

Outcomes for Adolescent Girls after Long-term Residential Treatment

by

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Abstract

Residential treatment for troubled adolescents continues to generate controversy. Youth may improve during treatment, but are these gains sustained upon return to the community? We explore this question by analyzing outcome data collected at three months and one year post-discharge for 49 adolescent girls discharged from long-term programs at a residential treatment center in Massachusetts. Qualitative data reveals the range of post-discharge challenges experienced by adolescents and their families. Quantitative data shows a 77% reduction in restrictive level of care placements comparing the year before admission to the year after discharge ($p < .001$). This success rate suggests that improvements accomplished during long-term residential treatment are sustained by a majority of adolescent girls up to at least one year post-discharge. We will also discuss the process we used to collect outcome data and its impact on our agency staff and clientele.

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Introduction

Recent studies and reviews suggest that both short-term and long-term residential treatment may be effective in helping troubled adolescents (Leichtman, Leichtman, Barber & Neese, 2001; Larzelere et al., 2001; Hooper, Murphy, Davaney & Hultman, 2000; Hair, 2005; Bettmann & Jaspersen, 2009). Yet, some studies argue that residential treatment may be ineffective or even harmful (McMillen, Lee & Jonson-Reid, 2008; Barth, 2002 & 2005; Asarnow, Aoki & Elson, 1996; Hyde & Kammerer, 2008). Regardless of research findings, limitations derived from methodological problems in conducting outcome research—most notably, the difficulty of constructing an accurate control group, and the improper comparison of different types of residential treatment—are prevalent (Butler, Little & Grimard, 2009, Butler & McPherson, 2007). Handwerk et al. (2006) also point out that adolescent girls enter residential treatment with different problems than adolescent boys, and are in general “more troubled,” suggesting that the gender of residents is also an important variable to consider.

While long-term residential treatment programs are commonly acknowledged as reserved for youth with the most difficult emotional and behavioral problems (McCurdy & McIntyre, 2004; Foltz 2004; Butler et al., 2009), an on-going concern is that “although adolescents often improve in residential treatment, those gains are frequently lost when they return to the community” (Leichtman & Leichtman, 2001, p. 21). In this study, we will address this concern with specific attention to the experiences of adolescent girls by examining post-discharge outcome data for one cohort of adolescent girls discharged from long-term programs at a residential treatment center in New England. We will also explain in detail the process we use to do outcome research, and how it benefits our agency, its staff, and its clientele.

Methodology

Agency Profile

Germaine Lawrence, a residential treatment center in Arlington, MA, offers long-term programs for adolescent girls and young women (ages 11 through 19) with problematic behaviors such as physical aggression, self-injury, suicidal thoughts and gestures, eating disorders, substance abuse, fire-setting, running away, sexual exploitation and sexual aggression. Almost all of these youth have experienced significant trauma, including physical, sexual, and/or emotional abuse; parental neglect and/or abandonment; significant loss through death or divorce; bullying; sexual exploitation and/or assault; gang involvement; and domestic violence. A majority of long-term residents are referred to treatment through the juvenile court system and are under Department of Children and Families (DCF) guardianship, while others are referred through medical, psychiatric and/or educational service providers and are under the guardianship of their parents and family members. A few residents are over age 18 and not under any guardianship. Germaine Lawrence is not a locked facility, and during the admissions process prospective residents must indicate a willingness to attend the program.

In addition to the long-term programs, two short-term programs (CBAT -- Community-based Acute Treatment and STARR -- Short-term Assessment and Rapid Reunification/Reintegration) are offered, as well as less-restrictive levels of care such as BTR (Behavior Treatment Residential) and two group home programs, one of which is designed for girls with a history of sexual exploitation. Some residents attend school on campus, while others attend a variety of schools in the community. Lengths of stay vary from an average of just over one year for long-term programs, to up to two months for short-term programs. Approximately

100 residents may be accommodated overnight at any one time, and over 250 girls and young women are served each year.

Treatment Process

The long-term treatment provided adolescent girls at Germaine Lawrence incorporates a psycho-educational motivational system in the milieu, and cognitive and dialectical behavioral therapy in individual sessions and groups. Both of these therapies emphasize teaching coping strategies that residents and their families can continue to use after discharge. Psychiatric and nursing services are also provided. Each resident is assigned a treatment coordinator who serves as her individual therapist and oversees her care. Structure, nurturance and consistency are emphasized. Expressive arts therapy is also offered, including studio art classes, as well as a wide range of physical activities such as soccer, basketball, softball, yoga and ballroom dance. All of these activities help girls to discover new strengths and build a positive self identity.

