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Special Issue Reprint

Residential Care of Children and Young People

Edited by
Graham Connelly, Sarah Deeley and Dan Johnson

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Guest Editors

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Guest Editors

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About the Editors

Graham Connelly

Graham Connelly is a psychologist and honorary senior research fellow in the Department of Social Work and Social Policy and the Centre for Excellence for Children's Care and Protection (CELCIS) at the University of Strathclyde. His teaching, research, and knowledge exchange activities have mainly been concerned with the education and wellbeing of care-experienced young people, and practices of alternative care internationally. In retirement, he has developed interests in the history of child and youth care. He is Editor-in-Chief of the *Scottish Journal of Residential Child Care* and an editorial board member of *Youth*. In addition to this, Connelly served as a board member of the children's charities, Who Cares? Scotland and Kibble and was awarded the Strathclyde Medal by his institution for outstanding contributions to the university and demonstrating its values.

Sarah Deeley

Sarah Deeley is the residential childcare lead at the Centre for Excellence for Children's Care and Protection (CELCIS) at the University of Strathclyde. A quality improvement leader, she supports and facilitates the improvement of care experiences for children and young people, focusing on residential childcare practices and policies. Deeley is also editor of the *Scottish Journal of Residential Child Care*. Her work reflects a deep commitment to enhancing the quality of care and support for both children and the workforce in residential settings.

Dan Johnson

Dan Johnson is Executive Director and forensic psychologist at Kibble, where he leads psychological, health, and therapeutic services and has implemented a holistic trauma-informed care model. A Churchill Fellow, he has published research on international approaches to trauma care, residential care, and self-harm. He has received the Butler Trust Certificate Award for violence prevention and held roles as honorary lecturer at Glasgow Caledonian University and visiting researcher at the Children and Young People's Centre for Justice (CYCJ) at the University of Strathclyde.

Preface

This reprint comprises a collection of 10 articles previously published in 2023 and 2024 to form a Special Issue of the journal *Youth* on "Residential Care for Children and Young People". The benefits of a reprint include increasing the visibility of the Special Issue, as the publisher distributes the reprint worldwide with an International Standard Book Number (ISBN), and convenience for the editors and authors, who can download the collection as a coherent whole for private study, use with students and associates, and to support scientific meetings.

Residential or group care for children and young people has faced serious criticism and its importance has become diminished in many countries, in comparison with family-type care settings; this criticism is largely, though not totally, a result of the traumatic care experiences of many children in orphanages and other large institutions, testimonies of historic abuse associated with institutional care, concerns for the human rights of children deprived of liberty, policy trends favouring deinstitutionalization, and reports about substandard care in contemporary children's institutions around the world.

However, family-type alternative care settings do not suit all children; for example, those who do not want an offer of what may appear to be an alternative to their own family or those who wish to stay along with siblings or close friends, which is not always possible where foster carers have space for only one child. Campus-based residential care facilities also have distinct advantages, including access to a range of services such as specialist therapies, education, health, and sport facilities, and can include full-service provisions such as family foster care.

The Special Issue of *Youth* focusing on residential care for children and young people was conceived to explore both conceptual and practice issues in relation to care experience and group care for children and youth. The 10 articles published in the journal are now brought together in this reprint. The collection, comprised of the works of authors from around the world, is bookended by two essays which reflect on the meaning of residential child and youth care in very different ways. The first article, by Kiaras Gharabaghi, considers what constitutes quality care, while in the final article, Mark Smith discusses the meaning of care through the lens of his own experience of working in a residential school in Scotland in the 1980s. The other eight articles, which appear in no particular order, are based on recent empirical research dealing with a variety of topics ranging from the size of group care, what helps adult carers help children, and the influences of social media.

As Academic Editors we hope that this compilation of articles will act as a valuable resource for everyone dedicated to ensuring that those in alternative care receive a positive experience, including the care-experienced community themselves, child and youth care workers, students, policy makers, academics, and anyone with an interest in the study of childhood. It has been a great pleasure to support the preparation of the articles which comprise this collection, and to engage constructively with so many creative thinkers in our important area of work. We also take this opportunity to thank the many anonymous peer reviewers, whose engagement with the articles has helped our authors to obtain the best from their work.

