

The impact of residential placement on child development: research and policy implications

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The accumulated knowledge on the development of children in residential settings covers a lot of ground but leaves a great deal unturned. The article summarises what is known about child development in the context of residential settings and concludes that there is little evidence to draw on to make clear recommendations about what types of children are likely to benefit from what types of residential settings. It maintains that, in the absence of evidence, policy and practice regarding residential care often has been guided by ideology. Residence has become a place of last resort for young people who cannot receive the support and/or safety they need from their own families or from foster families, or who pose a danger to others. The article calls for more rigorous evaluations of the impact of residence on child outcomes as well as concerted efforts to apply research evidence to policy and practice.

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Introduction

Between us, we three authors have over 50 years of experience of research on the development of children in residential settings. We know both a lot and a little. The accumulated knowledge in this area, as illustrated by other contributions to this special issue, covers a lot of ground but leaves a great deal unturned. Without more and better knowledge about residential care for children, we risk providing ineffective or even harmful residential services to some children and denying potentially helpful services to others.

This article does not attempt to rigorously review the existing knowledge base. This has been done elsewhere (Bullock, Little & Millham, 1993; Curry, 1991; Whittaker, 2004). Instead, we have these objectives: first, to summarise what is known about child development in the context of residential settings; second, to indicate areas where our knowledge is incomplete and why our knowledge is limited; third, to suggest how the knowledge base should be expanded if the provision of residential care is to have a substantive role in improving child development; fourth, to give a brief analysis of the public policy implications of the arguments made and to examine what must happen for the knowledge base to expand.

For the purposes of this article, we will use the following definitions of 'residential' and 'child

development'. Building on research in the UK (e.g. Brown, Bullock, Hobson & Little, 1998), we define 'residence' as any setting in which children are placed with other children for at least one night with the goal of meeting health, education or other developmental needs. The definition requires that children are placed without adult family members (they may be placed with a sibling)⁴ and that the number of children cared for is greater than the number of staff on duty at any one time (although an individual child may be supervised by more than one adult). The term 'children' refers to people between the ages of 0 and 18 years, irrespective of their needs and circumstances, who started their placement before the age of 17 years.⁵ This definition is deliberately broad in its construction.

Our primary interest is the extent to which residential provision promotes children's normative development, acknowledging that much intervention is focused on reducing impairments such as counteracting their deviant behaviour. By child development, we refer to normative patterns of health (physical and psychological)

⁴ Note, however, that in Europe and some North American contexts adult family members are increasingly able to stay in the child's residence.

⁵ This caveat permits the exclusion of young people aged 18 years and under who live in college and university residences.

and development (physical, behavioural, educational, social and emotional) as a child ages. Where there is impairment to health or development, meaning there is a significant deviation from the population mean, some professionals expect that residential services can reduce that impairment. Other residential settings seek to raise performance of normally functioning children above the norm, for example in residential schools. Our interest is in the extent to which services that comprise a residential component promote normative patterns of health or development in children.

We recognise that residence may have many other functions, such as providing a safety net, punishing children or minimising the harm children can do to themselves or others.⁶ The literature on these functions has been well reviewed elsewhere and is not covered by this article.

What do we know?

Although there is no aspect of residential care where knowledge is comprehensive and generally accepted, we know a considerable amount in certain areas. In this section, we review what we know about the types of children served in residential settings and the impact of those settings on their development.

How many children live in residential settings?

Neither the USA nor England (the two jurisdictions we know well) can provide reliable information on the number of children in residential care. Data are strongest for those sectors where the state pays directly for the intervention, for example child welfare and juvenile justice, and weakest where payment comes from private sources, namely insurance, the family or a charity. Below we provide estimates based on the best available data.

