Chapter 21
Mixed Methods Research on Clinical Consultation Within the REStArT Model in Residential Treatment

Catherine McConnell and Patricia Taglione

Chapter Highlights

- This chapter reviews the principles of the REStArT model related to its core family intervention: clinical consultation.
- Components of clinical consultation—its format and function—are presented.
- A case study is provided to demonstrate the application of the principles and process of clinical consultation.
- Both quantitative and qualitative results were used to examine trends in outcomes.
- Youths' involvement with state child welfare was found to be related to the process of treatment and stability of discharge placement.

Although the importance of working with families is accepted, the nature of this involvement is still being investigated. Family therapy is only one method of involving families in their child's treatment and has evolved in some cases to better meet the needs of families (Huefner et al. 2015). For example, in order to make services accessible to families, therapy by phone has been used (Robst et al. 2013). Letter writing as a family intervention also provides a unique form of contact between family and youth. Christenson and Miller in Chap. 2 of this volume discuss the use of letter writing in depth. The options appear broad for facilitating a family's role in its youth's care. Given this breadth of possibility, there is question about what makes family involvement optimally successful. While there is some evidence that almost any involvement—even if it is not specifically therapeutic—is beneficial, the need to provide therapeutic interventions to families and other caregivers

C. McConnell (✉) · P. Taglione
Allendale Association, PO Box 1088, Lake Villa, IL 60046, USA
e-mail: cmcconnell@allendale4kids.org

P. Taglione
e-mail: ptaglione@allendale4kids.org

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who will remain in the lives of youth with mental health challenges seems crucial (Lakin et al. 2004).

The Relational Re-Enactment Systems Approach to Treatment (REStArT) is a model for residential treatment that seeks specifically to address the challenges inherent in engaging families in their youth's care. While the introduction of this intervention at one agency precipitated improvements in outcomes broadly (McConnell and Taglione 2012), the study described in this chapter was intended to explore the aspects of treatment in aggregate, either case characteristics inherent to particular subsets of youths and their families or program dynamics, that differentiated youth who were successful in the program. This exploration included an examination of both the frequency of family participation and the process of the family involvement. By studying the characteristics of successful cases, we hoped to better understand the factors that encourage or possibly impede family involvement as a catalyst for positive youth outcomes.

The purpose of this chapter is twofold. First, the chapter will provide the reader with an example of a study conducted with a specific study methodology, which can help those beginning a research career to better understand the process. Second, the chapter will report the results of our study and improve understanding of the REStArT model and related outcomes. The study described in this chapter used a mixed methods approach to investigate outcomes. A mixed methods approach to research on family interventions in residential treatment potentially augments the research process, as Christensen and Gutierrez discuss in Chap. 19 of this volume. This study used qualitative methods to expand our understanding of our quantitative results and thus provides an example of the ways that one method can enhance the other.

Quantitative results, especially in exploratory studies and those without specific hypotheses that are being tested, may not be sufficient to explain results. Qualitative components then can be used to provide depth in the form of possible explanations for the results found. These process-oriented results, in turn, can help shape hypotheses for future research. Qualitative and quantitative components also augment one another in a specific way; the empirical findings allow for results which, although not free from bias, capture a more global phenomenon than participant observation. Qualitative material, however, breathes life into these broad results by giving voice to those who are experiencing the clinical work, either as client or provider. A mixed methods approach is most successful when approaches are given equal importance rather than viewing one as secondary to the other. In this current study, for example, our interest in exploring the impact of different client variables on outcomes came without specific hypotheses to direct our empirical analyses, and the ethic of transparency calls on the research to be clear that such results were generated without direction. However, such descriptive analyses are of limited value. When a difference is found, the meaning of this difference is less likely discovered through further empirical study, but rather by returning to those who did the actual work, which in this case meant turning to the therapists who worked with the clients and their treatment teams to assess their understanding of our empirical results.

The REStArT Model and Clinical Consultation

Before describing the study and results, some background information on the REStArT model and clinical consultation will be provided to put the research described below into greater context. The REStArT model originated at a multi-service agency for youth and their families that provides residential treatment. Within the agency's residential program, the *high-end* treatment units are unlocked, but considered the most restrictive level of care for youth whose behavior can no longer safely be addressed in the community. High end in the context of residential treatment, as used in this chapter, refers to level of care. It is a not a locked facility; however, the youth in care require a higher level of supervision and structure (due to the severity of their behaviors or symptoms) than that which can be provided by a less-intensive residential or group home program. Since the model's implementation in 2007, youth at this agency increasingly saw positive outcomes and movement to less-restrictive levels of care (McConnell and Taglione 2012). The model provides a coherent yet flexible approach to treatment that is informed by research on trauma-based treatment, attachment and developmental theories, systems theory, and object relations (Taglione et al. 2014). Thirteen guiding principles articulate the tenets of the model and provide the basis for training (see Appendix). Additionally, the principles are congruent with the model's primary intervention for working with families, which is clinical consultation.

