the model across the entire system and support each part's contribution to the plan, which promotes responsibility and accountability.*
- XII. Evidence-Based: *Use concrete data about the youth to determine conflict cycle and plan development and to evaluate effectiveness and outcomes.*
- XIII. Dynamic and Reflexive Process: *Establish a continuous process of looking at our own responses/reactions and evaluating whether the plan is effective.*