In the milieu, young women experience a motivational system that allows them to move through four to five stages of treatment upon the completion of goals they set themselves with guidance by their treatment team. After reaching the last stage, residents are considered to have made adequate progress and in most cases, are eligible for discharge. In preparation for discharge, the treatment team meets to set up appropriate aftercare services, which are then discussed with the resident and her parents/guardians at the discharge meeting.

Throughout the treatment process, parent/guardian involvement is emphasized. Clinicians work closely with families to provide family therapy and parent training, and in the eating disorder program, offer home coaches to help around meal times. Many residents who have reached preliminary treatment goals visit their families on weekends. In addition, on-campus family dinner nights are scheduled regularly, and family members are encouraged to attend. For

parents who live far away, clinicians offer to keep in touch through phone calls and email. For girls who have no adult family member involved in their care, treatment coordinators establish visiting contacts for them through the Germaine Lawrence volunteer mentoring program. In 2009, Germaine Lawrence also began offering in-home services, which have been utilized by increasing numbers of girls and their families after discharge.

Adolescent girls who come to Germaine Lawrence's long-term programs have almost always had multiple placements in hospitals and other institutional settings. Virtually all of these young women have experienced significant trauma while growing up. Given this background, the goal is not to cure girls and young women of all symptoms of emotional suffering, but to provide evidence-based treatment empowering them to return to their families and/or communities and to live in safe, less-restrictive environments without recourse to hospitalization, the criminal justice system, or further residential care.

For certain, many young women will continue to struggle with symptoms after discharge, and will sometimes return to challenging environments. But through treatment that emphasizes coping strategies and self-empowerment, and through the careful planning of appropriate aftercare services, a successful discharge should allow them to maintain the gains they have made during residential treatment and continue the recovery process. Mindful that recovery is a process and not a cure, the overall purpose of our outcome study is to measure the success rate associated with level of care and social functioning for the first year after discharge for one cohort of adolescent girls treated at long-term residential programs at Germaine Lawrence.

Population

Sixty-one adolescent girls discharged from long-term programs during the year November 2007– October 2008. Four of these girls are not included in this study, because they

stayed less than one month in the program. Eight girls who left the long-term programs via an internal program transfer to another program at Germaine Lawrence are also not included in this data set, but will be interviewed after they leave Germaine Lawrence.

Our analysis will focus on the remaining 49 adolescent girls, all of whom stayed at a Germaine Lawrence long-term program for longer than one month and left Germaine Lawrence upon discharge. Information about all residents in this cohort was gathered both from a chart review and from follow up interviews conducted at three months and one year post-discharge. Table I provides basic demographic information about this cohort, and Table II provides additional descriptive characteristics about this cohort that are relevant to this study.

Table I
Demographics and Characteristics of the Study Cohort

| | | Number | Percent |
|--------------------|---------------------------|--------|---------|
| Total participants | | 49 | 100.0 |
| Age (years) | 12 | 2 | 4.1 |
| | 13 | 2 | 4.1 |
| | 14 | 6 | 12.2 |
| | 15 | 13 | 26.5 |
| | 16 | 14 | 28.6 |
| | 17 | 9 | 18.4 |
| | 18 | 1 | 2.0 |
| Race/Ethnicity | White | 37 | 75.5 |
| | African American | 10 | 20.4 |
| | Latina | 2 | 4.1 |
| Guardianship | Parent/relative | 22 | 46.0 |
| | Child in Need of Services | 11 | 22.4 |
| | Care & Protection | 6 | 12.2 |
| | Self | 3 | 6.1 |
| | Permanent state custody | 3 | 6.1 |
| | Other | 4 | 8.2 |