Principles of the Model

Presented here is a very brief overview of some of the model's principles that are most relevant to working with families. The REStArT training manual (Taglione et al. 2014) includes a broader description of the model's principles, core concepts, and interventions than the scope of this chapter allows (the manual is available from the authors upon request). The first principle of the model and the one most central to consultations is the treatment providers' therapeutic alliance with youth and their families. The therapeutic alliance is often defined not simply as the quality of the relationship between clinician and client but as agreement on the goals of treatment as well as the process of obtaining those goals (e.g., Norcross and Wampold 2011). Developing a balanced therapeutic alliance in family treatment is difficult, even outside the residential treatment setting, due to the multiple relationships in the treatment process (Hogue et al. 2006; Robbins et al. 2003). But the therapeutic alliance is further complicated in residential treatment by not only multiple family members participating in treatment, but also multiple providers, sometimes from multiple agencies. The training and ongoing supervision involved in the model's implementation utilizes decision trees that guide providers through the process of assessing the alliance with youth and their families.

Sometimes, even when clients have articulated goals for themselves and appear committed to those goals—for example, to return to their family of origin or to move on to independence—they may still have ambivalence. In residential treatment, much like family work in other therapeutic settings, ambivalence is sometimes expressed through clients acting in ways that elicit a response in treatment providers to *take the other side* of the ambivalence (Miller and Rollnick 2013). The emphasis in the model on ongoing feedback provided by supervisors and colleagues allows therapists and other treatment providers to be cognizant of the pull to persuade family members. As a result of this reflection, providers can be aware of what factors may be motivating both sides of the family's ambivalence and give them the space in the family work to resolve the ambivalence in ways that are authentic to them. In doing this, therapists and others also activate the principle of the model that asks providers to expect health from youth and their families.

Being aware of how youth or their families may be engaging us in the process of avoiding their ambivalence is only one of the ways that self-reflection is used in the REStArT model. The model extends the work of Wood and Long (1991) in using *conflict cycles* to better understand the re-enactments that occur between youth and adults. The conflict cycle provides a unique understanding of each youth by identifying their individual stressors and their individual ways of emotionally and behaviorally responding to those stressors. The conflict cycle also includes the adults' ways of responding to youth behaviors. Often these adult responses inadvertently maintain the youth's conflict cycle either by amplifying the original stressor (a counter-aggressive response) or by protecting the youth from the stressor (a counter-indulgent response). Both counter-responses interfere with the youth's opportunity to develop new and more adaptive ways of responding to their own stressors.

The understanding of an individual youth's conflict cycle requires treatment providers to be aware of their counter-response, which may be indulgent (that is, feeling overly empathic and excessively externalizing the youth's presenting problem) or aggressive (such as feeling frustrated with lack of progress). Due to the histories of trauma that most of the youth in residential treatment have and the conduct disordered behavior that has then precipitated their placement, many of the children and adolescents in treatment present with a *control-sensitive* conflict cycle; that is, one in which they may alternately view themselves as victims or aggressors. They may elicit complementary feelings in the adults working with them that, in turn, can result in overly permissive or excessively controlling approaches to working with the youth. The understanding of re-enactments as conflict cycles, managing counter-response, and developing plans to interrupt the cycle are the focus of three of the model's principles.

These principles as described above closely inform the process and content of the REStArT model's family intervention, clinical consultation. While consultation has traditionally involved providers as experts informing family members about their youth, these principles create a clinical consultation process that is systems-oriented and inclusive. The purpose of the clinical consultations is driven by the principles in that the quality of the therapeutic alliance that the treatment team has with the youth and their family is assessed after every consultation. During

the consultations, the therapist and other team members work with family member and the youth to help them understand the youth's conflict cycle. And ambivalence, often a barrier to successful residential treatment if left unaddressed, can safely be explored as team members allow the family to determine the course of treatment and discharge.