This reprint is dedicated to the memory of Dr Ruby Whitelaw (1963–2024), Scottish academic and child and youth care worker, whose article exploring whether group size matters in residential child care is included in the compilation. A tireless campaigner for better care experience, she will be greatly missed by her family and our community.

Graham Connelly, Sarah Deeley, and Dan Johnson
Guest Editors

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Essay

Quality Care in Residential Care and Treatment Settings in North America: From Complex Research to Four Everyday Principles for Practice

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Abstract: Quality is a central topic in contemporary discussions about residential care, and specifically about group or congregate care. Such care settings have been contested in recent years specifically resulting from anecdotal evidence that quality is lacking. To this end, the response has focused on the development of quality indicators and standards. In this essay, the author argues that, although such approaches are necessary and have helped to embed evidence-based practices in residential care settings, they are not easily translated into everyday practice. Quality care must mean more than frameworks for care that are governed by professional system designs. Quality care also must include the experiences of young people living life in these settings. To this end, to help with the translation of quality care standards for residential care, the essay presents four core principles that, on the one hand, are familiar and easily translatable for youth workers and social workers in these settings, and on the other hand, honour and are congruent with core elements of almost all evidence-based practice approaches.

Keywords: residential care; quality standards; quality indicators; research to practice; life space intervention

1. Introduction

At a minimum, one might state that residential group care for children and youth is contested. Such contestation has been anchored in a spectrum of argumentation that includes, on one end, basic economic reasoning focused on the (real or perceived) high cost of this form of care coupled with limited certainty of value for investment [1,2], and on the other end, contestation that is framed in strictly ideological terms, centered around the mantra that “every child deserves to grow up in a family”, as reflected, for example, in the Family First Act in the United States [3]. The contestation of residential group care is further complicated by significant uncertainties and ambiguities, including, for example, ambiguity about what constitutes residential group care (and similarly, some ambiguity about what constitutes family-based care), differences in both the nature and role of residential group care in Global North versus Global South jurisdictions [4], and contradictory research findings about the outcomes of this form of care that range from terrible to excellent [5,6]. The whole discussion is furthermore highly politicized, often driven by public outcry over institutional abuse detailed and rendered spectacular in media through headings such as “child welfare in Ontario has catastrophic problems” [7], “children as young as five restrained in care homes” [8], and “Federal Watchdog finds abuse at for-profit youth residential centers in 18 states” [9]. In addition, there are many concerns about reported ethical problems and profiteering amongst, especially, private service providers, as exemplified by a press release from the Association of Directors of Children’s Services in the UK that speaks to “profiteering in the children’s placement market” [10].

In response to this contestation, those who continue to believe that residential group care has value and serves an important role in a diverse spectrum of placement options have focused their energy on documenting positive residential group care settings, adopting the language of evidence-based practices, and demonstrating positive outcomes. As part of the political work of the supporters of residential group care, young people from within these services are often given a space and voice to speak to their experiences and their successes [11–13].

One concept that has served as the framework for both attacking and defending residential group care is the concept of quality. In the face of ongoing critiques (often based on anecdotal evidence) that lament the absence of quality in these settings using a combination of perceived poor outcomes, decrepit physical plant documentation, and data that document the failure to meet licensing standards in local jurisdictions, the defense has focused on raising quality in the settings by developing quality standards that are measurable and that are given credibility through third-party accreditation and external (often academic) oversight and reinforcement. Local, regional, and even national governments have collaborated in this work and developed policy frameworks, some of which are very strong and constructive, that promote this focus on measurable quality standards [14,15]. Policies and regulatory regimes have been adapted to enhance licensing frameworks to measure aspects of quality, although enforcement of violations of such standards continues to be very weak almost everywhere. Perhaps most active in this space have been non-governmental groups such as FICE International and its country chapters across Europe, the Association of Children's Residential and Community Services (ACRC) in the United States, the Centre of Excellence for Children's Care and Protection (CELCIS) in Scotland, and provincial associations such as the Ontario Association of Residences Treating Youth (OARTY) in Canada in particular. Additionally, smaller and often quite informal groupings of scholars in partnership with academic institutions and practice-based leadership have found fertile ground for engagement in this debate as well, such as the Bronfenbrenner Centre for Translational Research at Cornell University, which had a significant impact on the widespread adoption of therapeutic crisis intervention (TCI) across residential group care settings in both the United States and in Canada, as well as a group of scholars and practice leaders self-appointed as The International Working Group on Therapeutic Residential Care, who produced the Consensus Statement on Therapeutic Residential Care for Children and Youth in 2016 [11].