For all types of residential settings, Chipenda-Dansokho, Little and Thomas (2003) estimate that fewer than one in 120 children in the United States will sleep in a residential placement each night, a ratio that increases to about one in 85 in England. Out of this group, on any single night in the school year, around 200,000 US and 80,000 UK children (about 0.5 per cent of the school age children in the USA and 1 per cent

in the UK) are placed in various forms of boarding schools (Chipenda-Dansokho et al., 2003; Department of Health, 1998). It is also estimated that each night around 100,000 US children (about one-fifth of the state care population) and 10,000 UK children are in the variety of residential settings purchased or provided by child welfare agencies (Department of Health, 1998; US Department of Health and Human Services Administration for Children and Families Administration on Children Youth and Families Children's Bureau, 2001). In the USA, it seems reasonable to assume that between 20,000 and 40,000 children will be placed in various types of residences that cater to mental health problems, and that about 140,000 to 210,000 children will pass through these settings each year (Center for Mental Health Services, 2000; National Advisory Mental Health Council's Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001). These latter rates are much higher than for the UK (Department of Health, 1998). In the juvenile justice sector there are approximately 100,000 in the USA (Sickmund, Sladky & Kang, 2004) and 3,000 in the UK (Hagell, Hazel & Shaw, 2000). There are also children in hospitals for physical health needs, but national data are unable to provide a good estimate of their numbers.

Although patterns of child development are reasonably similar across developed nations, the use of residence by different countries differs considerably. As the above figures show, in England, there is a greater proportion of children in boarding schools and a much lower ratio of children in child welfare settings than in the USA. Additionally, it has become extremely rare for English children with mental health problems to be placed in a residential context (Rushton & Minnis, 2002).

What types of children live in residential settings?

Residential settings in the USA tend to be segregated by income. Children from families with financial means can be found in elite boarding schools or, if they have emotional or behavioural problems, in mental health facilities supported by private insurance. In contrast, children in low-income families with similar problems are more likely to be found in residential treatment centres and correctional facilities, which are supported with public funds. Also, a small number of boarding schools, supported by private funds, serve normally functioning low-income children (Kashti, 1988; Rosen, 1999).

The most frequent problems reported for young people entering US child welfare settings are child physical abuse and neglect (Brady & Caraway, 2002; Hussey & Guo, 2002), but patterns vary according to the referral source and treatment setting (see e.g. Department of Health, 1998). In the USA and UK, there is a reasonable amount of evidence on the prevalence of

⁶ A shift from a dependence on institutional care for poor and mentally or physically disabled children in North America and Europe occurred in the 20th century. Prior to that time large numbers of children were placed in orphanages, industrial or training schools, hospitals for the mentally or physically disabled, or boarding schools. Beginning in the 1960s, there was a general push towards 'deinstitutionalisation' and community-based care in foster families or other smaller groups. The purpose of residential care also shifted over time, from custodial to protection and care to treatment (Anglin, 2002).

mental disorders and other mental health problems, including anti-social behaviour, among children entering child welfare, juvenile justice and residential treatment settings (Center for Mental Health Services, 2000). Children in several of these studies also reported multiple traumatic events and placement transitions prior to placement. In comparison, there is little evidence on the circumstances of children entering boarding schools.

It should be noted that, because patterns of referral tend to reflect socio-economic status and because residential settings are continually adapting to changing public policies and market conditions, each type of residential placement tends to deal with a broad range of presenting problems.

Impact of the residential experience

In this section, we first review what we know about children's developmental progress while in residential care. We then look at the evidence concerning the long-term impact of such placements and what factors appear to predict positive outcomes. Lastly, we summarise knowledge about the impact of three key aspects of the residential experience on children: separation from family, contact with family during placement and living in a group setting.

Improvement during placement

There have been numerous studies of children's progress during and soon after placement. One of the most commonly reported areas of improvement is the reduction of clinical symptoms. Symptom improvements have been noted in areas such as self-concept, locus of control, behaviour problems and diagnosable psychiatric disorders (Curry, 1991; Larzelere et al., 2004; Weinstein, 1974). Meta-analytic studies have also reported decreases in arrest rates for delinquent youth from before intake and after discharge from residential programmes using the Teaching Family Model (Lipsey, 1999; Lipsey & Wilson, 1998). Lastly, some investigators have reported significant gains in academic achievement (Conrad, 1988; Weinstein, 1974).

The evidence, however, is mixed, with some studies pointing in the opposite direction (Lyons, Terry, Martinovich, Petersen & Bouska, 2001; Vorria, Rutter, Pickles, Wolkind & Hobsbaum, 1998). Additionally, many of the studies that have produced evidence of improvement were single sample pre-test-post-test designs, so it was not clear if young people would have made similar gains without residential placement.