Clinical Consultation

Clinical consultation was originally developed to address deficits in engaging families in their youth's care. Clinical consultation involves regularly scheduled collaborative contact between members of the youth's treatment team, the youth, and their family. Caseworkers from funding sources, as well as other collaterals, are also encouraged to participate in the process. Especially for youth who have funding through a state child welfare agency, the external caseworker for that youth is considered an integral part of the consultation process because of the youth's legal standing with the state. Consultations are scheduled at the convenience of the family and more often than not take place via telephone in order to accommodate work schedules and travel distance. Unlike a more traditional approach to consultation, clinical consultation does not position the treatment providers as the authorities and the family as recipients of the providers' expertise and direction. Nor are these contacts an opportunity for staff simply to inform family members or collaterals about the youth's progress. Rather, consultations are intended to address multiple principles of the model.

On center stage during the consultation process is the assessment of the therapeutic alliance between youth, family, and treatment providers. As mentioned above, the alliance between family and providers is even more complex in residential treatment than it may be in a traditional family therapy setting. Families encounter many providers within milieu treatment. It is this complex system that clinical consultation seeks to balance, in part by addressing in each clinical consultation the goals for discharge that the youth and their family have identified, even if those goals differ from what the providers think they should be. Additionally, clinical consultation removes the compartmentalization of relationships between family members and different providers within the agency that may make it more likely for splits to develop. Therapists and other providers are asked to look for evidence of the strength of the alliance in each consultation meeting.

Clinical consultation also provides a forum to address ambivalence about treatment and discharge goals that youth or families may be experiencing. Clinical consultation requires providers who are facilitating the consultation to be aware of this ambivalence and watch for ways that it may be acted out rather than explicitly communicated. Because progress toward discharge is a regular focus of clinical consultation, providers have the opportunity to consistently assess and bring to the attention of youth and families discrepancies between their stated goals and their progress toward those goals.

The importance of the youths' conflict cycles in clinical consultation cannot be overstated. The conflict cycle provides the opportunity for therapists, caseworkers, and family members to create a shared understanding of the youth. This shared understanding also addresses a criticism sometimes leveled at residential treatment providers by families, that family members feel blamed by their youths' providers (c.f., Walter and Petr 2008). Additionally, the conflict cycle offers a rationale for the ongoing structure that youth may need when they return to a less-restrictive environment, which helps families see the importance of this. Because the clinical consultation process is nuanced and can seem abstract to those who are not familiar with the process, we have included a case example below that is intended to illustrate some of the components of this type of intervention.

The REStArT Model: A Case Example

A case that illustrates the implementation of REStArT model and its family intervention is that of Carlos, a 15-year-old Latino adolescent who came to residential treatment following many years of out-of-home placements such as psychiatric hospitalizations, state mental health hospitals, and group homes. He had a history of aggression against other children and adults, including a security guard at a hospital. He also engaged in self-harm that included ingesting foreign objects. Additionally, he made what were deemed to be false accusations against others. Carlos' medical history was complex, leading him at times to claim that he needed hospitalization even when it was not necessary. Furthermore, Carlos' brother had died when Carlos was young and he appeared to be re-enacting the trauma of this loss, as well as fears about his own mortality, through his repeated medical hospitalizations. Clinical consultations included the treatment team as well as Carlos, his mother, and the caseworker from his funding source. At the time he was admitted, Carlos' mother was identified as his discharge resource, but his funding source did not agree with this goal.

Despite wanting to be discharged from residential treatment, Carlos often made allegations against others and requested hospitalizations. During consultation, the treatment team started to point out the ambivalence that was emerging. On the one hand, he wanted to return home to his mother and have more freedom, but another part of him may have sought the structure that was provided by the hospital and acted out in ways that ensured he would stay in residential care. Carlos' mother also appeared to be ambivalent about having him return home. The treatment team identified that Carlos and his mother sometimes avoided addressing their ambivalence about one another by joining together in conflict with treatment providers. Interventions to address this ambivalence started with the team's awareness of ways in which they felt pulled to either indulge requests made by Carlos and his mother in order to avoid conflict or to withhold reasonable requests out of frustration with their many demands. By interrupting this cycle of conflict, Carlos and his mother were then able to engage with the treatment team in their alliance of working

together to have Carlos safely discharged. This process also helped Carlos and his mother see ways that he would need to continue to have structure in place even if he was no longer in treatment.

As his acting out subsided, however, his funding source still did not support his placement with his mother, but rather wanted him to step down to a group home. Although staff were aware of their wish to take on this battle for Carlos and his mother, and maybe try to convince the funding source that Carlos should return home, the team instead sought a more balanced response that allowed Carlos and his mother to work with the funding source more realistically. Carlos, wanting to leave even if he didn't go home, eventually agreed to go to the group home. This step down was, therefore, technically a positive outcome, but was not sustained. Soon after being placed in the group home, Carlos ran away from treatment. But rather than running to the hospital as he had in the past, he ran to his mother. He remains stable and with his mother over two years later.