Discussions about quality standards and quality care have been active in North America for at least three decades [16], although references to this concept can be found in much earlier work as well. The discussions themselves are complicated and not always easily navigated because of the very significant variations across national and often regional jurisdictions in how residential care systems for children and youth fit into other systems such as child welfare, child and youth mental health, health care, and education. Nevertheless, it is fair to summarize these discussions as having an overwhelming focus on indicators and outcomes, which are sometimes articulated in the form of clinically measurable outcomes (improved scores on validated assessment instruments as part of pre-/post-program evaluation designs) and at other times in the context of placement outcomes (return to family) [17–20]. Thrown into the mix often without much theoretical framing are additional process and experiential items such as child and youth participation and voice, family engagement, educational outcomes, outcomes with respect to social participation, and avoidance of youth criminal justice systems, to name a few. More recently (perhaps over the past ten years) in North America, quality discussions have incorporated, but not always meaningfully integrated, a combination of outcome-focused and experiential factors related to equity-seeking identity groups, with particular attention to Black youth, Indigenous youth, and young people identifying outside of gender binaries and as part of LGBTQ2s+ communities [21]. Of note here is that young people with disabilities continue to exist primarily at the margins of these discussions, perhaps symptomatic of the societal and political hesitation to confront ableist norms and practices.

Much of the quality care discussion has centered around quality standards [16]. There is a very strong desire across North American jurisdictions to be able to measure quality indicators that correspond to common standards articulated across several core domains of the institutional practices of service providers. For example, commonly promoted standards relate to case management, individualized treatment planning, family engagement, evidence-based practices, education, and, almost always, some element of equity, diversity, and inclusion [16]. In some jurisdictions, detailed scales have been developed to measure quality in residential settings. For example, one study describes the development of such a scale in Florida in great detail. The authors note that the translation of such standards into practice presents challenges that "cannot be understated" [22]. Governments are generally supportive of this approach, as it yields data that lend themselves to public relations exercises and political rhetoric of government engagement and commitment. Interestingly, almost none of this discussion has applied to the much-preferred family-based care sectors, which often operate largely in a vacuum of meaningful oversight, standards, or quality considerations.

In this paper, I want to discuss not the merits of quality standards but instead the fallacy that the mere articulation and measurement of such standards actually raises the quality of experience for young people or even for the human resources directly engaged with young people in these settings. The issue is not the validity of what is being proposed but the absence of any meaningful way of translating standards into everyday practice. "Establishing a solid set of quality standards for residential care for children and adolescents is a good start, but the essential next step involves implementing those standards into daily practice" [16]. To be clear, it is not that such standards are not being translated into everyday practice at all (although sometimes that is, in fact, the case), but instead that such translations are often not very meaningful and become re-translated into old practice habits prevalent amongst teams of youth workers who find themselves confronted with young people demanding the acknowledgement of their humanity and subjectivity on the one side and leadership demanding the adoption of technical, often medically-based practice approaches on the other side. "The organization of a positive living climate seems to be complex. Consequently, group workers are looking for guidance concerning how they can act professionally and what good professionalism means in the current establishment of a positive living climate" [23]. Having little control over what they are instructed to do in their work, youth workers begin to belief that imposing standards of quality on young people that improve their outcomes is the same thing as improving the quality of life of young people as they share with us this contested space in the setting.

