After ideology

The effectiveness of residential programs for 'at risk' adolescents

Frank Ainsworth

This article reviews recent research evidence about the effectiveness of residential care, education and treatment programs, singularly referred to as treatment programs, for 'at risk' adolescents. This evidence is drawn from child welfare, mental health services and education studies. The national and international evidence is that foster care is in crisis and is unable to provide stable and continuous placements for many of our most difficult youth. It is time to reconsider residential alternatives. The research suggests that these alternatives are not 'all bad' and that they have an important place in the continuum of child and family services.

NOTE

A small part of this article was published in an earlier edition of *Children Australia* (see Ainsworth, F. 1999, 'Social injustice for 'at risk' adolescents and their families', *Children Australia*, 24(1), pp14–18). For this article the material has been updated and more detail added.

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In an earlier article the author commented on the precarious state of residential care in Australia (Ainsworth, 1998). The decline in the use of residential placements as a form of out-of-home care has been well documented (Bath, 1994; 1997). This decline was from 2,416 placements in 1993 to 1,818 placements in 1996, or a reduction of 8%.

By June 1998 the figure had fallen even further with only 1,486 or 10% of the children in out-of-home care being placed in facility care (AIHW, 1999). Facility care includes care in a facility-based (residential) building whose purpose is to provide placements for children and where the staff are paid. Placements in 'family group homes' are counted as facility-based care. These children were older than those in other forms of out-of-home care, that is family foster care or kinship care (AIHW, 1998). In fact, in NSW 88% of the children in facility care were aged 10-17 years with 33% aged 15-17 years. These youth were also more likely to be male than female. In Tasmania, of those in facility care, 55% were male and in Queensland, 79% were male.

Yet, in the same time period the number of children and youth in out-of-home care in Australia rose from 12,273 in 1993 to 14,677 in 1996 and then declined to 14,421 in 1998. These figures represent a rate 2.7/1000 of children in the population for 1993 and 3.1/1000 for June 1998. For reasons that are not clear, Australia has fewer young people in out-of-home care than most other western type nations. Bath (1994; 1997) provides these details for a number of European countries. In doing so he shows, as does the 1997 figure, that the Australian trend is against international experience. For example, in the US it is estimated that residential programs provide something short of 25% of all out-of-home care placements (US Dept. of Health and Human Services, 1997). While in two of the three European countries cited by Bath (1997), the percentage of children placed in residential programs is significantly higher than the US estimate. In Denmark the figure is 39% and in Germany the figure is 58%. In Britain, where recent studies have reported that many young people who have experienced residential placement speak favorably of this experience, the use of this type of placement appears to be slightly on the increase (Sinclair & Gibbs, 1998).

Omitted from this picture of Australian out-of-home care programs for children and youth is information about children in boarding schools, juvenile justice programs and in health care facilities. It is very difficult to obtain reliable figures about the number of children in these settings. In Britain, in 1995 figures for child stays of four weeks or more were 100,000 in boarding schools and 30,000 in hospitals. This represents 1.3% of the total child population for that year (Utting, 1997). The majority of these children and youth were aged 10 to 17 years. A similar projection for Australia for the year 1996-1997 would produce a figure of 16,630 or 1.7% of the child population (AIWH, 1998).

There is also a known drift of children in the care of child welfare authorities into the juvenile justice system (Australian Law Reform Commission, 1997; Community Services Commission, 1996). In Britain, in 1995 there were 1,680 youth aged 14 to 17

years in juvenile justice institutions (Utting, 1997). Unfortunately, statistical data about all of these youth from school, hospital and justice settings is not routinely collected in Australia.

Overall, the international experience suggests that mature child welfare systems continue to require some residential programs for young people. Yet the decline in numbers of residential placements in Australia seems to suggest a unique belief, that is not supported by evidence, that out-of-home care can always be provided by non-residential, primarily foster care, settings. It is doubtful if in either Britain or the US the AIHW (1998) definition of facility based care that includes group homes, would be regarded as anything other than multiple foster care placements. Group homes and similar small units (Clarke, 1997) offer care, support and accommodation, but not residential treatment services.

Nonetheless, the decline in the use of residential placements continues regardless of the fact that foster care is in crisis, as the recent New South Wales report has demonstrated (Community Services Commission, 2000). The limited Australian foster care studies report a high incidence of placement breakdown and disruption (Delfabbro, Barber & Cooper, 2000; Fernandez, 1996; Wise, 1999). In fact, foster care currently fails to provide a continuous and stable placement for many very vulnerable adolescents. International reports provide the same evidence (Curtis, Dale & Kendall, 1999).