Table II
Characteristics of Study Cohort prior to and during Treatment at Germaine Lawrence

| Months in treatment | | | |
|---------------------|---------|----|------|
| | 3 to 5 | 6 | 12.2 |
| | 6 to 8 | 5 | 10.2 |
| | 9 to 11 | 10 | 20.4 |

| | | | |
|-------------------------------|-----------------------|----|------|
| | 12 to 15 | 14 | 28.6 |
| | 16 to 20 | 10 | 20.4 |
| | 21 to 24 | 1 | 2.0 |
| | 25 and over | 3 | 6.1 |
| Residence prior to admission | Hospital | 14 | 28.6 |
| | Residential | 26 | 53.1 |
| | Correctional facility | 4 | 8.2 |
| | Parents/family | 3 | 6.1 |
| | Group home | 2 | 4.1 |
| Presenting needs ¹ | Physical aggression | 17 | 34.7 |
| | Substance abuse | 14 | 28.6 |
| | Eating disorders | 12 | 24.5 |
| | Running away | 11 | 22.4 |
| | Suicidality | 6 | 12.2 |
| | Self-harm | 6 | 12.2 |
| | Sexual exploitation | 6 | 12.2 |
| | Sexual aggression | 5 | 10.2 |

Of note is that the age at admission for this cohort ranged from 12 to 19 years, with a mean age of 16 years. 12.9 months was the mean length of treatment. The number of out-of-home placements (defined as hospitalizations, foster homes, residential programs, group homes and correctional/detention placements) prior to admission to Germaine Lawrence ranges from 1 to 17, with a mean of 6.5 out-of-home placements.

Nearly three-quarters (73.5%) of this cohort had planned discharges, defined as adequate progress on treatment goals. The percentage of unplanned discharges was slightly more than the percentage of withdrawals; 14.3% of residents had unplanned discharges (defined as inadequate progress, discharge to a hospital or a run), and 12.2% of residents withdrew prior to the completion of treatment goals against the advice of the treatment team. If they were over 18, young women themselves made the decision to withdraw, and if they were under 18, their parents/guardians made this decision.

Procedure

In keeping with Germaine Lawrence’s mission to provide the highest quality of care to adolescent girls, and also its commitment to provide a supportive environment for its staff, a guiding principle for outcome research at Germaine Lawrence is making the process of doing this research of benefit to all concerned: clinical and milieu staff, administrators, families/guardians and the adolescent girls themselves. In other words, tracking and analyzing outcomes has three main purposes: “evaluation” to identify what is working well and what needs to be improved, thereby benefiting the agency as a whole; “follow-up” to offer individual help to adolescent girls and their families/guardians as needed; and “research,” to add to our knowledge base about the effectiveness of residential treatment.

Due to the focus of our study on a single residential treatment center and the impossibility of constructing an accurate control group, we used a longitudinal design to track outcomes for all adolescent girls in this cohort at three months and 12 months post-discharge. We also used a chart review to incorporate information about functioning in the year prior to admission to Germaine Lawrence. Our research design was reviewed and approved by the board of directors at Germaine Lawrence.

For the follow-up interviews, we contacted former residents of Germaine Lawrence and/or their parents/guardians/social workers by telephone at three months and 12 months post-discharge. Permission for these interviews was obtained upon intake to Germaine Lawrence. Participation was voluntary, and interviewees were given the opportunity to decline the interview when contacted. In this cohort, we were able to obtain follow up interviews at both three and 12 months with a parent/guardian, social worker and/or the girl herself for 100% of the girls discharged.

Interview Protocol

¹ Adolescent girls are frequently admitted with more than one presenting need.

The interview protocol we use combines open-ended and closed-ended questions designed to elicit key information about social functioning after discharge. These questions focus on each adolescent girl's behavior in the following five areas: level of care, education, hospitalizations, arrests/detentions, and aftercare services. Interviewers utilize empathic, non-judgmental listening skills and encourage interviewees to share both positive and negative opinions and experiences. Telephone calls are made at various times of day, including evenings and weekends, to maximize the response rate. After the interview, notes are sent for review to the treatment coordinator who worked with each girl, and quantifiable data is entered into an Excel table for analysis. Qualitative data is coded and analyzed thematically.

To make these interviews of mutual benefit, if during the course of the conversation it becomes apparent to the interviewer that further assistance may be required, or if the interviewee him/herself requests it, assistance is offered to former residents and their parents/guardians. In most cases, they are referred to their former treatment coordinator at Germaine Lawrence. Types of help offered included referrals for therapists/psychiatrists, locating clothing/personal goods that may have been left behind, and sending school/medical records. Some interviewees also appreciate the phone call itself. One former resident, who was treated for an eating disorder, commented that being contacted for the follow up interview made her feel that "Germaine Lawrence still cares about you after you leave." While some parents/guardians and girls decline to be interviewed or are not interested in a lengthy interview, others are grateful for the chance to provide feedback about their experience. In the words of one parent, "it's good to know there's still interest there," and in the words of another, "thank you for listening."