Quantitative and Qualitative Methods of Exploration

As noted above, research in residential treatment is inherently complex (Curry 2004). As such, our approach to our questions about family interventions and outcomes was exploratory in that we assumed family involvement would be an important factor in successful treatment, but did not have specific hypotheses about the nature of this relationship. We used a mixed methods approach in which we began with aggregate descriptive data to look at group differences in outcomes. We then sought qualitative descriptions of successful and unsuccessful cases from therapists in order to create a more three-dimensional look at youth and family's experiences in the program. This type of design is often referred to as a sequential explanatory mixed method design. The processes for both the quantitative and qualitative components of the study are as follows.

Youth Sample

The agency involved in this study is a comprehensive treatment facility for youth and their families. The high-end residential program—that is, the most restrictive of the residential programs—has a capacity of approximately 130 youth at any given time. We selected as our sample all youth who were discharged in the fiscal year 2014 from the high-end treatment program. The youth in this program either have a conduct disorder diagnosis or have exhibited behaviors that are related to conduct disorder that cannot be contained in a less-restrictive environment. These behaviors are the precipitants to placement, although additional diagnoses may include mood disorders, Post-Traumatic Stress Disorder, autism spectrum disorders, and borderline personality disorder. The selection of this particular group allowed for a sample

that was recent enough to reasonably reflect the current implementation of the model, but also allowed for a sample from which we would have information on whether discharges that were favorable had been sustained for 6 months.

In this current sample, there were 100 discharged youth who ranged in age from 13 years old to 21 years old, with an average age at discharge of approximately 17 years (M = 16.76, SD = 1.51). Most of the youth discharged were boys (68%) and the majority of the youth were African American (56%). An additional 34% of the youth identified as White, 7% as Latino/a, and 3% as bi-racial. The Department of Child and Family Services (DCFS) was the funding source for and, therefore, also the legal guardian of 66% of the youth. The remaining 34% had an alternative funding source and a guardian who was either a biological family member or adopted family. These clients had state School Board of Education funding (ISBE) (18%), Department of Human Services funding (DHS) (13%) or funding through a neighboring state (e.g., Wisconsin) (3%).

Therapist Participants

Six therapists were asked to participate in the qualitative portion of the study and all six agreed to participate. All were therapists at the agency during the fiscal year 2014 in which the youth for this study were discharged. They had all received ongoing training on the implementation of the REStArT model. Therapist training in the principles and practice of the REStArT model is multifaceted. When therapists first join the agency, they receive didactic training that covers the model's principles, the purpose and process of clinical consultation, the trauma-informed components of the model, and working with control-sensitive youth. On an ongoing basis, therapists have multiple opportunities to observe others practicing the model and to get feedback on their implementation of the model. Therapists and case workers complete a checklist following clinical consultation designed to provide a self-report of their fidelity to the intervention. Four of the six therapists were female. They had an average of 4.8 years of experience, with a range of 3 to 8 years as therapists at the agency. Each therapist worked primarily with a single residential unit and they provided individual therapy to the youth in this unit. Therapists also facilitated the clinical consultation intervention with the cooperation of the youth's agency caseworker.

Variables

Discharge outcome as a dependent variable was assessed both at the time youth exited the program and also after 6 months. A *favorable* discharge was one in which the youth left the high-end residential program for a less-restrictive level of care including a group home (this program's or another's), family home, foster care, a

transitional living program, a more moderate residential program, independence, or a less-restrictive adult mental health facility. Lateral discharges to other residential programs or psychiatric hospitals, as well as more obviously negative outcomes such as detention and running away, were considered *unfavorable* discharges.

The agency routinely offers aftercare consultation to youth and their families or caretakers following program discharge, and this also allows us to track whether youth have maintained their placement. For this study, we measured sustained outcomes at 6 months. Because we consider youths' ability to maintain their placement as a measure of our alliance with the youth and their family, for the purposes of this study, we delineated our sample as follows: *positive* outcomes were those that were favorable and sustained at 6 months and *negative* outcomes were those that were either unfavorable at the time of discharge or were not sustained for 6 months. This was conceptually congruent for our model, but it also allowed for *oversampling* of unfavorable discharges as our favorable results proportion at the time of discharge is high and would create uneven sub-samples.