RE-ESTABLISHING THE VALUE OF RESIDENTIAL PROGRAMS

Even today, discussions about residential treatment are often overshadowed by reference to old sociological studies of mental hospitals from the 1950s and 1960s when Barton's (1959) 'Institutional Neurosis', Goffman's 'Asylums' (1961), and Vaizey's (1959) 'Scenes from institutional life' created powerful anti-institutional images. These images captured the hearts and shaped the minds of a generation of child welfare personnel who quickly absorbed these materials and generalised them to other residential programs. From then on all residential programs, irrespective of their differences, were increasingly viewed as negative. In the same era and into the 1970s, of equal importance were the writings of Bowlby (1951, 1978) and Winnicott (1965), and the remarkable Robertson's films from the Tavistock Institute in London in the 1960s that illustrated the importance of attachment theory. These writings in turn led to the realisation that long-term placement in poor quality residential programs could have devastating effects on young children. As shown by Bullock (1999), in Britain these events, plus the high cost of residential treatment that became an issue in the 1980s, led to the continued decline in the use of residential placements. Other influences from the 1950s and 1960s stemming from the concepts of normalisation, deinstitutionalisation, mainstreaming, least restrictive environment, minimal intervention and diversion, also had a marked impact on the way residential treatment was viewed (Ainsworth, 1999).

In Australia residential programs were tainted through their use as instruments of Aboriginal oppression and because of the way child migrants placed in these settings were abused (Ainsworth, 1998; Gill 1997; Human Rights and Equal Opportunity Commission, 1997). The negative history of government and non-government institutions for 'at risk' youth also contributed to this outcome (Ainsworth, 1997a; Community Services Commission, 1999; Forde, 1999). All these influences are visible in the influential Usher Report (1992) into substitute care services in New South Wales.

Surprisingly, given this chequered history and the negativity about the value of residential programs for older 'at risk' youth, programs of this type remain well established, even if controversial, in most countries, although not in Australia (Whittaker, 2000a; Whittaker, 2000b; Ainsworth, 1999). By comparison, in Australia by the early 1990s residential treatment had been dumped and foster care had became not only the option of choice for children and 'at risk' adolescents in need of out-of-home care, but the only option. Since then evidence shows that this response misses the mark for 'at risk' youth (Bath, 1998). This is hardly a surprise as 'at risk' youth are a population for whom foster care was not originally intended. These are youth, especially males, who display:

> ... depression, seriously disruptive, aggressive and violent anti-social behaviours and an inability to live peaceably with others, including their immediate family *and foster families* (italics added) (Ainsworth, 1999, p. 15).

Without interventions more powerful, intensive and durable than those provided by a series of foster care placements, these youth face long-term unemployment, homelessness, an inability to maintain adult relationships resulting in a life of social isolation, adult crime, poor mental health and poverty.

THE NEW EVIDENCE

New evidence from the 1990s now throws a different light on the vexed question of the effectiveness of residential treatment, as a modality for behaviour change, for 'at risk' youth. This evidence is drawn from American, British and European child welfare, mental health services and educational research studies. These studies are of four types that are cross-sectional or longitudinal in design (Sarantakos, 1998). The first are those that seek to analyse changes in resident functioning from the start to the end of treatment. Then there are studies that either examine the efficacy of different treatment regimes or compare the outcome of residential treatment with a no-treatment group. Finally, there are studies that compare residential services to alternative types of service.

FROM CHILD WELFARE

The most rigorous large-scale empirical outcome study in child welfare to date is of the Casey Family Program (family foster care and residential care) in the US (Fanshel, Finch & Grundy, 1990). In the context of the study the researchers hypothesized that a residential placement would be associated with positive therapeutic benefit for the child. Such a placement was used at least once in 21.1% of the cases of 'at risk' youth. The researchers reported that when used planfully,

positive benefits flow to the children from these placements ($r = .483, p. < .001$).

There is an equally impressive study of youth and family characteristics and treatment histories at Boysville, which is a large residential facility for delinquent adolescents (Whittaker, Tripodi & Grasso, 1990). Using the data relating to the youth's release status and by defining 'planned release' as a measure of outcome, it was possible to examine the relationship between a series of family and youth treatment process variables and intake characteristics. On average, those who stayed in the program longer had twice the family worker face-to-face contact, received significantly more family work by staff and had higher total family contact, achieved better outcomes. Success also related to a number of intake variables including age at admission, the number of prior adjudications and the living situation prior to entering Boysville.