Long-term benefits

Few studies have addressed the issue of the long-term benefits of residential care. Chamberlain and Moore

(1998) conducted a study in which 79 serious chronic juvenile offenders were randomly assigned to treatment foster care or group care placement and found those in treatment foster care fared better in terms of number of arrests and time in lock-up settings. A quasi-experimental longitudinal study of primarily delinquent youth served by a large programme using the Teaching Family Model reported higher rates of high school graduation and more positive attitudes toward school in adulthood than a comparison group of youth who were served in primarily community and family-based care (Thompson, Huefner, Ringle & Daly, 2005; Thompson et al., 1996). There were, however, no significant treatment effects for other long-term outcomes such as subsequent out-of-home placement, criminal activity, employment, or quality of life measures (Oswalt, Daly & Richter, 1992). Similarly, studies that have followed up children who qualified for admission but went elsewhere have found some indications of positive outcomes for the children who did not receive residential services (Bullock, Little & Millham, 1998; Thompson et al., 2005). Erker and Amanat (1993) reported a ten-year follow-up study of youth who were enrolled in either a residential or day-treatment programme for emotionally disturbed children. Youth received a wide range of psychotherapeutic interventions. Two-thirds of the children reported improvements in personal and social adjustment at follow-up, but there were no significant differences between outcomes of residential and day treatment programmes. In conclusion, some children will continue to be placed in residence because there is no other practical alternative – such as when there are no available foster placements or when needs are rare and economies of scale mean concentrating provision on a single residential site. Despite this, there is no conclusive evidence that it has lasting benefits. Fonagy captures the situation well when he says,

There is no empirical evidence either for or against the use of residential and day treatment facilities. However, there is clinical consensus that the severity and complexity of some disorders . . . may require access to inpatient and day patient treatment units. (2002: 389)

Predictors of success

Some evidence from research on residential care suggests factors that predict positive outcomes. For example, studies have found that high IQ, low severity of presenting problems and high family stability at intake are each associated with better outcomes for children in residential settings (Blotcky, Dimperio & Gossett, 1984; Hussey & Guo, 2002; Vorria et al., 1998). The results on IQ, however, are not consistent across

studies. One report (Prentice-Dunn, Wilson & Lyman, 1981) indicated a positive correlation between high IQ and academic gains, but a negative correlation between high IQ and behavioural improvement. The authors suggest that this may have been because the programme employed only externally imposed contingency management, which may have not been as successful with young people with higher IQs. The studies cited used improvement on ratings of child behaviour, scholastic achievement and peer relationships as outcome measures.

Few studies have reported relationships between treatment components and outcomes. Variables related to positive outcomes that have been reported include longer length of stay (Blotcky et al., 1984; Daly, Thompson & Coughlin, 1994), higher parental involvement (Prentice-Dunn, Wilson & Lyman, 1981), and involvement in aftercare (Blotcky et al., 1984; Prentice-Dunn, Wilson & Lyman, 1981). However, the research designs for these studies limit our ability to clearly ascertain whether the outcomes are attributable to the treatment given or to the selection of children who may be more prone to success.

Key aspects of the residential experience

Separation

A significant amount of research on the impact of separation on child development has been conducted (Rutter, 1981). While there are data pointing in different directions and sometimes fierce ideological debate about current knowledge, it is generally accepted that, although the residential experience can be very stressful for children, separation is seldom a critical factor in explaining impairment to development. Moreover, where effects are recorded, they frequently reduce over time. There is some indication that separations earlier in children's lives have greater impact than later placements. Such evidence may have influenced reductions in the use of residential settings for children below the age of nine. However, the ability of some very young children to recover from even the most severe forms of maternal deprivation should also be noted (Beckett et al., 2003; Rutter & ERA Study Team, 1998).

Parental contact

Evidence on the impact of parental contact during separation is mixed. Children frequently report that contact with families is beneficial (Smith, McKay & Chakrabarti, 2004), and such findings have resulted in recommendations for an individualised approach to planning and managing family contact (Bar-Nir & Schmid, 1998). However, frequency of contact with families alone does not appear to improve child

development (Vorría et al., 1998). Evidence from England suggests that contact with relatives in the context of the full range of out-of-home services reduces the length of separation and improves the endurance of re-unification, although not necessarily the child's well-being (Bullock et al., 1998; Bullock, Little & Taylor, 2004).