Feedback from clinicians indicates that they find the follow up interview notes and the outcome data presentations helpful. One clinician commented that the outcome data gave her

“some useful perspective – we get so focused on the day to day and especially the failures that it’s useful to see the trends and bigger picture.” Another clinician summarized her thoughts as follows:

More than anything, it was validating to see the data and to hear the comments about what is and isn’t helpful. I wasn’t really surprised at the data, but it did give me some ideas about planning for increased community access when girls are ready to leave in order to better prepare them for life after Germaine Lawrence.

In addition to providing the follow up interview notes and group presentations for clinicians, the director of research also presents outcome data at Performance and Quality Improvement (PQI) meetings, which allows agency administrators to use the findings in program evaluation.

Results

Altogether, we conducted a total of 118 interviews for this cohort. At three months post-discharge, we spoke with 65 people, including 12 former residents, 20 non-kin guardians/caregivers (i.e. case workers, foster mothers, visiting resources) and 33 parents/family members. At one year post-discharge, 53 people were interviewed, including six former residents, 10 non-kin guardians/care givers, and 37 parents/family members. Post-discharge outcome data about all 49 young women in this cohort was collected.

Qualitative Data

Thematic analysis of the follow up interviews from the 2007-2008 cohort at Germaine Lawrence reveals that accounts of the first year after discharge range from youth and parent/guardians who report having “no significant problems” to those who experience much difficulty.

Transition after Germaine Lawrence

Some adolescent girls and their families report an easy transition to living at home after leaving Germaine Lawrence. When contacted at 3 months post-discharge, the father of a twelve year old girl treated for post-traumatic stress disorder (PTSD) felt that his daughter was doing “remarkably well” back at her home, “better than her siblings are on occasion.” He also reported that she had no difficulty adjusting back into the public school in her community.

Other girls and their families note some adjustment to the lack of structure and increased freedom, as compared with the very structured environment of Germaine Lawrence. One former resident felt that her biggest challenge was “trying to stay on the same track I was on at Germaine Lawrence – it was so scheduled there. Nothing was too hard, just a lot of adjusting.” And the mother of a 15 year old girl treated for unsafe behaviors commented that her daughter “misses being in a program . . . when she’s in a program, she does so well, she thrives on the structure. But I can’t run the house like a program, it’s not fair to the other kids.”

One case worker noted that the adolescent girl she worked with had the most difficulty right after discharge, but then settled down: “when she first left Germaine Lawrence, it was rocky out of the gate, but for the last month and a half she has been doing remarkably well.”

In contrast, other young women experience the most difficulty between three months and one year after discharge. When contacted for the one year interview, one mother responded: “(My daughter) left there thinking everything was great, but then reality set in, and she went back to what she knew – the eating disorder.”

Coping Skills

Some adolescent girls and their parents commented on specific coping skills learned during treatment that continued to help them, such as journaling or listening to music. Overall,

dialectical behavioral therapy (DBT) was mentioned most frequently as providing significant help after discharge. In the words of one former resident, “the entire DBT package changed my life . . . I use mindfulness and DBT without even knowing it.” Another former resident mentioned that she still uses relaxation strategies she learned at Germaine Lawrence, and especially remembers “the advice they gave me—I learned how to go to people when I’m struggling, tell them how I really feel, and get my feelings validated.”

Family Involvement

The follow up interviews also suggest that the high degree of family involvement at Germaine Lawrence may make the transition back home go more smoothly. Sixty-three percent of girls in this cohort had at least one adult family member who was very involved in her treatment, defined as participating in family therapy, family dinner nights, parent support groups, and/or parent training. Twenty-nine percent of girls had an adult family member who was somewhat involved, defined as keeping in touch by phone or email. Only eight percent had no adult family member involved during treatment. A few young women treated for eating disorders also had in-home coaches that helped especially around family meal times. One of these adolescent girls noted in her follow up interview that prior to discharge, she would visit her home with a Germaine Lawrence staff member, have dinner together with the staff member and her family, and then return back to Germaine Lawrence. She felt this helped her with the transition back home. Parents also found this service helpful; one mother of a girl being treated for an eating disorder described her home coach as follows: “She would observe the family meals and give us feedback . . . it was incredible . . . (I would think) wow, this is what we need to do to help (our daughter).”

