

Follow-Up Report

Jasper Mountain Aggregate Data

January 2014

Overview

This is the eighteenth report on follow-up data obtained from graduates and their families. Since January of 1998, we have kept in touch with our graduates and compiled information on these contacts. Over these years the numbers of interviews have continued to grow and the results have maintained a very positive reflection of how the children are doing years after graduation. The mental health system has moved to shorter stays and more violent and more disturbed males and females are referred to us, but with our aftercare services we continue to see significant gains in the children many years after treatment at Jasper Mountain.

We continue to formally obtain data on all children out of the intensive residential program from 6 to 60 months. This eighteenth report includes all data obtained to date. Although the overall positive themes are consistent in all eighteen reports, there are minor differences. Our efforts have been successful in contacting the majority of the children who left the program either in a planned or unplanned discharge (thus all children). However we are experiencing more difficulty contacting some children in recent years and we are taken additional steps to address this. It becomes more difficult to obtain contact information years after leaving Jasper Mountain. Each follow-up report reflects a higher numbers of children and because of this, the data has increasing value in providing an accurate picture. We now have 542 follow-up interviews and the data has been generally consistent since 1998.

It is important to remember that the children reflected in this data are the most challenging in our system of care. In fact, standardized tests have shown an increase in severity of mental health disturbance over the last eight years, with the highest level of measured disturbance the last three years. Our success with this population has been a

factor in our international reputation and the increased numbers of referrals coming to the program from across the United States.

Procedure

The follow-up procedure involves tracking information in five areas important to the treatment programs:

- Personal independence/daily living skills,
- Social skills/success in school
- Communication skills
- Problem behaviors
- Personal information coming from the former resident

Twenty-one total questions were asked under the above headings. Information in the first four areas was provided by adults who are the most familiar with the former resident. This was done to prevent overestimations of progress by the graduate. Information from the child's current parent figure has been deemed the best easily obtainable reflection of the child's progress. This report does not assume that the parent's reflection is always accurate. In fact, in some cases we have other information that the parent's reflections are probably inaccurate in the negative direction regarding a child. It must be stated that all children and families are contacted, including cases where parents or payers withdrew the child against advice and before the child could take full advantage of the program. Most parents have very positive views of our agency and cooperate with our interviews, but there are some who react negatively when contacted years later but regardless we still seek their input.

Even though we know some parents are overly negative in viewing their child (some parents have given their child negative marks in all 21 areas), it is also probable that some parents gave their child somewhat higher marks than the child may deserve. For example, we are interested in the child's progress over time, but we may have

contacted the parent on a very good day or possibly a very bad week and this may affect the data we obtain. Research on reports from parents has indicated bias in both negative and positive directions, but parental reports are valuable in efforts like our follow-up as one of the best overall reflections of how the child is functioning. It is assumed that overly positive and overly negative scores will balance out with a large sample. We also continue to ask former residents to answer several questions including memories of the program and their personal goals for the future.

A staff person from Jasper Mountain does the detective work to, first of all, find the former residents, and then to obtain the necessary cooperation to get the data. It is interesting that nearly all children have agreed to provide information, but not all adults have cooperated with the follow-up study. As has been the case in each of follow-up data collection efforts, some adults did not want the child to be interviewed because they wanted to "leave the past behind." However, the vast majority of parents have been very helpful in obtaining the follow-up information, and have allowed us to interview the former resident.

Data has been divided into four time periods to obtain a measurement at different time intervals. The procedure identifies the collection of data at six months, twelve months, thirty-six and sixty months. In addition, the data is divided up by children who are twelve and older or eleven and younger. The data has been divided by age to track differences in the data based on age as well as by length of time out of the program. An additional analysis has been conducted related to length of stay. As can be seen in the results, there were differences associated with length of time out of the program, age of the child during treatment, and length of stay in the program.

Results

Follow-up information has been obtained from 542 interviews of the former residents of the intensive residential program. The breakdown

of responses by time periods is as follows: six months - 144, twelve - 77, thirty-six - 136, and sixty - 85. The numbers reflect that the longer the child is out of the program the more difficult it is for us to find and interview the parent and child. There are sufficient numbers in all of the areas to obtain a view of the children in groups by time out of the program.

The substantial amount of information coming from the interviews has been broken into several aspects to provide results that can potentially reflect trends. Three steps have been taken to analyze the data. First the data has been divided by time frame (6, 12, 36, 60 months) and by age of the child (11 and under, 12 and over). Second, the aggregate data has been reviewed and broken into positive and negative replies. Third, any area that reflects it is true for greater than 60% of the graduates have been considered significant either in a positive direction (strength) or negative direction (weakness). A 'forced choice' format (Yes or No) was chosen over a Likert scale to avoid middle of the road responses.

Positive responses were those that indicated an increased or improved capacity to be successful in the area being measured. The trend from the first review of the data has continued reflecting that overall the strengths of the children, as measured by positive responses from parents, outnumber the weaknesses or negative responses by 11 to 1.