Living in a group

Existing research also provides an understanding of how the people with whom a child lives while in residential care affect some dimensions of his/her well-being. This evidence has had considerable effects on the style of the residential experience. The research that has addressed this issue has primarily employed surveys and interviews with children placed in residential settings and staff who work in them.

Surveys of youth during and after placement in residential care suggest that relationships between youth and staff are among the most helpful and positive aspects of their residential experience (Anglin, 2004; Devine, 2004; Smith, McKay & Chakrabarti, 2004). During the last century, a general move towards family-style living has occurred. Evidence on the benefits of this approach, however, is mixed. For example, Anglin (2004) found that young people with intact families living in group homes disliked attempts by the residence to imitate a family, and benefited from having a diverse care staff and a wider variety of adults with whom to relate. On the other hand, Devine (2004) found that young people reported a critical sense of belonging in family-style homes that they had never experienced in their own homes.

Relationships with peers in residence also produce opportunities and challenges for children in residence. Devine (2004) found that positive peer relationships were an important protective factor for youth placed in residential care, although several studies (Sinclair & Gibbs, 1998; Silverstein, Thompson, Little & Kohm, 2004; Smith, McKay & Chakrabarti, 2004) have reported on the incidence of bullying and sexual abuse between residents that act as risk factors for several aspects of child development. Vorría and associates (1998) found 'a lack of confiding peer relationships' for young people in residential settings as compared with those raised in two-parent families. Several studies of the influence of exposure to deviant peer culture (e.g. Dishon, McCord & Poulan, 1999) have shown how grouping troubled young people together can make their problems worse. Specifically, this research suggests that antisocial boys tend to reinforce one another's aggressive behaviour when they are together in group settings. However, Handwerk, Field and Friman (2000) have reported that family-style residential care and education can actually mediate these potential

iatrogenic effects of living in a group. Critical treatment components cited by the authors were behavioural treatment, community-like settings, positive relationships with adult providers, positive attention, praise and careful monitoring/supervision of young people in treatment settings. Similarly, in the UK, Sinclair and Gibbs (1998) have shown that potentially damaging effects can be mitigated, even for high-risk populations, provided care homes are small, staff agree on aims and methods and managers feel in control of admissions. These findings reflect those of Brown and associates (1998) that emphasise the beneficial effects for children placed in homes where there is congruence between structure and culture.

Challenges in group-living have led to much investment in structuring routines and schedules. Surveys of young people during and after placement in residential care have suggested a beneficial effect of the highly structured routines and schedules (Devine, 2004; Smith, McKay and Chakrabarti, 2004). Two of the most highly structured models of residential care in the USA that have been carefully described and evaluated are Project Re-Ed (Hooper, Murphy, Devaney & Hultman, 2000; Weinstein, 1974) and the Teaching Family Model (Phillips, Phillips, Fixsen & Wolf, 1973). Both models focus on positive relationships between caregivers and young people, along with highly structured teaching in both academic and home settings. In the original Project Re-Ed approach, a two-teacher/counsellor team was assigned to eight boys for 24 hours a day. It is an ecological approach using structured teaching to improve both adjustment and achievement. The approach also includes visits and treatment with family members, in the community, so that the re-integration of children into the home is eased. The Teaching Family Model, also highly structured, is a behavioural treatment programme carried out by a married couple with six to ten young people in a home. The youngsters are taught social skills using a point system, and academic achievement is emphasised. These models or components of them have been replicated in many residential settings in the USA, and the Teaching Family Model has also more recently been studied in Western Europe.

In the absence of support for solid evaluation, research on living in a group has tended to focus on the experience of children and staff and has lent itself to common sense observations for healthier environments. For example, Anglin (2002), who completed an extensive survey of youth and staff in British Columbia, outlined seven positive characteristics of living in staffed group homes, including: it is not a family setting so there is no confusion about the identity of the youth's family; the physical setting is not owned by anyone living there so caretakers do not take destruction of property personally; there is a diversity of staff with

whom to relate; staff get time off work to rejuvenate; the sole purpose of the home is to focus on the youths' needs; there is an intensity of care that is not available in other settings; and there is supervision to support and challenge direct care staff.