Independent variables that we examined for their relationship to discharge status included rate of consultations (average number of consultations occurring in each month of stay), length of stay, and funding source. The rate of consultations was selected in order to determine whether frequency of this particular form of family contact influenced outcomes. Although it is not clear from previous research if length of stay is associated with deleterious effects for the youth in treatment, it was selected as a variable due to recent increased focus on its impact on treatment (James et al. 2012). Length of stay was measured by the number of months the youth was placed in the agency's high-end program. Funding source was divided between youth who were funded by the Department of Children and Family Services and youth funded by all other sources, which included the DHS and the state School Board of Education. This variable stands in for the different case dynamics present in working with youth whose families are their legal guardians compared to youth for whom the state is their guardian.

Data Analysis

Quantitative analysis. Consultation rate, length of stay, and funding source were all assessed for their relationship to outcomes 6 months post-discharge. Separate two-tailed t tests assuming unequal variance were conducted to measure the difference between the mean consultation rate by outcome type and between the mean length of stay by outcome type. As an exploratory study, we were interested in their independent relationship with outcomes rather than their combined explanation of variance. A chi-square test was used to assess the difference between the proportion of positive and negative discharges by funding source. Because this chi-square test produced the only significant relationship between one of the variables (funding source) and outcomes, we also conducted t tests for the mean consultation rate and mean length of stay by funding source.

Qualitative analysis. Because, with few exceptions, the negative outcomes in this sample were youth who were funded by DCFS, we also conducted a qualitative review of the model's implementation across selected cases. Residential therapists of the units whose youth were included in the discharge sample were asked to provide recollections about the process of consultation with DCFS youth and their families. In particular, we were interested in exploring the ways in which the model's primary family intervention, clinical consultation, impacted differential outcomes. Therapists were provided with a list of DCFS youth who had discharged in the fiscal year 2014. Therapists selected two cases to discuss, one with a positive and one with a negative outcome, based on their ability to recall details about the process of the youth's treatment in those cases. Written responses were requested because the schedules of both the researchers (who also provide direct care) and the residential therapists made it difficult to schedule face-to-face interviews without disrupting services to clients. The culture of the agency is one in which the process of treatment is discussed often, so therapists were knowledgeable about how to respond to an open-ended request for their reflections on this. They were asked to respond to the question, "What aspects of treatment, especially related to consultation, did you notice seemed to help or hinder the case?" The therapists were instructed to focus on the process of clinical consultation because we were specifically interested in their reflections on family involvement. The written responses from therapists were separated into groups by discharge outcome. Narratives were assessed for themes related to REStArT model principles and were considered salient if they occurred across a majority of respondents.

Understanding Youths' Outcomes

The results of the quantitative and qualitative components contributed to our understanding of outcomes for the youth in this study. It is useful, however, to start with a view of the quantitative findings that then led to our qualitative questions. Most youth discharged in fiscal year 2014 had a favorable outcome at the time of discharge (82%, $n = 82$). Although it is difficult to compare outcome studies to one another given different populations and methodologies, this rate of favorable discharges appears comparable to other favorable studies (c.f., Hair 2005; Thomson et al. 2011). Most favorable discharge outcomes for the youth in this sample were either to a family home or to a group home (25 and 31% of total discharges, respectively). The remaining favorable discharges were to transitional living programs (10%), moderate residential treatment (7%), foster care (6%), adult mental health programs (2%), or independence (1%).

Youth with DCFS funding accounted for 48% of the discharges to family homes and this represented 18% of all DCFS-funded discharges. Alternately, 34% of youth without DCFS funding returned home. The unfavorable outcomes at the time of discharge included runaways (11% of total discharges), detention (5%), and lateral moves to other high-end residential programs (2%). All of the discharges that were

Table 21.1 Discharge distribution by funding source

	Total $N = 100$	DCFS $n = 66$		Non-DCFS $n = 34$	
		At discharge	Sustained at 6 mos.	At discharge	Sustained at 6 mos.
Favorable discharges	82	49	38	33	30
Group home	31	14	12	17	16
Family home	25	12	9	13	12
TLP	10	9	5	1	0
Moderate residential	7	7	6	0	0
Foster care	6	6	5	0	0
Adult mental health	2	0	0	2	2
Independence	1	1	1	0	0
Unfavorable discharges	18	17		1	
Runaway	11	11		0	
Detention	5	5		0	
Lateral residential	2	1		1	

due to runaways and detention were youth who had DCFS funding. Table 21.1 contains discharge type by funding source.