Other trends of previous data have been supported: significant positive responses overall tended to maintain or slightly increase one or more years out of the program, and negative responses remained at a low level and were much less pronounced than strengths. The two consistent areas of weakness reported at most time interval was that the child was not ready to live independently, and the parent was suspicious of covert behavior. Regarding independence, we don't expect the child to be ready to live independently, we ask the question to see if a move toward independence is reflected over time. There was improvement (92% down to 68%) in this area over time. The areas of strength have been consistent since the data has been

collected starting in 1998. The following information is a cumulative report of all responses to date. Data obtained during 2013 reflected very similar themes as in the past.

Six Months

At the six month timeframe, the following seventeen areas received positive responses: working on educational and work goals—98%, no involvement with the police or courts—92%, obtaining passing grades in school—92%, improved behavior—89%, having activities s/he does alone—88%, ability to communicate personal needs—82%, no illegal behavior—82%, demonstrating good personal hygiene—80%, showing more personal independence—76%, reading and writing at grade level—76%, not being a victim—75%, ability to appropriately meet personal needs—74%, ability to communicate with peers and adults—73%, making wise choices—68%, communicate long distance with others—67%, no violent or sexual behavior—65%, and make and maintain friendships—63%.

At six months parents identified two areas of personal weakness, the first is children were not ready to live independently—87%. Although we do not expect young children to be ready to live independently, we track whether the answer to this question improves over the time the child is out of the program (which it does). The second is having concerns about covert behavior—63%.

Twelve Months

At the one-year mark the trends toward strengths or positive responses continue with sixteen strengths. Positive responses were: working on educational and vocational goals—94%, getting passing grades in school—92%, enjoying solitary activities—89%, letting others know your personal needs—85%, showing improved behavior—83%, no police or court involvement—83%, communicating with adults and peers—79%, good hygiene—79%, no illegal behavior—76%, showing more independence—75%, appropriately meeting personal needs—74%, showing personal drive to succeed in

school--74%, making good choices--71%, reading and writing skills to meet goals--70%, communicate long distance with others--70%, and learning not to be a victim--69%.

At twelve months three areas were identified as weaknesses including being not ready to live independently--88%, the child being avoided by others--68%, and parents being suspicious of covert activity by the child--62%.

Thirty-Six Months

At thirty-six months positive skills continue to be maintained in fourteen areas, and the negative issues continue to be minimal (1). Positive responses were obtained for: activities working on educational and work skills--92%, activities s/he does alone--83%, showing more independence--77%, showing improved behavior--77%, reading and writing skills to meet goals--77%, good hygiene--84%, letting others know personal needs--82%, no police or court involvement--71%, communicating with adults and peers--79%, no illegal behavior--67%, not being a victim--62%, no violent or sexual behavior--62%, making and keeping friends--62%, and communicating with others at a distance--60%.

The one identified weakness three years after discharge was not being able to live independently 83%.

Sixty Months

There were fifteen areas of strength and two areas of weakness at five years. Areas of strength included: working on educational and work skills--92%, solitary activities--89%, communicating needs and wants--88%, improved behavior--87%, showing more independence--84%, good personal hygiene--85%, enjoying reading and writing sufficient to meet goals--80%, communication with adults and peers--79%, having no violent or sexual behavior--75%, staying in communication with others by mail and electronic means--69%, making and keeping friends and developing a support

system—68%, no police or court involvement—67%, having realistic goals for the future—65%, and showing good social skills—64%, and no illegal behavior—60%.

The two identified areas of weakness at five years are the ability to live independently now down to—68%, and suspicions of covert behavior—62%. Although not being ready to live independently was a weakness in all time periods, the percentage improved over time.

Differences Based on Age during Treatment

As was mentioned earlier, the data was collected by age. This was originally done to modify the questions to make them more appropriate for different-aged children. To do this we collected data for children eleven and under and twelve and older. Since the first report a pattern was noticed—there was a significant difference on the same question due to the age of the child, and in a direction that does not immediately seem logical. The pattern was observed that children who were under eleven actually did better on specific issues than children twelve and older. It would seem to make more sense that older children would show more skills or progress due to developmental improvement, but that is not what the parents in our interviews have reported over the years. In the majority of issue areas, younger children showed more strength than older children. For example, the following areas reflect better progress for children entering the program at a younger age: level of improved behavior, better hygiene, not being a victim, drive to meet goals, not being avoided by others, communication skills, no illegal behavior, realistic goals, and reading and writing at grade level.