Boysville have also completed a longitudinal study of adult imprisonment in Michigan of male youth released from their group homes and campus residential facility between 1985 and 1987 (Kapp, Schwartz & Epstein, 1994). The cohorts for 1985 were followed for five years and for 1987 for three years. These results show that of the 242 youth released in 1985, 75% or 184 were not subject to imprisonment in the five years to 1990. For the 1987 cohort of 317, an even larger percentage, 255 or 80%, avoided imprisonment in the three years to 1990. The risk factors identified as associated with increased odds of imprisonment were race (white vs. non-white), number of adjudications prior to placement (juvenile offender vs. non-offender) and venue at discharge (home setting vs. non-home).

Another US study draws on data collected between 1981 and 1985. It is a large-scale longitudinal quasi-experimental follow up study (n = 581). The aim of the study was to explore the validity of five prevalent beliefs about residential placements for troubled adolescents (Friman et al, 1996). These beliefs were identified as being about the failure to deliver helpful treatment, negative relationships with supervisory adults, increased isolation from family, isolation from friends and the loss of a sense of personal control. The study sample consisted of a treatment group (n = 497) of youth who were referred to what was a new generation of teaching-family model (TFM) residential programs and a non-residential comparison group (n = 84). Starting in 1981, on admission to a TFM program, these youth aged 10-17 (mean 14.4 years) completed a series of instruments that measured the five areas of interest. These instruments were then completed every three months culminating in 10 administrations by the spring of 1987. There was then six monthly follow up until 1989. The follow up rate for the final 14th administration conducted in 1989 was 84% for the treatment group and 70% for the comparison group (Friman et al, 1996).

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Hierarchical linear modelling was used for data analysis purposes to take account of the complex longitudinal evaluation design (Osgood & Smith, 1995). On the first and second measure the treatment group is reported as experiencing statistically significantly higher levels of helpful treatment and higher levels of satisfaction with the supervising adults than the comparison group ($t = 5.64, p < .001$ and $t = -2.84, p < .005$). Against the issue of isolation from family and friends, after an initial period, youth in the treatment group reported feeling significantly less isolated than those in the comparison group ($t = 2.16, p = .03$ and $t = 2.11, p = .04$). Finally, the treatment group and the comparison group both reported an increased sense of personal control over the course of the study This was not statistically significant ($t = 1.79, p = .07$), although there was a marginally greater increase in personal control in the treatment group than in the comparison group. The authors of this study claim that these results are not consistent with the beliefs that, once in a residential placement, life inexorably worsens for troubled adolescents. They suggest that negative beliefs about life in residential placements for adolescents do not apply to all programs.

In a further study, the effectiveness of the Boys Town Residential Treatment Center (BTRTC) was examined (Daly et al, 1998). The BTRTC offers medical, psychological and social treatments within a psycho-educational model (PEM) of care. The components of the model are pharmacological interventions based on DSM-IV diagnosis, as necessary, traditional individual, group and family therapy and academic and social skills training. Pivotal to PEM are direct care staff who have an ongoing role in teaching social skills, self control strategies and relationship building skills. This is the same TFM material as in the earlier study by Friman et al (1996).

Since beginning in 1995, BTRTC has served 52 youth in a 20-bed co-educational unit, who on average were 13 years of age. These youth have a history of physical and/or sexual abuse, police and court involvement, school failure, psychiatric and behavioural disorders, and numerous previous placements. For the cohort of youth examined in this study, the average stay was 151 days (range 11-330 days). The mean IQ was 88 (range 60-113). Only one third of the youth came from intact families.

Of the 52 youth, 70% (n = 36) came from more restricted settings than the BTRTC. The remaining 30% (n = 16) were from group homes, emergency shelters or parental home. At discharge one group went to settings that were either equal to or less restrictive than their placement prior to entry to the BTRTC (n = 29). Another group went to less restrictive placements (n = 22) (foster care = 3, group home = 8, parental home = 11).

In addition, the Children's Global Assessment Scale (CGAS) was administered to a sub-sample of youth in this study (n = 25) both at admission and discharge from BTRTC. For this

group the mean score on the CGAS was 37.8 on admission and 54.2 on discharge. This is a positive result although these scores are below 70, that is the cutting score for normal functioning.