Of the 82 favorable discharges, 83% (n = 68) were sustained at 6 months. Therefore, from the original sample of 100 discharges, 68% were positive at 6 months. The remaining 32% were negative, meaning they were either unfavorable at discharge (n = 18) or were not sustained or unknown at 6 months (n = 14). Of the discharges that were not sustained, four of 25 discharges to family homes disrupted, three of 31 group home discharges disrupted, and half of discharges to transitional living program disrupted (five of 10). Three of the favorable discharges were considered negative outcomes at 6 months because their disposition was unknown. These included one foster care discharge and two discharges to family homes.

As the primary family intervention, clinical consultation is offered to all families. In the current sample, 95% of the youth and their families participated in clinical consultation during their treatment. Youth who had positive outcomes had, on average, fewer consultations per month (M = 1.17, SD = 0.69) than youth with negative outcomes (M = 1.26, SD = 0.87). This difference in rate of consultations was not statistically significant, nor was it practically meaningful. See Table 21.2 for differences between outcomes.

Both youth with positive outcomes and those with negative outcomes were participating in approximately one to two consults for each month they were in treatment. Although there was a statistically significant difference between rates of

Table 21.2 Differences between positive and negative outcomes

	Positive outcome at 6 months			Negative outcome at 6 months				
	n	*M*	*SD*	*n*	*M*	*SD*	*t*	*p*
Length of stay (in months)	68	13.47	7.41	32	12.56	5.78	0.67	0.51
Rate of consultations (consults per month)	68	1.17	0.69	32	1.26	0.87	−0.48	0.63

Table 21.3 Differences between funding sources

	DCFS			Non-DCFS				
	n	*M*	*SD*	*N*	*M*	*SD*	*t*	*p*
Length of stay (in months)	66	14.14	6.23	34	11.32	7.85	1.82	0.07
Rate of consultations (consults per month)	66	1.00	0.64	34	1.58	0.81	−3.63	0.000

consultation for DCFS youth and non-DCFS ($t = -3.63$, $p < 0.001$), the actual difference was an average of half a consultation a month ($M = 1.00$, $SD = 0.64$ and $M = 1.58$, $SD = 0.81$, respectively). While this may represent a larger issue about how DCFS youth were approached, the actual difference is small. See Table 21.3 for differences between funding sources.

It was somewhat surprising to find that there was no relevant difference in the amount of time spent with families related to discharge outcomes considering previous research that has found such a link (Huefner et al. 2015). This suggests that the agency was equally involving youth and their families in treatment regardless of outcomes, implying that variables other than simply the amount of treatment were at play in the relationship between family contact and the maintenance of favorable discharges. Notably, of the five youth who did not participate in any family intervention during their stay, three youth were discharged due to running away from the program.

The average length of time in treatment for all clients was 13.18 months ($SD = 6.92$), with a minimum stay of 6 months and a maximum stay of over three years (39 months). Length of stay did not differ between positive and negative outcomes ($M = 13.47$ months, $SD = 7.41$ and $M = 12.56$ months, $SD = 5.78$ respectively). The length of stay for youth with DCFS funding was 14.14 months ($SD = 6.23$) and the length of stay for youth with an alternative funding source was 11.32 months ($SD = 7.85$). The difference between these two groups was not statistically significant ($t = 1.81$, $p < 0.07$); however, the difference may still be meaningful in that DCFS youth were spending almost 3 months more in treatment. Longer lengths of stay have not always been associated with an actual need for a longer stay, but rather the absence of a post-discharge placement option (James et al. 2012).

The proportion of positive and negative discharges varied significantly by funding source, X^2 $(1, N = 100) = 9.69$, $p < 0.01$ (see Table 21.4). Youth with

Table 21.4 Proportion of positive discharges by funding source

	n	Positive outcome at 6 months (%)	*N*	Negative outcome at 6 months (%)	Total
DCFS funding	38	57.6	28	42.4	66
Non-DCFS funding	28	87.5	4	12.5	32

DCFS funding represented two-thirds of the youth discharged, but were just over half of the sustained positive discharges. On the other hand, only four of the 34 youth without DCFS funding had negative discharges (meaning, discharges that were either unfavorable or not sustained at 6 months). Certainly some of this difference is apparent in how many returned to a family home. Of the 68 DCFS-related discharges, 12 returned to a family home (18%), and nine of these youth were still in that home at 6 months. On the other hand, 13 of the 34 youth without DCFS funding (38%) returned home and only one was not sustained at 6 months.

While the lack of a family resource seems the obvious source of difference between working with the youth and families with DCFS funding, discharges to *step-downs* in level of treatment (i.e., group homes, transitional living programs, and more moderate residential care) also resulted in disrupted favorable discharges. This lack of continuity in placement suggests that in some way, the REStArT model's treatment was differentially effective for youth with different funding sources even though both sets of youth and their outside resources took part in family-oriented consultations at rates that were, practically speaking, very similar.