The purpose of this paper is to articulate a series of concepts that give youth and social workers something familiar to work with, without, however, undoing the necessity and importance of the more professionally articulated quality standards many stakeholders in residential care and treatment hold on to. In other words, two different ideas about quality care can co-exist and become complementary. The goal is to provide direct care practitioners (those working directly with young people on a day-to-day basis in the setting) a way of contemplating and reflecting on their practices not only in relation to the fidelity needs of evidence-based practices but also in the context of a more experiential undertaking in which both young people and practitioners see their relational context shaped with every interaction and through the time spent together in a common space and social context. In addition, this approach is responsive to the fundamental reality that, across residential care and treatment settings, the qualifications and pre-service education of direct care practitioners vary significantly. In some jurisdictions, including in Canada and across most of the United States, there are no or, at best, very limited regulations about pre-service qualifications, such that staff teams include individuals with significant and relevant child and youth care training, as well as individuals with no training at all and, not infrequently, individuals who are using employment in residential settings for children and youth as a stepping stone to other careers, including policing, for example. In recent years in particular, human resources challenges have been ubiquitous across settings, especially in North America but also in European countries [24], and it cannot be taken for granted that staff teams are equipped to make the connections between the programmatic elements of their settings and the human, relational, and cultural elements of that setting. To this end, the four core concepts discussed below provide an opportunity to serve as a foundation for building treatment capacity iteratively such that diverse practitioners can feel confident that their use of prescribed practices based on program adoption of specific evidence-based practice packages does not violate the spirit of being with vulnerable and often wounded young people who are seeking, first and foremost, relational safety.

2. Four Concepts of Quality Care

If one were to break down all the theories of residential care and treatment into basic concepts that really are the foundation of a high quality of care in the everyday life space, one could articulate four core principles as follows: kindness, healing, wisdom, and autonomy. These are not separate or discreet concepts. They are, instead, reflective of a deeply connected dynamic process in which these concepts continuously mutually reinforce one another. There can be no healing without kindness, no autonomy without wisdom. One flows from the other, and each reinforces the strengths of all the others. These concepts are chosen based on longstanding efforts amongst residential care and treatment practice leaders and scholars to reinforce the relational context of direct care practice. Kindness, for example, has repeatedly been articulated through a range of subcategories, including love [25–27], caring [28,29], and humility [30,31]. Healing has a strong foundation in trauma-informed practices [32] and also corresponds to Indigenous and other non-Eurocentric worldviews related to change and growth [33]. The role of wisdom, and specifically practice wisdom, has long been understood as critical in social work, where practice wisdom is often said to inform evidence-based practices [34]. Finally, autonomy lies at the core of the social pedagogy approach that has been the core theoretical orientation for residential care and treatment in much of Europe and more recently also in the UK [35,36]. In short, although there are other concepts or other terms and labels reflecting the substance of these concepts, these particular ones are chosen based on their longstanding presence in scholarly and professional discussions of the practice, and each of these is also reflected in, and certainly does not violate, the theoretical underpinning of most evidence-based practices one might encounter in residential care and treatment.

Before expanding on each of these principles and how they work together, it is important to answer an obvious question: Why simplify our thinking about quality care and treatment when so many excellent scholars and practitioners have worked so hard to develop much more complex frameworks for quality that are based on research evidence and have been evaluated by professionals equipped to do so? Do we not have enough knowledge already to ensure quality care and treatment?

The answer is that we do and we do not. We do in fact have extensive knowledge about what works for most young people, what creates opportunities for change and for growth, and what results in the kinds of outcomes we might be striving for. Evidence-based practices have led us down a path of trying to do better; they have helped us organize and systematize our knowledge, integrate trauma-informed practices, and plan our work with purpose and tools. Knowledge alone, however, does not lead to better practice. In fact, sometimes knowledge leads to nothing at all, and sometimes it can even lead to worse practice. This happens either when knowledge becomes an end in itself or the distribution of knowledge in our service settings is very uneven. In the first instance, we begin to strive to create practices that correspond to and reinforce the knowledge we believe we hold, and we assess the quality of our practices based on its congruence with that knowledge. We ask questions such as “Are our interventions trauma-informed?” or “Are we following the commands of dialectic behaviour therapy with fidelity?” However, we do not ask, “How is the young person healing?” or “Is this young person becoming someone unique to their autonomous self?” In other words, when we focus on knowledge too much, we end up working to serve our knowledge rather than the development and experiences of the young person or persons we are entrusted to care for. In the second instance, knowledge becomes concentrated in leadership, and there is an ever-growing distance between the knowledge held by the leadership and the practices that unfold on the ground. This distance is exacerbated by staff turnover and the previously referenced human resource challenges. Leaders typically have accumulated knowledge over a long period of time, absorbing new ideas and concepts in an iterative fashion. Many youth workers, on the other hand, have little background for the knowledge now being shared and often are not around long enough to build the knowledge base assumed by leaders to be present.