Aftercare Services

Significantly, all but one adolescent girl in this cohort who had a planned discharge utilized therapeutic aftercare services for at least three months after discharge (97%). The one girl who did not utilize aftercare was waiting to join a Job Corps program in a different town. While some young women fail to connect well with their new therapist, and others feel they don't need this service anymore, many find these services helpful. At one year post-discharge, about half of the adolescent girls in this cohort (53%) were still using therapeutic aftercare.

Staying in Touch

Some adolescent girls and their families also continue to visit or stay in touch informally by phone with their Germaine Lawrence therapist during the transition period. Both girls and their families/guardians are encouraged to return to campus for the family dinner nights and graduation ceremony each June. One adoptive father of a fifteen year old girl treated for unsafe behaviors brought his daughter back to Germaine Lawrence "5-6 times" for family dinner nights over the year since discharge.

Overall, comments about the transition to life at home and/or in the community suggest a continuum of post-discharge experiences. Those girls and their families who had trouble felt this was due to lack of structure, lack of help, and reversion to previous behaviors. While not true of all discharges, as discussed above, some girls and their parents did mention that coping skills learned in treatment carried over into the post-discharge environment. Interviewees also felt that involving family members in the treatment process and offering home coaches helped with the post-discharge transition, as did maintaining an informal connection with Germaine Lawrence staff and utilizing appropriate aftercare services.

Quantitative Data

Reduction in More Restrictive Level of Care Placements

A criterion often cited for the effectiveness of treatment programs is the number of more restrictive level of care placements that occur in the first year after discharge from a residential treatment center (McMillen et al., 2008). For the 36 adolescent girls with planned discharges from Germaine Lawrence long-term programs in 2007-2008, the average number of residential, correctional and hospital level of care placements in the year prior to admission was 2.97. In contrast, during the first year after discharge from Germaine Lawrence, the average number of residential, correctional and hospital level of care placements for this cohort was .69. This represents a 77% reduction in the number of hospital, correctional and residential level of care placements (year before admission versus year after discharge) for girls with planned discharges. The results of a paired T-test reveal that this is statistically significant at the .001 probability level ($p < .001$) (see Table III).

Table III
Comparison of Hospital, Residential and Correctional Placements in the Year Before vs. the Year After Treatment at Germaine Lawrence

| Number of hospital, residential and/or correctional placements | The year before treatment at Germaine Lawrence | | The year after treatment at Germaine Lawrence | |
|--|--|---------|---|---------|
| | Number | Percent | Number | Percent |
| none | 0 | 0 | 24 | 66.7 |
| one | 10 | 27.8 | 6 | 16.7 |
| two | 7 | 19.4 | 1 | 2.8 |
| three | 9 | 25 | 3 | 8.3 |
| four or more | 10 | 27.8 | 2 | 5.6 |

Further analysis of the data reveals that 86% of all residents with planned discharges experienced a reduction in more restrictive level of care placements, and 67% had no more restrictive level-of- care placements in the first year after discharge. The length of more restrictive placements varied from one day to several months.

Importantly, the 12 adolescent girls who were treated for eating disorders all had planned discharges, but had a higher rate of more restrictive level of care placements after discharge than

residents successfully treated for all other presenting needs. 75% (8) of girls treated for eating disorders had at least one more restrictive level of care placement in the first year after discharge, compared with 17% (4) of the 24 residents with planned discharges treated for other presenting needs. Yet, youth with eating disorders also had higher rates of more restrictive level of care placements prior to treatment at Germaine Lawrence, and did experience a statistically significant decrease in more restrictive placements after treatment. The average number of more restrictive level of care placements for girls treated for eating disorders was 3.58 in the year prior to treatment and 1.16 in the year following treatment (67% decrease, $p < .01$), compared with a decrease from an average of 2.67 placements in the year prior treatment to .46 placements in the year following treatment for girls treated for all other presenting needs (83% decrease, $p < .001$).