The qualitative component of our study allowed us to add texture to our understanding of these differential outcomes for youth with and without DCFS involvement. Across examples of unsuccessful DCFS cases, therapists noted that youth often wanted to live with a family member, but were discouraged from doing so. Youth were either informed by a DCFS caseworker that their chosen family members were not appropriate as a discharge resource or the youth and their family members perceived barriers with family members that interfered with the youth being placed in their care. Sometimes therapists spoke of this broadly, such as a case in which a therapist noted, "The youth had other family in state, but there was little momentum from the system to pursue those avenues." In other cases, the therapist's view of the youth's barrier was more specific: "The expectation was that they [any identified family member] come visit him on campus several times and then she [the DCFS caseworker] would talk about home visits." In both of these cases the youth ran away from treatment to be with family. Another therapist discussed a case in which a youth was detained by corrections, which resulted in his discharge. "After dealing with his legal issues, he went to live with family."

Therapists commented on cases in which the initial discharge was favorable, a group home or transitional living program, but ultimately the placement was not sustained. One therapist observed,

> Sometimes DCFS youth remain [in treatment] for years, and so when a group home is finally suggested….the client is just desperate to leave, and agrees to the goal…in reality they were hoping all along they could go to [a] parent.

In a specific example of this, one therapist reflected on a case in which a client wanted to return to family in a different part of the state. When a group home was offered, the youth agreed with the expectation that the group home would be closer to his family. It was not, and his behaviors deteriorated once he was placed in the group home. The first principle of the REStArT model is the development of a working therapeutic alliance with the family and youth that includes youth- and family-driven goals. These examples suggest that, at times, it is possible that the model was not being implemented as intended in that the goals identified by the youth and family were not accepted by treatment providers or collaterals.

Therapists also reflected on factors internal to the agency that may impact the success of DCFS-funded cases. The theme that emerged was one in which fidelity to the model's emphasis on the recognition of ambivalence during consultation may be abdicated when DCFS is involved. Therapists and other treatment providers may see the responsibility of finding an appropriate discharge as the DCFS caseworker's responsibility. One therapist observed that "we come up against a natural split with DCFS" in which DCFS staff may advocate one discharge plan and treatment providers may advocate another. In the process, the youth's treatment needs tend to get overlooked because families may simply choose to align with whoever will support their discharge goal. If this split is left unacknowledged in the consultation process, the discharge is less likely to be stable. In another case, a youth was discharged to a former foster home, but then soon re-hospitalized. The therapist thought that "maybe we were pushing too hard and not hearing her [the foster mother] or her concerns and that is why there was not as good as a partnership as there could have been in the treatment process." Therapists seem to be identifying ways in which the principles of *finding imbalances in the system* and *working with ambivalence* were neglected in these cases.

Not surprisingly, for DCFS cases that were successful, therapists noted that agency providers were able to work cooperatively with DCFS caseworkers, the youth's biological family, and the youth. In particular, they observed that the youth were given the opportunity *to drive that conversation*. In one case described by a therapist, a youth was encouraged to find a family member who "was willing to participate in treatment and the youth was discharged to them." This resonates with other studies that have emphasized more than simple contact between youth and families, but rather the development of collaboration and partnerships between providers and families in order to work toward their goals (Geurts et al. 2012; Scarborough et al. 2013; Sharrock et al. 2013).

The lack of emphasis on finding family members by an agency such as DCFS that is charged with protecting children from potential unsafe family situations is understandable. It is notable, however, that the average age of discharge for these youth was just under 17. One of the therapists shared the case of a youth who stated that he intended to leave treatment when he was 18 in order to reunite with family,

whether or not his move was supported by treatment providers. As a recent literature review suggests (Collins et al. 2008), the developmentally appropriate focus on knowing one's place with family is a significant aspect of adolescence, so treatment that acknowledges and preserves those relationships seems likely to be successful in a more enduring way. The successful cases therapists noted appeared to preserve these family relationships, which is consistent with the model's principle that asks providers to *expect health* from youth and their families.

Summary

In investigating outcomes related to family involvement and the REStArT model, we were interested in answering the question, "Do youth and their families benefit from treatment when they leave and is that benefit enduring?" Most of the youth who left the agency's residential program were older adolescents living in a less-restrictive placement. The durability of the treatment's impact, however, varied depending on the youth's guardianship. Those youth whose families were involved with DCFS were much more likely to leave without completing treatment or to have favorable discharges that disrupted. When therapists' reflected on the process of individual cases, both positive and negative, they suggested that the model's implementation was challenged in a number of ways, such as the development of a therapeutic alliance in which youth and their families were given ownership over their goals. These results suggest on the one hand that, in response to the need for family-driven treatment to improve residential outcomes, the REStArT model offers one way of successfully responding to families' needs. But the results also suggest that families with DCFS involvement may not be receiving the same benefits of the model's efforts at collaboration.