Conclusions about what we do know

As noted, we did not set out to produce a comprehensive review of the literature. There are many more studies in each of the six areas we have highlighted. There are whole strands of literature, for example the sociological studies of asylums (e.g. Goffman, 1959), social policy studies of the workings of private boarding school systems (e.g. Lambert, Millham & Bullock, 1975) and criminological investigations into adaptation in penal contexts (e.g. Hood, 1965; Little, 1990) that we have not considered here.

We hope, however, we have illustrated those aspects of the literature that are relevant to the impact of residence on child development. The research evidence might be summarised in the following way: a tiny minority of children will experience life in a residential context. Evidence on children entering residence suggests heterogeneous risks – for example when maltreatment leads to behavioural or mental health problems – that often do not reflect the administrative function of placements, which often focus specifically on recovery from effects of maltreatment, mental health or treatment for behavioural problems. There is some evidence of short-term improvement in development for some children, and in some cases these improvements sustain in the long-term. Since the development of significant proportions of children does not improve, it seems reasonable to hypothesise that for some it further deteriorates. The separation is generally stressful, but effects will generally reverse. Living in a group may enhance development (for example, when damaging family relationships are replaced by consistent adult figures) as well as increase risks (for example, of bullying or other misconduct by peers.) What little is known about outcomes comes from studies of children with significant impairments, and hardly anything is known about children entering boarding schools.

What we do not know

By any estimation, although there has been much research, the current evidence base is less than satisfactory for understanding the impact of residence on child development. A number of gaps exist. First, we need longitudinal studies of children whose development was in the normal range at the point of separation, such as those going to boarding school. Unfortunately, what we know about children's developmental trajectories while in care is based on studies that are primarily from

previous generations reflecting residential practice 10 or 20 years ago, focused on children whose development was impaired at separation, and concerned with narrow aspects of well-being. In addition, they do not meet the standards of modern epidemiology.

Second, there are hardly any data about which developmental impairments residential placements might be expected to have an impact on. There are some studies, already cited, charting the impact of treatment facilities on mental health symptoms and the impact of models that imitate aspects of family life on children's behaviour. Although there are no studies that adequately estimate the impact of interventions that have a residential component on attachment, antisocial behaviour measured from a developmental perspective, physical growth or educational progress, many residential programmes seek or claim to be successful in one or several of these areas.

Third, despite Rutter's (1972) observation 30 years ago that more needs to be known about the reciprocal nature of family life, very little is known about the impact of separation on the functioning of the separated adult and its impact on the separated child. Indeed, the quality of data on the impact of parental contact during residential placement on either child or adult remains poor. Most available studies tackle this issue from an ideological perspective or take the pragmatic view that it is going to happen so it may as well be managed well. Unfortunately, the conceptualisation and measurement of parental involvement (including contact, engagement and responsibility) remains extremely uneven, so where data exist, it is difficult to compare results from one context to another.

Fourth, understanding of which children might be expected to benefit from what residential programme and for how long is extremely poor. Most jurisdictions lack what might be termed simple service epidemiological data charting the circumstances of children served by different parts of children's services. However, in some European jurisdictions, England for example, extensive use has been made of practice development methods designed for this purpose (Dartington Social Research Unit, 2001). Where information on the success of residential interventions exists, it usually indicates that some children do well, meaning others do not improve (and, as we have hypothesised, that some may actually be worse off as a result of the experience). Matching placements with the needs of children might do much to increase the number of children who benefit from residential care.

Fifth, there are few studies on how common risks to child development manifest in residential contexts. Bullying, for example, is a feature of life for about 30 per cent of children in the USA and in the UK. But, what are the prevalence rates in residential contexts? In addition, 58 per cent of US children and 30 per cent

of English children will smoke at some point in their upbringing (Centers for Disease Control, 2003; Nansel et al., 2001). One might reasonably expect residence to reduce this major risk to health, but there are no data on the issue. In the same vein, there is little information on how variation of treatment within single residential contexts affects aspects of development such as attachment, behaviour, physical and psychological health and intelligence of children. Even where standard programmes are introduced such as the previously cited Teaching-Family model, there is considerable variation in age, knowledge, understanding and tactics used by adults directly responsible for children in residential contexts.