Finally, from the US, there is a follow-up study of young men from a New York residential treatment program for 17-21 year olds (Karminsky, 1998). The aim of the program was preparation for independent living. It consisted of living skills workshops, educational and vocational programs, psychiatric evaluations and psychotherapy. The study consisted of young men (n = 30) who were in the program between 1986 and 1993. These were all young men with complex histories of impoverished education, learning difficulties, substance abuse, lack of social skills, psychological problems and negligible work histories.

Data was collect from the sample group using two instruments, the Personal Adjustment and Role Scale (PARS) and the Records Assessment Scale (RAS). PARS measures the community adjustment and functioning of adults who have received mental health services. The RAS instrument was used to collect data from case records about the functioning of former residents with respect to treatment goals.

As with other follow up studies, the inability to trace all of the former residents of the program and to select a representative sample of residents is a limitation of this study. Nevertheless, the author concludes that the results, at least for this sample, indicate that all but those from the most extreme dysfunctional backgrounds, and those with extreme antisocial behaviour, benefited from participation (83%) in this program. In terms of independent living nearly half were in their own apartments and another third were partially supported while working, in continuing vocational training, or in adult care programs because of psychiatric disability.

From Britain a recent series of publications has carefully delineated the role and functions of residential programs in that child welfare system (Department of Health, 1998). One of these publications reports a follow up study of seriously disturbed adolescents discharged from a secure program that offers integrated treatment, education and residential group living (Bullock, Little & Millham, 1998). The outcomes for these high-risk young people, which are not reported with the same degree of statistical sophistication as the US studies, were very poor for around 10%, another 10% were better than expected, with 80% being moderately successful or successful. Results in relation to physical and psychological health were reasonable, given the poor expectation at entry, but poor in regard to education and employment.

Derived from earlier work and associated with the Department of Health residential treatment research initiatives, one part of which resulted in 'Children's homes: A study in diversity' (Sinclair & Gibbs, 1998), is another study. In this study Gibbs and Sinclair (1999) reported on a further project on treatment outcomes in children's homes. This is a follow-up study of 141 young people in 48 homes spread across five local authorities. The study aimed to test the assumption that 'if children's homes do have an effect, this is likely to vary between homes and to reflect the approach taken by the head of home' (p. 2).

In order to do this they took a series of measures. The first of these measures related to the head's approach and was the product of guided interviews with the heads of homes. This measure used their responses to questions asked in this interview and rated on a four-point scale. This scale was then used to generate a treatment emphasis and a family emphasis score for each head. The treatment emphasis score reflected the strategies (1 = minimal, 4 = extensive) used to achieve change in five areas – behaviour, emotional problems, school performance, work and family relationships. The family emphasis score was computed in a similar manner using the fifth area identified above.

The second set of measures related to the young people and the sources of support and stress as experienced. These measures consisted of items about contact with family, ties to a caregiver, relationship with a key-worker, with a social worker, having a group of friends, reports of bullying and reports of attempts to take sexual advantage since admission to the home.

The third and final set of variables related to outcomes and consisted of three measures. The first measure concerned the young person's mood and consisted of nine items taken from an earlier study of adolescents. The next measure related to adjustment and was based on social worker ratings of the young person's self-esteem, appearance, behaviour, ability to communicate, ability to situationally adjust behaviour, emotional and behavioural problems and age appropriate self-care skills. Finally, the last outcome measure was concerned with family relationship. For this purpose a family involvement index was created based on social worker rating of two items, emotional ties with at least one caregiver and contact with family of origin.

As data on each of these outcome measures was available at the time of the first interview and at follow up, a change score was constructed by subtracting the first score from the final score. Regression analysis was then used in an attempt to relate changes in mood, adjustment and family relationships between the first and second data collection points to the approach taken by the head of home as measured by their treatment and family emphasis score.

The results reported indicate almost no change in average mood scores between the two data collection points. However, there was considerable change in individuals with some getting happier, others less so. The correlation between the two data points was low but statistically significant because of the confidence level ($r = .53$, $p = .001$). As with mood there was little difference between the average adjustment of the sample at first interview and the average at follow up. However, there was a fair amount of change among individuals, with some improving and others deteriorating. Again the correlation between the two data points was low but statistically significant ($r = .63$, $p = .001$). On average the scores on family relationships were almost exactly the same at data points one and two. Again, some individuals improved on this measure while others deteriorated. The correlation was

similar but again statistically significant ($r = .64$, $p = .001$). Finally, when the score for treatment emphasis was substituted for the score for family emphasis there was a strong association between this score and positive changes in family relationships ($p = .003$). The claim is that these results underline the key role of the head of home in relation to positive treatment outcomes from residential treatment.