Limitations, Implications, and Research

A number of limitations need to be acknowledged that temper the interpretation of these results. While it appears that the model's emphasis on family involvement has differential effectiveness based on the family's relationship with DCFS, this study examined only 1 year of discharges, so it is possible that this sample of youth with DCFS guardianship is different than other years. Indeed, previous research (McConnell and Taglione 2012) found more comparable results, at least at the time of discharge, even in returns to family homes between youth with different funding sources. However, the previous study did not consider the sustainability of favorable outcomes.

One possible hypothesis for why relatively equal frequency of family interventions was less successful with DCFS-funded youth relates to the implementation of the model. The therapists interviewed speculated that the fidelity of the model

was compromised in cases that included DCFS involvement. Another limitation then of this current study is that it did not contain a fidelity check that would allow us to see if, in fact, therapists and other treatment providers were not implementing the model as it is intended, despite providers being trained to monitor fidelity (as described above). Without such a check, it is unclear if the model was implemented accurately, but was less effective in these cases or if the model was not being used as intended.

This study looked only at whether discharges that were favorable at the time of discharge were sustained. A number of therapists observed anecdotally that DCFS-funded youth sometimes ran away from treatment and returned to live with family in response to being limited in their family contact by treatment providers, DCFS, or the courts. An additional limitation then of this study is that there may be youth who were able to return successfully to family homes despite external prohibitions.

The need for family involvement in residential treatment has been soundly supported by research and increasingly accepted by residential treatment programs. However, the effectiveness of family interventions will remain limited if providers and the larger system working with youth remain ambivalent about youth returning to their families. There is some research to support therapists' assumption that youth sometimes return to their families when they are old enough to make their own choice (Collins et al. 2008). The REStArT model asks treatment providers to help youth and families address their ambivalence about their relationships with one another but likely needs to do more to address the ambivalence in the larger system.

This chapter shows that mixed methods can be effectively used in residential settings serving adolescents. In the study described here, the mixed methods approach allowed the researchers to understand empirically the characteristics that differentiated outcomes and also to bring some depth to that understanding by looking at the treatment process that may explain those results. In other words, the qualitative results provided a possible explanation for the quantitative data: perhaps clinical consultation was differentially effective because its application varied depending on the youth's guardianship. With that hypothesis in hand, future studies may be conducted to further assess the accuracy of this. For example, empirical studies could examine whether the two groups, DCFS-funded and non-DCFS-funded youth, varied in any other ways that may play a mediating role in the correlation between clinical consultation participation and quality of outcomes. Another benefit of a mixed methods approach is its accessibility to providers. Empirical results at times can seem remote and disembodied from daily practice. The narrative lens can help providers make sense of quantitative outcomes by understanding the process at play behind the numbers.

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 their 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. **System-Oriented**: Identify all the adults involved with the youth and have them come together to develop a shared understanding of and way of approaching the youth.

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. **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).

VIII. **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.

IX. **Working with Ambivalence**: Be aware of and identify examples of ambivalence toward the current circumstance in the family and the youth so that this can be verbalized instead of expressed through behavior.

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.

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Author Biographies

Catherine McConnell Ph.D. has been at the Allendale Association for almost 20 years, having been drawn there initially as a pre-doctoral intern because of its reputation for self-reflective psychodynamic work with children and adolescents who have experienced trauma. Catherine McConnell holds a Ph.D. from the University of Wisconsin-Madison and is a licensed clinical psychologist. In addition to providing therapeutic services to children and their families across a variety of settings within Allendale, Dr. McConnell has had the opportunity to work with staff across the agency in developing and conducting research on the agency's treatment model: the Relational Re-Enactment Systems Approach to Treatment.

Patricia Taglione Psy.D. is a licensed clinical psychologist and the Senior Vice President of Clinical and Community Services at the Allendale Association. Dr. Taglione holds a Psy.D. from the Forest Institute. She has over 30 years of experience working directly with youth and their families, as well as supervising trainees and psychologists. As a founding developer of the agency's Relational Re-Enactment Systems Approach to Treatment model, she has developed and conducted dozens of innovative trainings and presented in multiple forums to help all levels of staff who work with traumatized children and families.