The reason the data cited above are lacking can be attributed to there being few rigorous evaluations of the impact of residence on child outcomes (Curtis, Alexander & Lunghofer, 2001; Kutash & Rivera, 1995; US General Accounting Office, 1994; Whittaker & Pfeiffer, 1994). In the preceding discussion we have cited the important natural experiments (e.g. Voirra et al., 1998), quasi-experimental trials (e.g. Thompson et al., 1996, 2005) and longitudinal work (e.g. Rutter & ERA Study Team, 1998). These studies can be counted on the fingers of two hands. If the criteria are tightened to include only random allocation studies, only one hand is needed. In the rare examples from the 1960s and 1970s, the principal investigators all report continued frustration in trying to maintain a rigorous study. This disillusionment has been cited as a factor explaining the subsequent fall in the number of such trials commissioned by the UK government (Farrington, 2003). Where experimental studies have been mounted, they have been hampered by problems of sample size, selection effects, treatment contamination and heterogeneity of the referred population (Bottoms & McClintock, 1973; Clarke & Cornish, 1972). The welcome increase in attention to ethics has further complicated the situation (Thoburn, 2000).

Despite these problems, the rarity of experimental studies with regard to residential services for children is ironic in the sense that many of the problems that handicap high-quality evaluation in the social sphere are less pervasive in the residential context. For example, it is common to have many more referrals than the placement can accept. The excess of referrals allows the researcher to randomly allocate subjects to treatment and control conditions without reducing the overall number of people served and thus violating research ethics. There are few more intrusive interventions in the lives of children than residential placements. Their potential positive or negative impact alone justifies the cost of rigorous evaluation.

In addition to experimental designs, Curry (1991) called for the use of good measures of childhood behaviour problems, evaluation of the effects of specific

types of treatment, and measurement of multiple levels of outcomes at specific post-discharge periods. Studies completed since Curry's article have addressed some, but not all of these issues. It remains difficult to draw general conclusions about the response to intervention. There is little evidence of sustained improvement post placement, and there is no clear indication that good outcomes can be attributed to residence. Future studies should measure carefully the characteristics of the children and families served, the types and quality of service provision, and the adult outcomes across relevant domains. Comparisons should be made with normative development as well as outcomes for similar young people served with different interventions. This will require well-described interventions and measurement of model fidelity or implementation and analysis of the relationships between treatment components and outcomes.

Perhaps most important, the absence of good logic models or theories of change have meant that, even where there is some indication that some aspects of the development of some children benefit from periods of residence, we have little idea *why* these improvements are occurring. Thus it is difficult to successfully replicate and improve promising models.

Conclusions, public policy implications and an alternative agenda

There is a mutually reinforcing relationship between policy and research. Policies that do not lead to the type and amount of research needed to adequately understand residential care result in research not able to adequately guide policy. Thus, rather than serving children most likely to benefit from residential services, residence has become a place of last resort for young people who cannot receive the support and/or safety they need from their own families or from foster families, or who pose a danger to others (Whittaker, 2004). The notable exception is elite boarding schools, which Kashti (1988) has argued have served as hothouses for wider social change. Possibly as a consequence, a negative subjectivity has surrounded residential sectors. In the absence of strong evidence on success, scandal – such as abuse by carers, dismal images from fiction, for example Dickens – and the worst excesses of ideology – such as the use of boarding schools to eradicate native cultures in the USA and Canada (Anglin, 2002; Davis, 2001; Whittaker, 2004) – have also coloured the perceptions of policy makers and the general public.

Where options for positive change have been forwarded, they have tended to be ideological in nature and to focus on using residential placements to address the negative consequence of other policies. For example, Goldsmith and Hahn (1996) have proposed that residential care provides a safe haven for children growing

up in dangerous neighbourhoods. Anglin (2002), citing the 1988 Wagner Report in the United Kingdom (National Institute for Social Work, 1988), lists additional potential benefits of residential care, including respite for families caring for disabled children, keeping siblings together (who might otherwise be split among foster homes), and care and control for children deemed dangerous to themselves or others.

Lastly, what research that exists is not being used to improve outcomes for children. For example, Lipsey (1999) concluded from his extensive meta-analysis of interventions for juvenile offenders that residential and other programmes that had the greatest impact were those that: (1) were well established (had been in place for two or more years); (2) were staffed by treatment-oriented as opposed to correctional personnel; (3) used interventions (e.g., behaviour modification) that had demonstrated effects; (4) had a course of treatment for six months or longer; and (5) assessed the fidelity of the implementation of the programme. However, Whittaker and Pfeiffer (1994) note the grim reality that decision-makers have a tendency to rely on techniques learned in graduate school, to be reluctant to or lack the time to read research literature, and to fail to see the programmatic and clinical significance in many research articles.