There is also a longitudinal study from Holland the intent of which was to explore the factors governing the successful residential treatment of adolescents with serious behavioural difficulties (Scholte & Van der Ploeg, 2000). In addition to exploring factors in the residential environment that might influence the outcome of treatment such as climate of firm, but not harsh, control coupled with consistent, but non-obtrusive, emotional support, cognitive-behavioural training, intensive monitoring of treatment and home-orientedness of the program, they also collected self-report data from a random sample of these young people.

The random sample consisted of 230 adolescents (mean age 15.5, SD 1.7 years). One third of the sample was female and a quarter came from an ethnic minority background. Their social development was tracked over a 2-year period. Initially, their developmental status was established at admission using a staff completed questionnaire with known reliability and validity that tracks psychosocial risk factors (Scholte, 1998). Measures of behavioural and emotional development were also taken at admission and at 6 and 24 months using a shortened Dutch version of the Achenbach child behaviour checklist (CBCL). At the second administration, 134 young people or 67% of the original sample were tested. The other 96 had prematurely left the program to which they had been admitted. At 24 months, 9 or 7% of the 134 young people were still in the same residential program. The remainder of the sample (125) was treated on average for 15 months (SD 8 months). By the time of the final administration, the mean age of the sample had risen to 17.3 (SD 1.7) years. Other measures of education or workforce involvement were also taken.

On the CBCL items that report externalising problem behaviours, 60% of the young people displayed clinical level scores at admission. This number dropped to 40% during the first 6 months of residential treatment and remained constant for the following 18 months, establishing a significant positive behavioural trend ($X^2 = 11.99$, $df = 2$, $p < .01$). Likewise, on the CBCL items that report internalising or emotional problems, again 60% of the young people at admission scored at a clinical level. This number dropped slightly during the first 6 months of treatment and kept dropping for the next 18 months to 26%, establishing significant positive emotional development over time ($X^2 = 24.55$, $df = 2$, $p < .01$).

No matter how painful or ideologically unsound it may be, it is time for Australia to slowly move beyond institutional scandals and the current impasse about the use of residential programs for 'at risk' youth.

In concluding, the authors note that 42% of the young people admitted to residential treatment ended their stay within 2 years and achieved the treatment goals originally set. They also comment on the favourable level of behavioural and emotional development among these young people, which at discharge was approaching that of the general Dutch adolescent population of comparable age and socio-demographic background (Scholte & Van der Ploeg, 2000, p.149).

The only recent Australian study that examines the effectiveness of a residential program is by Halliday (Halliday & Darmody, 1999). This qualitative study is of 21 parents and 10 youths that had participated in the Boys' Town program across a five-year period. The research reports that the parents regarded the program as a vital part of the process by which they and their sons received help. This help enabled them to survive as a family and their sons to become competent adults.

FROM MENTAL HEALTH

A US review from the health sector examines 18 outcome studies of residential treatment for children and youth (Kutash & Rivers, 1996). From this review the authors conclude:

> ... that despite the wide variability among residential treatment programs and a lack of rigorously controlled studies, residential treatment services have been found to result in improved functioning for some children (Kutash & Rivers, 1996, p. 121).

In another review of 34 studies, Pfeiffer and Strzelecki (1990) found that the following factors were related to positive outcomes: a standardised treatment regime, after care services, and less severe child and family dysfunction. Length of stay and intelligence level were also found to be moderately predictive of positive outcomes. Further to this review, Parmelee, Cohen, Nemil, Best, Cassell and Dyson (1995) found that residing with a family member at admission and having family involvement during treatment were also factors predictive of a positive outcome.

In another small longitudinal study of an Ohio residential program for youth with mental health and delinquency-related problems, Shapiro, Welker and Pierce (1999) report the outcomes for 27 youth from this program. The youth were African American (24%), Caucasian (72%), and 4% from other ethnic groups. At admission the age range was 11-15 years ($M = 13.17$, $SD = 1.56$). The treatment period was approximately 12 months ($M = 12.05$, $SD = 5.28$ months).

