Allendale Association Treatment Model

Executive Summary:

Relational Re-Enactment Systems Approach to Treatment

The Allendale Association has been providing care to youth and their families for over 100 years, offering behavioral health services from most to least restrictive. As providers of services for children and adolescents are aware, it is sometimes difficult to assess treatment effectiveness. Nonetheless, the call for providing an evidence base for our services is important, and we have been responsive to this need by looking for multiple sources of feedback on our work. Internally, our quality improvement process involves examining trends during treatment stabilization and ownership as well as in outcomes, both at and post-discharge. Additionally, we solicit ongoing feedback from the youth and families we serve and others who purchase our services.

Our model grew out of this reflexive process. We had anecdotal evidence that youth and their family were satisfied with our programs. We also had outcomes to suggest that the majority of the youth who came to us improved. But we chose to look at the cases in which treatment was not successful and we found that those cases were characterized by a lack of alignment, or "splits." These splits occurred in many ways: between or within our treatment teams, with the youth and family or within the broader system. We were less successful with the youth in our care when we had struggled to create an alliance with families about treatment goals and discharge plans. Furthermore, we observed that it was more difficult to create an alliance between treatment providers and family members when we did not have a shared understanding of the youth that included both their strengths and their challenges. It was out of this observation that we sought to strengthen and make more intentional our process of working with families and the collateral "systems" that are often involved in length of stay expectations as well as discharge planning and decision-making.

To assess whether the components of our work were consistent with established evidence-based practices, we sought out Dr. Bruce Wampold, a leader in the field of research critically examining what it means to be "evidence-based." A review of residential outcomes research conducted by Dr. Wampold suggested that three factors were common across treatment approaches with positive outcomes: 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). Additionally, Dr. Wampold posited a fourth factor that is key to positive outcomes across mental health services: a coherent treatment model. This proposition has support across treatment settings with children and adolescents (e.g., Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Rivard, Bloom, McCorkle, & Abramovitz, 2005).

When held to the standard of the above factors, Allendale's model compared favorably (Wampold & Malterer, 2007). The **REStArT** model emphasizes the need for an alliance with youth and their families as a cornerstone to the treatment approach. This alliance is more than a positive relationship; rather, the alliance the model promotes is one that is built on a shared understanding and shared treatment and discharge goals driven by the youth and family. This emphasis is also consistent with the definition of evidence-based treatment according to the American Psychological Association (APA, 2006). According to the APA, evidence-based practice is not solely research-derived but is also dependent on client collaboration. In general, research has suggested that treatment is more effective when there is agreement on tasks and goals between client and service provider, otherwise known as the therapeutic alliance (e.g., Wampold, 2010).

The model also guides the treatment providers' work with youth and their families to address their potential ambivalence about discharge placement, which helps strengthen the stability of the youth's ultimate placement. These components are kept on center stage throughout treatment using the intervention of clinical consultation. These consultations are regularly scheduled, systems-oriented (child/youth & family team), and intentional in their process. The consultations allow the alliance to be regularly assessed and, if needed, provide timely opportunity for repair. They also offer an ongoing venue to create a shared understanding of the youth, one that helps all participants in the system to acknowledge and understand both the adaptive and maladaptive facets of the children and adolescents with whom they are working or in a supportive relationship. The model includes a youth group component that facilitates this insight of self within the youth as well.

The elements of the **REStArT** model have been created through practice that is firmly grounded in theory. It has evolved over time using facets of life-space crisis intervention, attachment theory and research, neurobiological findings, object-relations theory, trauma-informed interventions, and systems theory (e.g., Bowlby, 1980; Masterson, 1976; Schore, 2003; Senge, 1990; Siegel, 1999; Wood & Long, 1991). More recently, the model has also been held to the test of assessing outcomes over time. The Allendale Association was awarded the Council on Accreditation's 2011 Innovative Practice Award as recognition for the **REStArT** model. A cross-sectional analysis of our outcomes over a four-year period concluded that improvement in

residential treatment outcomes was associated with the implementation of the **RE-StArT** model (McConnell & Taglione, 2012). A follow-up study that assessed the durability of positive outcomes at six months post-discharge found that most youth had maintained their ability to be successful in their placement following treatment with the **REStArT** model (McConnell & Taglione, 2016).

Although the **REStArT** model was originally developed for use in our residential program, many of its components are well-suited for use across our multiple levels of treatment environments including therapeutic day school and foster care. Over time, the use of the model across program types has become ubiquitous. In addition to the intervention of clinical consultation's use in the residential program, it has been implemented successfully with youth and families in community-based transitional living, day education, and foster care programs. The guiding principles of the model are able to be implemented successfully across Allendale's continuum of levels of treatment – from community-based mentoring within biological or foster family to highly restrictive residential treatment settings.

A particular emphasis is placed on the importance of developing and maintaining a treatment alliance with youth and their families – an alliance that supports the goals desired by them. Additionally, training on the use of clinical consultation and youth/family driven treatment goals development has been offered to personnel in local public schools outside of Allendale with successful outcomes. The use of the **REStArT** model not only across Allendale's programs but also outside of Allendale is an important aspect of its development and suggests promise relative to broad implementation. The model was designed to be coherent and guiding in its principles and interventions and yet flexible enough to be adapted for effective use in multiple settings and across all levels of care, home, school and treatment environments. This flexibility allows the model to be incorporated into programs that already have an existing structure for treatment regardless of theoretical orientation.

The training manual contains the foundational principles and guidelines that create the basic structure of the **REStArT** model. The thirteen principles are explained in theoretical and narrative form, and also further elucidated through training slides. The manual also contains specific treatment guidelines which provide definitions of terms as well focused questions and suggestions to assess and respond to the treatment process. Training materials are also provided for understanding the difference between providing much-needed structure (including true choice and decision making) for youth in treatment as opposed to simply controlling their environment. The intervention of clinical consultation – its purpose and process – is elucidated through training slides tailored for different program areas (residential treatment, school settings, and family and/or foster homes).

FOR SUPPLEMENTAL MATERIALS, OR FOR CONSULTATION AND TRAINING OPPORTUNITIES, CONTACT:
Dr. Pat Taglione, Vice President of Clinical and Community Services

Related training materials are not all-inclusive and may be modified to fit individual implementation needs based on existing program components and culture. Consultation is available to discuss interest and determine next steps. Additional consultation or direct implementation training/supervision would be subject to a fee.

References

American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271-285.

Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss.* New York: Basic Books.

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.

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.

Masterson, J. (1976). *Psychotherapy of the borderline adult: a developmental approach.* New York: Brunner/Mazel.

McConnell, C., & Taglione, P. (2012). Collaborating with clients and improving outcomes: The Relational Re-enactment Systems Approach to Treatment model. Residential Treatment for Children and Youth, 29:2, 103-117

McConnell, C. & Taglione, P. (2016). Clinical consultation as a family intervention in residential treatment: Exploring what impacts outcomes. Contemporary Family Therapy, 38, 97-107.

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.*

Schore, A. N. (1994). *Affect regulation and the origin of the self.* Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Senge, P. M. (1990). *The fifth discipline.* New York: Doubleday.

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 of 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, Texas: pro-ed.