Living Situation at One Year Post-Discharge

As mentioned, most of the more restrictive level-of-care placements in the year after discharge were short-term, and by the time of the one year post-discharge interview, 81% (29) of all young women with planned discharges were living in a safe, less-restrictive residence. This included 72% (26) who were living with their families, 6% (2) who were living in group homes, and one adolescent girl (3%) who was living in a pre-independent living program. The remaining seven girls (19%) with planned discharges who were not living in safe, less restrictive residences at the one year interview included two girls living in institutional settings (long-term residential and hospital level-of-care) and five girls who were living on their own in apparently unsafe situations (i.e., on the run, with an abusive boyfriend, involved in prostitution, etc.).

Of note is that 67% (24) of the young women in the 2007-8 planned discharge cohort were age 18 or over at the time of the one year interview, and 33% (12) were under 18. The percentage of young women 18 and over living on their own in unsafe settings was 17% (4).

71% (17) of those over age 18 were living with their families at the time of the one year post-discharge interview, one (4%) was living in a group home, one (4%) in a pre-independent living program, and one (4%) in a Department of Mental Health (DMH) locked facility. Thus, although concerns are evident in the literature about increased homelessness and dependency on public assistance for youth who age out of foster care and/or congregate care (Freundlich & Avery, 2005; Hyde & Kammerer, 2008, Dworsky & Courtney, 2009), in this cohort, a relatively small percentage of young women over age 18 decided to live on their own in unsafe situations, and only one was in a more restrictive level-of-care institution.

In comparison to the living situations described above for the 36 adolescent girls with planned discharges, at one year post-discharge all seven residents (100%) who had unplanned discharges were still living in institutional settings. Three girls were hospitalized, three girls were in residential treatment centers, and one girl was in a correctional facility. This contrast with the living situation of adolescent girls with planned discharges further suggests that improvement during treatment is associated with a greater likelihood of living in a less restrictive residence for at least the first year after discharge.

Comparison of Social Functioning at Three Months and One Year after Discharge

As demonstrated below in Table IV, the percentage of girls with planned discharges who avoided arrests, hospitalizations and attended high school remained relatively stable between discharge and three months post-discharge, decreasing just 7% to 8% in each separate domain. Between three months and one year post-discharge, the percentage of girls with these positive outcomes decreased an additional 9%-20% in each separate domain. (Note: The percent decrease in the educational/job status of young women with their high school diplomas is larger, but not directly comparable since only six former residents had their high school diplomas at three

months post-discharge, and 13 had their diplomas or equivalent at one year post-discharge). Thus the percent decline in all domains was greater between three months and one year post-discharge than between discharge and three months post-discharge. Yet, within each of these domains except the educational/job status of high school graduates, 72%-83% of girls still had a positive outcome at one year post-discharge.

Table IV
Measures of Social Functioning for 36 Girls with Planned Discharges

| | 3 months post-discharge | | One year post-discharge | |
|--|-------------------------|---------|-------------------------|---------|
| | Number | Percent | Number | Percent |
| No hospitalizations | 33/36 | 92 | 26/36 | 72 |
| No arrests | 33/36 | 92 | 30/36 | 83 |
| Attending high school or GED class | 28/30 | 93 | 19/23 | 83 |
| Graduated from high school or equivalent, attending higher education or employed | 5/6 | 83 | 7/13 | 54 |

Discussion

Contrary to Leichtman & Leichtman’s statement that “although adolescents often improve in residential treatment, those gains are frequently lost when they return to the community” (Leichtman & Leichtman, 2001, p. 21), for the 36 adolescent girls described above who completed their treatment goals at Germaine Lawrence, the first year after discharge is associated with a statistically significant reduction in more restrictive level of care placements when compared with the year prior to admission. Thus, improving in treatment and achieving a planned discharge is associated with a better outcome after discharge; former residents with planned discharges are much more likely to be living in a less-restrictive placement at one year after discharge and to have experienced a reduction in hospitalizations or residential placements than their peers with unplanned discharges, who did not succeed in treatment. A majority of adolescent girls also avoided arrests and attended school in their communities.

Significantly, our research at Germaine Lawrence differs from previous studies of outcomes at residential treatment centers in at least two ways. First, unlike all other published residential treatment outcome studies, we prioritized making the follow up process of mutual benefit by engaging in conversation with girls and their parents/guardians and offering help when requested. Second, unlike the study by Hooper et al. (2000), which used a cross-sectional design that contacted each youth only once over a two year period, and Larzelere et al. (2001), which contacted youth and their parent/guardians at an average of ten months post-discharge (a range of six – 21 months) with a 65% response rate, our study includes data about 100% of youth in a particular cohort from the year prior to admission, to discharge, to three months post-discharge, to one year post-discharge.