These youth had an average of 4.74 previous out-of-home placements. For 44% this had included previous residential treatment, and 54% had had past psychiatric hospitalisation. Past involvement with the juvenile justice system was present for 60% of the youth with 54% having experience of juvenile detention. Commonly these youth had multiple DSM-IV diagnoses. Conduct disorder (92%) and attention deficit disorder (32%) were the most

frequent categorisations used. Of these youth 75% were in the custody of the state child protection department.

The battery of measures, which included self-report and staff report instruments, were administered at the beginning and end of treatment and at several time points in between. These focused on behavioural and emotional problems, delinquency related maladjustment, response to psychotherapy, and client satisfaction. Specifically, the outcome measures used were the Achenbach child behaviour checklist (CBCL), youth self report (YSR) and the teacher report form (TRF). Also used were the social maladjustment and Asocial index from the Jessness Inventory (JI), the target behaviour rating scale (TBRS) consisting of a symptomatic and behavioural component and a staff critical incidents report form (CI).

In addition, five process measures using Likert scales were constructed. One measured the youth general satisfaction with the facility while two others measured satisfaction with psychotherapy. These were also self-report progress measures with a separate instrument for individual treatment and group counselling. Finally, therapists completed two measures, one that assessed the quality of the youth's engagement with treatment, and another their treatment progress. All of the outcome measures were administered at baseline (4 –6 weeks from admission), 3 months, 6 months (TBRS only), 7.5 months and 12 months. Process measures were taken every six weeks.

On the measures of change over time for the CBCL behaviour problems there was a marginally significant trend towards decreased scores for the baseline/3 month comparison (t (25) = 1.72, $p < .10$). All the other t-tests for CBCL, YSR and TRF scores were uniformly non-significant. On the JI social maladjustment and Asocial index there was evidence of improved functioning. On social maladjustment this was significant at baseline/3 months (t (10) = 2.39, $p < .05$) and the first and final administration (t (16) = 2.05, $p < .05$). For the Asocial index there was significance at baseline/3 months (t (10) = 3.13, $p < .05$) and at the first and last time point the result was marginal (t (16) = 2.05, $p < .06$).

For the TBRS measure of symptomatic behaviour the results between baseline and final administration were marginal (t (25) = 1.85, $p < .08$). The results at all other points were also non-significant. On the second TBRS measure of developmental behaviours the results were more positive. These showed at baseline and 6 months as (t (25) = 2.76, $p < .05$), baseline and twelve months (t (15) = 2.14, $p < .05$), and baseline and final assessment as (t (25) = 3.12, $p < .01$). Finally, the CI and satisfaction data (life at the facility, psychotherapy and individual and group counselling) was analysed. On these measures of individual therapy compared to group therapy, a significant difference emerged. On first and final administration the differences were significant (t (21) = 5.04, $p < .0001$; t (24) = 4.61, $p < .0001$). The therapist-generated data also suggested improved functioning, for ability to engage in therapy (t (25) = 4.56, $p < .0001$), and treatment progress (t (25) = 5.22, $p < .0001$).

Overall, these results are not consistent. There is clear evidence of improvement on 5 of the 11 measures. The evidence on 3 measures is equivocal and on another 3 there is no improvement. The evidence on improvement is on the measure of delinquency related problems (JI), the youth self-report (YSR) ratings of developmental problems (TBRS) and the therapist's ratings of ability to engage in treatment and treatment progress. Given the history of serious psychiatric and delinquent behaviour including detention of the youth in this study, these results are positive. However, these results are not conclusive because of the limitations of the study, the small sample size, lack of a control or comparison group and the use of instruments for data collection that have not been subject to validation. Nevertheless, studies that attempt to measure any reduction in disruptive behaviours and conduct-related problems through participation in a residential treatment program are to be welcomed. Noticeably, in this instance, these treatment gains occurred within the first six months of placement. No measurable improvements took place after 7.5 months (Shapiro, Welker & Pierce, 1999, p. 47).

FROM EDUCATION

Boarding school education has always been highly regarded by some families as it is seen as providing opportunities and advantage that bring lifetime benefits (Kahan, 1994). In fact, in many western societies boarding schools provide services almost exclusively for children of the economic and political elite (Ainsworth, 1985). Recently, in Canada, Schub and Caneda (1997) have argued for residential education to be a choice for children and families from socially and economically disadvantaged backgrounds. In the US, in response to the issue of 'at risk' children and youth, a call for residential education to be an option for 'at risk' youth has also been heard (Beker & Magnuson, 1996). The Beker and Magnuson (1996) position is heavily supported by Israeli research evidence that underlines success in using residential schools as 'modifying environments' for this group of young people (Levy, 1996).