Without significant changes, the future of residential provision for children looks bleak. Certain sectors, such as the elite boarding schools, will, of course, remain, although it seems reasonable to assume they will continue to decline in terms of numbers of children served. Without evidence about 'value added' by residential care, incentives to send children away from home may be reduced. Likewise, there will continue to be a need for 'last resort' provision for children whose needs are compounded by poverty. However, because of concerns about the costs of residential services and potential dangers to children in care, pressures to reduce residential placements might continue to prevail over calls for expansion.

Is there an alternative scenario? We do not know which children benefit, or which combinations of provision are the most effective for whom, or why interventions work when they do. But we have evidence that there are positive outcomes for some children in some domains, and we should build upon this knowledge.

A change in direction would not just be a matter of funding more experimental studies. We believe that services for children should be designed to meet needs and be equally available to all children, regardless of socio-economic status. If there is evidence that residential care works, then demand for such services will respond. The prospect of such a situation is closer in some European jurisdictions, like England and The Netherlands, where the creation of state-sponsored services aimed at all children in need and organised to

reduce impairment and improve outcomes are part of legal statute, if not yet practice. Nearly all parents (and children who can fully assess their own situation) will select services with residential dimensions when there is solid evidence that the intervention is likely to improve the health of their child. For example, most families will choose acute hospital care when their child has leukaemia. Evidence on the contribution of residence to psychological, behavioural, family life and educational outcomes is critical to proper appraisal for those assessing appropriate responses to children's needs.

In addition to the need for experimental studies about what works, for whom, when and why, a change in direction would require other investments in research. It is surely unsatisfactory that Michael Rutter's *Maternal Deprivation Re-Assessed*, originally published in 1972, remains the primary source on the effects of separation. More fundamental research is needed. At least three examples with considerable practice as well as scientific implications make the point. First, little is known about individual change before, during and after the residential experience. Nearly all assessments of the worth of residence are post placement. Second, little is known about the physiological stresses produced by trauma of separation, the way these may impact children's behaviour and the way practitioners interpret behavioural signals without understanding their underlying cause. Third, apart from some crude rules of thumb that result in very few children aged nine years or less being placed in residential placements in England, hardly anything is known on the fit between provision and developmental stage and performance of children. A placement suitable for a nine-year-old may be quite unsuitable for a 15-year-old, and vice-versa.

In addition, better examination of the epidemiology of service use could lead to a more rational allocation of children to services. As has been seen, data on usage are appallingly poor. It is bad enough that little is known about how much provision is available in each sector, but it is even more handicapping not to know how many children experience a residential sojourn, why the placement became necessary, how long it lasts (and whether it recurs) and why it comes to an end. Too much of the data on the size and nature of the sector can be described as 'speculation'.

Lastly, there are obligations on researchers. We too have to change. More multidisciplinary work is required, with a readiness to move beyond our obvious collaborators. This article speaks to the sociological, historical, psychological, educational and social policy dimensions of residential services for children, yet there is nowhere in the world where multidisciplinary teams covering these domains work with any certainty. Moreover, there are few settings with any track record in connecting science and policy for the sector.

As has been said, a preparedness to adopt the most rigorous methodologies appropriate for the task of understanding the impact of residence on child development is critical. The old-fashioned approach of starting with a question, developing a hypothesis and finding a method to test the hypothesis has much to commend it in a world where partisan policy makers look for researchers with methods that might support their cause. Policy makers need to suspend their ideas about the merits or dangers of residential care, and researchers should resist participation in projects that have the sole mission of providing ammunition for those who are for or against residence. Too many researchers, ourselves included, have been drawn into contexts where our evidence is being used as ammunition for those who are 'for' or 'against' residence.

Generally speaking, the call of this article is for less ideology and more science, alongside building expertise to apply research to policy and practice. The alternative, of basing decisions on ideological position, is not sustainable in the long-term and will eventually fall foul of ethical scrutiny that demands that we 'first do no harm' and second, that we seek equality of provision so that residential services that are proven to meet identified needs are offered to all who can benefit.

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