Two limitations of our research must be mentioned. First, the quantitative part of our study concentrated mainly on four key behavioral areas up to one year after discharge, and did not analyze a full range of behaviors and measures of social function for each adolescent girl. We focused on whether youth were living in a less restrictive setting, if they had had hospitalizations and arrests, and if they were in school. We did this not because we were unable to collect more detailed reports, but because we feel these areas are the most important outcomes that can be successfully defined, collected and compared for nearly all former residents. These areas are also based on observable behaviors (i.e., going to school, not going to school; hospitalized, not hospitalized, etc.) which are less vulnerable to inaccurate reports, contrasting perspectives, or changing thoughts over time. We realize that such an approach yields a “big picture,” more simplified view of the post-discharge experience than would a quantitative analysis of a wider range of behaviors and measures of improved social function, or a qualitative analysis of each adolescent girl’s experience from multiple points of view. However, we feel

that this big picture allows us to see that the majority of adolescent girls do not suffer relapses for the first year after discharge, but continue to avoid more restrictive level of care placements and arrests, and to attend school in their communities.

Second, while we found a statistically significant decrease in restrictive level of care placements for the first year after discharge, and that a majority of girls with planned discharges avoid hospitalizations, arrests and attended school, we cannot say this success was a result of the treatment received at Germaine Lawrence. However, as pointed out by Leichtman et al. (2001) with reference to a study of short-term residential care at the Menninger Clinic, “Although falling short of the rigorous criteria of experimental science, patients in the study may be seen to function as their own control group if judged by the looser standards of ordinary clinical practice . . . With rare exceptions, children are neither referred for nor accepted into residential treatment unless they have had extensive trials in outpatient therapies, day treatment programs, group homes, or other residential facilities and hospitals”(p.232). In this regard, it is clear that prior to treatment at Germaine Lawrence, all youth admitted had failed to sustain benefits from earlier out-of-home placements.

Implications for Future Research and Social Policy

Overall, our data suggest that long-term residential treatment using a psycho-educational model can be a helpful intervention for troubled adolescent girls with a variety of presenting needs, especially with regard to reducing the need for more restrictive level of care placements after discharge. Furthermore, our study also demonstrated that comprehensive outcome data with regard to social functioning and level of care can be collected successfully for the first year after discharge, and both the data and the research process can be beneficial to the agency and its clientele. But to make full use of these findings, more attention is needed to integrate data

collected through post-discharge outcome research with treatment protocols and clinical care (Lyons & McCulloch, 2006). This includes analyzing and reflecting upon the experiences of youth and their families/guardians and when appropriate, making changes in treatment practices and policies.

For example, our research has identified a greater decline in social functioning between three and 12 months post-discharge than between discharge and three months post-discharge. More data must be gathered to determine whether this pattern is true for other cohorts discharged from Germaine Lawrence, and from other residential treatment programs. If so, we must then determine what factors may be responsible for this decline, and what can be done to improve the recovery process during the three to one year post-discharge time period. An area that deserves careful exploration in this regard is the role of aftercare services, including the growing field of in-home services provided by the residential treatment center after discharge. Our data also suggest that the educational/job status of young women who have graduated from high school is especially problematic. This is an area that requires more attention to improve the transition from high school to either further studies or employment.

In addition, given that adolescents are in a constant process of change and maturation, longitudinal studies conducted ten or more years after discharge may provide a more accurate view of the lasting effects of residential treatment. A recent study conducted sixteen years after youth discharged from Girls and Boys Town revealed that “the time spent in a treatment-oriented residential care program was associated with lower adult intimate partner violence (IPV) rates” (Huefner et al., 2007:187). Although difficult to complete, such studies are a necessary complement to research measuring outcomes for the crucial first year after discharge.

Our study further suggests that residential treatment is an effective part of the system of care which, if overlooked and underfunded, may put some adolescents at greater risk. A real-life experiment in Australia confirmed just this; when residential treatment centers were closed, many more youth ended up homeless and in juvenile justice detention facilities (Ainsworth & Hansen, 2005). While more research is needed to identify which youth, in which situations and at which points in time may benefit the most from long-term residential treatment, making sure this option exists and is utilized appropriately is an effective means to improve the lives of some of our most vulnerable young people--not just in the present, but into the future.

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