ALTERNATIVE SERVICES

In another review article that brings together the research on a range of services including residential treatment, family preservation, treatment foster care and individualised service programs, Bates, English and Kouidou-Giles (1997) make the following final comment:

> In sum, at present the empirical data do not provide a strong foundation to support statements regarding the differential effectiveness of residential group care and its alternative treatment approaches. Despite this lack of evidence, residential treatment is often characterised as 'bad' and rejected while non-residential alternatives are often considered to be 'good' or more desirable forms of treatment (Kahan, 1984; Whittaker, 1979). Unfortunately, in the debate over the differential value of residential and non-residential alternatives, statements are often made without supporting evidence, and inadequate attention is paid to the appropriateness of outcome measures (Kahan, 1984).
> (Bates, English & Kouidou-Giles, 1997, p. 51)

COMMENT

Clearly, the studies reported here offer a different perspective on residential treatment from those heard in most Australian debates where the overwhelming emphasis is on the negative features of residential programs. Elsewhere, especially in Britain and the US, a review of the role and value of residential programs for 'at risk' youth within a total continuum of child and family services is well under way. This is occurring through policy reviews and calls for research aimed at enhancing practice (Utting 1997; Wagner 1988; Whittaker, 2000a; Whittaker 2000b). Remarkably, this is happening even though controversy about the use of residential treatment still persists in both the US and Britain. In Britain, it is also occurring against a background of national publicity arising from a series of criminal cases involving the abuse of children in public and private residential programs that equals the worst Australian scandals (Levy & Kahan, 1991; Waterhouse, 2000; Community Services Commission, 1999).

THE CHALLENGE

As Whittaker (2000b) indicates, for two decades or more residential programs have:

> ... suffered from a lack of model development, innovations in treatment, the development of treatment and training protocols and controlled empirical studies.

Vividly illustrating these points are the two studies referenced earlier (Friman et al, 1996; Gibbs & Sinclair, 1999). The Gibbs and Sinclair study claims that improvements in family relationships and in individual adjustment is more likely in a children's home where the head can describe strategies for fostering family ties and ways of enabling change in key areas of a resident's life. Thus, strong leadership from a head is the key variable that explains positive treatment outcomes. By comparison Friman et al (1996) argue that not all residential programs are alike and that the outcome of residential experience – helpful or unhelpful, improvement or deterioration – may be dependent on the design of the residential program, staff adherence to a prescribed model of residential treatment and a high level of integrity of service delivery.

The fact is that we do not know which of these opposing explanations or whether any other explanation is correct, or how different explanations may interact. There are, as would be expected, questions about the methodology used in these studies. In their study Gibbs and Sinclair (1999) aggregate data from 48 different residential programs as do Scholte and Van der Ploeg (2000) from 15 programs. Yet, Friman et al (1996) in their conclusion suggest that all programs may not be the same. If this is correct, then the Gibbs and Sinclair (1999) and Scholte and Van der Ploeg (2000) studies that use aggregated data may be described as flawed. And again we do not know if this is correct. These studies highlight the importance of building knowledge about the essential component required for effective service delivery in the child welfare system.

CONCLUSION

No matter how painful or ideologically unsound it may be, it is time for Australia to slowly move beyond institutional scandals and the current impasse about the use of residential programs for 'at risk' youth. It is time to consider new evidence that suggests that these programs, when carefully planned and professionally managed, have a place in the continuum of child and family services. No one can afford to ignore this evidence.

A particular problem Australia faces is how to design a new generation of non-abusive residential programs that take account of recently developed knowledge, and how to staff them with skilled and highly trained personnel. To do this will mean looking to the future for program models, program policies and processes and for clarification about the expertise a new practitioner workforce will need (Ainsworth, 1991; Ainsworth, 1996).

It will be necessary to draw on the rich and extensive international literature on residential treatment (for a review of this literature, see Ainsworth, 1997). For the last decade or more, while residential programs have been weathering much negative comment, there has been no incentive for any individual or organisation to develop this area of expertise. How to overcome this deficit and ensure that Australian 'at risk' adolescents and their families have the full range of services available to assist them as they struggle for healthy development is not a simple task. □

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