Stated in another way, younger children outscored older children 73% of the time, and older children outscored younger children only 27% of the time. What might cause this result that would not necessarily be expected? Considering this question over the last decade has resulted in the theory we believe to be most likely. This age separation actually identifies in an aggregate way children who entered the program at young ages and those that entered the

program at the upper age range of the program's target population. For example, if two children came out of the program one year ago and one was under ten and the other above twelve, this would say that the years of treatment for one occurred at a younger age than the other. Looking at the results from this point-of-view, it makes more sense. It has been our observation over the years (and now supported by brain research) that the younger the child receives the treatment they need, the shorter the treatment duration, the more progress they make, and the better the future outcomes. In the same way if a child receives treatment at an older age the problem may be more habitual. Although our theory cannot be confirmed by this data since this was not causal research, it suggests that younger children progress further in residential treatment when compared to older children. This information has become more important in the intake process when considering children for the program.

Conclusions

The data to date points to trends that have been consistent over many years with a strong interview base of 542. The results suggest that children who discharged from the intensive treatment program are for the most part indicating significant gains in a vast majority of the twenty-one indicators measured. The pattern shows children are doing better at every follow-up than at graduation. It also reflects that problem areas as a group are very few and this pattern of 9 positive for every negative persists for the full five years. Additionally children who come into the program before age 10 reflect more improvement than children coming into the program 11 and older. Finally data is now reflecting that shorter lengths of stay in intensive treatment are correlated to more deterioration over time on the measures collected.

It is important to point out that this data has limited longitudinal information. Because this data is reported as an aggregate over eighteen years, this data does not compare specific individuals over time. To do this a report on longitudinal data is needed. The final disclaimer is that all information is self-report or observer report.

Research studies have previously shown the possibility of error in both types of data.

As with the previous follow-up reports, we now have eighteen years of data collection that indicates several trends.

1. Children are demonstrating skills and successes following treatment.

Considering the population that the agency accepts into residential treatment, this data overall is significantly weighted in the positive direction (by a factor of 11 to 1). Overall this data indicates that the children are functioning much better months and years after discharge than they did at admission to the program. At the same time, the children do not show deterioration in the years following treatment other than weaknesses that would be developmentally expected (not being ready to live independently). Rather than deterioration the children show significant improvement that continues up to the last interviews at five years following discharge.

2. Improvement appears to continue with period of time out of the program.

Due to the intensive setting of residential treatment where all environmental factors can be controlled, the question is often asked "will the positive improvement in the treatment setting carry over to a family setting." It is not unusual for children from some residential treatment programs to show deterioration in positive outcomes and an increase in negative symptoms the longer the timeframe out of the treatment setting. This data appears to indicate the opposite pattern, not only do treatment gains appear to carry over to less structured settings, but additional gains continue to be made. It must be pointed out that the advantage of working with young children is they tend to develop and mature with age. Therefore gains that a young child makes following treatment cannot be solely attributed to treatment, the gains may be due to maturation or other potential factors. However, severely abused and disturbed children often escalate problem behaviors in teen years rather than show improvement. It is quite possible that the trends of progressive of

therapeutic steps to address factors that would have otherwise continued a negative rather than positive spiral as the child grows older. One example of this would be positive brain change through altering internal perceptions and building resiliency and optimism.

3. Negative traits and behaviors maintain at a low rate for years following treatment.

With eighteen years of data and 542 interviews, the data indicates that children discharged out of the program for any reason continue to improve for several years and then, for the most part, maintain this improvement for as long as we track them. Jasper Mountain's formal follow-up of all graduates for five years after graduation is the longest follow-up period by any treatment center we are aware of in the Nation.

4. Follow-up data does not explain the causes of why a child is doing well or poorly.

Even if most graduates of Jasper Mountain are very successful following treatment, this lends evidence but does not prove that the program works, because factors other than this treatment program may be more influential in explaining this outcome. However, a significant pattern of positive growth is a more preferred finding than the opposite. For a treatment perspective, it is preferable to share credit for the successes than to share responsibility for the failures.

5. We continue to follow the emerging trend that children who receive treatment in the program at young ages do significantly better in follow-up data than do children who are in the treatment program at older ages.

This initially unexpected pattern has been monitored for eighteen years with consistent results. The program has made adjustments in intake decisions based on this information. This trend appears to indicate that treatment efforts and funding are best spent on younger populations for our program.

6. The length of stay in intensive treatment has an impact on improvement following treatment as well as the need for future placements.

Over the last decade system factors have intervened to shorten how long children receive intensive treatment with our agency. This has allowed us to track changes after treatment among children whose length of stay in intensive treatment was abbreviated due to financial or system considerations. All interviews prior to the system change in 2005 were compared to all interviews with child graduating after this system change who had significantly shorter lengths of stay in intensive treatment. The results reflect that of 41 measures 12 improved, 3 remained the same and 26 showed deterioration. Of the 12 that improved the average improvement was 1.8%. Of the 26 measures that deteriorated they averaged 4.5%. The only variable that changed in this data was length of stay, which resulted in deterioration in 63% of the measures and the deterioration was 2.5 times as strong as the measures indicating improvement. This suggests that length of stay in intensive treatment was correlated with deterioration in outcomes following treatment for this sample.