It is also important to note that much of our knowledge focuses on what *we* do while young people are placed in our settings; almost none of it focuses on what young people do with their experiences of care and treatment when they are no longer young people. At best, we can point to follow-up studies six months or a year post-discharge to determine where young people are (at home, in school, etc.). Yet, what we do while they are placed with us will form part of the memory of care and treatment that young people will carry with them throughout their lives. How that memory is shaped and narrated by the young person matters a great deal. Very soon, they will do the shaping and narrating of what we did while they were with us in our settings without us being present. Often, what young people remember about their time in residential care and treatment does not correspond to what we think we were doing with them. Retrospectively, young people remember less what *we did* with them, and more how *we were* with them. In a report on residential care completed by the Provincial Advocate for Children and Youth in Ontario, Canada, one young person demonstrates how their time in residential care will be remembered [37], p. 23:

> A group home is like an institution. Well, that's basically what it is. If the government is going to apprehend you and take you from your home, from your parents, then they should provide you with parents, not staff. That's not a place for a child to grow up, that's not a place where a child will be loved or nurtured.

This young person's comment has been repeated over and over again across studies and technical reports involving young people from care exploring their experiences while in care [38–41]. These comments indicate that, despite what may well be excellent fidelity in the implementation of evidence-based practices, young people often remember their time in care based on much more fundamental things; they remember how it *felt* to be in care based on their relationships with staff and peers and their experiences of dignity and wellness. It is important to understand that knowledge on its own rarely drives behaviour. In fact, almost all our behaviour is contrary to what our knowledge holds. For example, we all know that as settlers on the lands of Indigenous peoples across North America, we are reinforcing the theft of Indigenous lands and territories, and yet this does not stop us from building homes and exerting the right to private ownership. We know our carbon footprint ought to be as small as possible, and yet many of us buy gas-guzzling sport utility vehicles (SUVs) and commute long distances to work. Slightly more provocatively, we know that relationships are incredibly important in residential settings, and yet those settings still do not pay workers enough to ensure retention. Just because we know how to do things better does not mean that we do things better, but it does generally mean that we can talk more effectively about how well we do things, because we know what the better way would be to do these things.

The knowledge we do not have, or that at least remains somewhat ambiguous, is how to ensure that those engaged with young people show up to be with them in ways that support their healing and their growth not based on external assessment but based on young people's experiences. This is not about what *we do*; it is about how we are and what *they do* in response to how we are. The focus here is on quality of life rather than quality of treatment. This is not a novel focus. Quality of life was a central concern in the work of Redl [42], Bettelheim [43], and Meier [44]. In their ethnographic study of a setting for the treatment of "emotionally disturbed children", Buckholdt and Gubrium discovered that quality-of-life issues and, specifically, the nature of interactions between youth workers and children in a residential treatment centre, were at the centre of the life space and largely defined the experiences of the young people much more so than the planned interventions of the caregivers [45]. Levrouw, Devlieghere, Vandevelde, and Roose [23] explored precisely these kinds of questions in their study of the "living climate" in residential group care. Garfat, Fulcher, and Digney speak of "making moments meaningful" and emphasize the role of daily life events as foundational for meaningful care [46]. For this reason, there is enormous value in articulating, alongside the knowledge embedded in evidence-based practices, a practice wisdom that is based not on specific facts and research outcomes but on the humanity and social worlds in which both professionals and young people, as well as their families and communities, navigate. It is in this context that I propose we focus on the four principles introduced earlier: kindness, healing, wisdom, and autonomy. What these four principles offer is a way of being that shapes social worlds. What they do not offer is an instruction manual on what to do and when to do it. Collectively, these principles serve as a foundation for quality care and treatment, encompass many elements of evidence-based practices and what the research tells us about young people's healing processes, and ultimately, allow for residential group care to emerge as a setting of health and wellbeing in ways that we rarely talk about.

3. Kindness

Although there is much kindness in the world, the world itself is not a kind place. The kindness we do experience is largely a privatized kindness that unfolds between loving parents and their children, friends, and neighbours, and sometimes in communities. In the public domain, however, kindness is much more difficult to find. In fact, it is probably fair to say that we intentionally avoid social situations in which kindness would be the appropriate response. Examples of this include walking past a homeless person clearly struggling to get by, ignoring the predicament of a woman being berated by a man in a public place, or crossing the street to avoid engaging with someone with obvious intellectual disabilities. No matter how kind we might think we are as individuals, when operationalizing kindness requires any sort of effort, or presents the possibility of inconvenience or a lack of safety, we generally walk away from the situation at the expense of kindness.

Most of us can balance these ambiguities around kindness. We might feel challenged by the cold and detached ways (ironically, the definition of "clinical") in which the social world unfolds, but we can retreat into private spheres where kindness exists in abundance. Most young people, like most everyone else, develop a sense of apprehension about the world around them, but they experience kindness every day such that this apprehension is not functionally debilitating but instead serves to enable their participation in the social world on their own terms but supported by an extensive social network of friends, family, and community. The young people placed in residential care and treatment settings often do not have access to these social resources. They are navigating an unkind world without the opportunity to retreat, at least predictably, into a private sphere where kindness awaits. As a result, they develop a level of apprehension about the social world that is far more impactful on how they are in that world. They are, by necessity, guarded, ready for fight or flight, and expectant of problems and challenges rather than positivity and opportunity.

When young people are guarded, prepared for fight or flight, they are not able to maintain a longer-term perspective on their lives. Instead, what happens in the next moment is of great importance and requires all their focus. This is very different when young people have an expectation, gained over years of experience, of kindness being available to them now and into the future. For them, what happens in the next moment is somewhat important but is not likely to disrupt their future. When things go badly in the next moment, someone will be available to help, to support, to nurture, or to help them fix whatever the problem might be. In other words, the expectation of having access to kindness secures a safe enough context in which to be socially engaged in the world. There is always somewhere to retreat. When this expectation is not present, the very concept of safety becomes an ambivalent one—it is hard, if at all possible, to feel safe when we have to prepare for the next battle at any moment [31,47].

Understanding that most young people living in out of home care suffer from a kindness deficit, the most foundational task of youth work in residential settings becomes the intentional enrichment of the setting with unconditional kindness [26]. This means that the setting itself must exude kindness across multiple dimensions. Obviously, it means kindness at the interpersonal level in staff–young person interactions, no matter what a young person may be presenting to us. But it also means kindness in staff–staff interactions, supervisor–staff interactions, and agency operations [47]. We can ensure kindness is available in abundance by moving away from needs-based approaches in which we respond to every young person based on the needs that have been identified for that young person. Kindness is much more generous than that! It does not merely respond to individual needs as identified through assessment but also anticipates desires. For example, young people in a residential setting should never have to ask for hot chocolate on a cold winter day; the setting should provide this without young people having to ask for it. There should never be performance-based incentives or privileges (such as point and level systems or token economies) [48] because young people in residential settings have already been labelled as poor performers, and therefore, any performance-based incentive system is inherently a deficit-based system that is anything but kind. There must be endless willingness to listen, to engage, and to proactively offer presence and care. Staff must model kindness amongst themselves, helping and supporting each other. Agencies must invest in kindness resources such that staff and young people can engage with one another based on what is important to them. For example, when a staff member who is not on shift comes across a t-shirt at a store that would be perfect for one of the young people in the setting, agencies must support the procurement of the t-shirt so that the young person experiences the concept of being thought about at moments when there is no direct interaction. This is important, as evidenced by this observation from a young person living in residential care: “In group homes, you’ve got staff that come in for eight hours, get their paycheque, go home and don’t care what happens to you for the rest of the day, until tomorrow, when they have to deal with you again” [37], p. 29. The idea that kindness must prevail across all relationships amongst service providers involved in residential care is well captured by the Sanctuary Model, itself an evidence-based practice ubiquitous across North American human services [49–51].

In short, it is foundational to high-quality residential care and treatment that young people learn to trust that the setting itself is primarily a space for kindness, no matter what happens. In their exploration of adolescent and parent perceptions of good care in secure treatment settings, Harder, Knorth and Kalvadoer [52] found that both adolescents and parents are essentially looking for an environment that is attentive, responsive, and offers a balance of structure and flexibility. They furthermore found that adolescents generally do not view youth workers in the setting as a support if they are experiencing a lack of kindness in the program implementation culture. As one youth from care put it [37], p. 24:

> Then there’s the other staff that just don’t really care. There like just there to make sure you’re not doing anything wrong. They’re not there to help you. I’ve had staff tell me “I’m not here to hold your hand.”

Whether they are doing well or poorly, regardless of whether goals are being achieved, and regardless of whether care plans are proceeding as hoped for, the setting itself is a retreat from the lack of kindness young people experience every day. They ought to be able to count on this kindness much like most young people can go home after a miserable experience in school or in the community and know that a hug or some other manifestation of kindness is waiting for them there. This is captured to some degree by an approach often referred to as trauma systems therapy (TST), which aims to maintain a dual focus on individual-level treatment initiatives and the social environment where young people live [53]. TST aims to enact “treatment modalities [that] are designed to help the youth become better regulated as well as to help stabilize the social environment that is contributing to this dysregulation” (p. 694). The authors of the study argue that even if individual-level work is unfolding well and in a trauma-informed manner, milieu-based experiences of a lack of kindness, such as staff during breakfast time offering young people second helpings but staff at dinner time refusing such an offer, largely undo the efficacy of individual-level treatment practices.

It is of note that many manualized evidence-based practices, including, for example dialectical behavioural therapy (DBT) and Stop Now and Plan (SNAP) (both very common in North American settings), make no reference at all to kindness and instead focus on skills training across various milieu [54–56]. Youth workers are trained to implement specific measures (that are positive and constructive), but they are not trained to implement these measures with any kindness, nor to ensure that the context in which such measures are introduced and implemented reflects a setting where kindness is the norm. In fact, it is quite possible to follow the requirements of DBT, for example, while being unkind and even dismissive of young people. Fidelity in this evidence-based practice does not require kindness at all. In this way, although the efficacy of such evidence-based practices in residential settings has been demonstrated repeatedly with respect to individual-level outcomes at the time of discharge (and sometimes at the six-month post-discharge follow-up), the relationship between these practices themselves and the quality of the setting as a whole has hardly been explored at all.

4. Healing

We place much more emphasis on change than on healing in residential settings. In fact, almost everything we do is about creating change, and typically, it is about creating behavioural change or change in the performance of the young person in various performance-based settings, most notably in the program itself and in school. Change in residential services often happens in very uneven ways, with a great deal of change early into a placement and a levelling off later into the placement, but our treatment interventions remain largely the same throughout the placement [57]. Most of our evidence-based practices are about change. They are systematic approaches to changing the way young people respond to various kinds of stimuli in their interpersonal relationships, their families, and their communities. But when it comes to healing, we provide at best a generalized but quite ambiguous narrative about moving on from (or learning to live with) very difficult experiences. One reason for this is that unlike in the context of creating change, in which we, as professionals, maintain a great deal of agency and control, healing is about what young people do, and the work of professionals is secondary in this context [58,59].

One misguided assumption often made by case managers is that assessment processes and diagnostics, as well as social histories, that are essential for the development of meaningful treatment plans are also critically important for young people to heal. Yet, much like a broken arm can heal without us knowing how it was broken, a young person’s wounds, whether emotional, psychological, social, familial, or something else, can heal without us knowing much about the origins of those wounds. Many quality standards in residential care settings focus on assessment processes, and some residential settings in fact aim to do nothing more than to provide assessment followed by recommendations for aftercare. The healing process is a difficult one for caregivers because it does not primarily rely on them, although they certainly do have a role to play. The kinds of wounds young people bring into residential settings are quite complicated and rarely just reflective of a single injury. Instead, these are wounds that have developed and often deepened through exposure to multiple forms of invalidation and disempowerment [60,61]. In the context of residential services in Canada, this often includes invalidation and disempowerment of Indigenous, Black, and racialized identities and ways of being in the world, and the wounds resulting from this are not only deep but also are connected across multiple people and communities, and frequently, across generations of peoples and communities [62–64].

Given the nature of the wounds, we must acknowledge that our professional training is not well suited for healing. The Eurocentric and largely medicalized ways in which we seek to support young people is comparable to placing a bandage on a wound. We know that the bandage does not actually heal the wound, but it might protect it from further injury. The healing happens beneath the bandage, and much of that healing comes from within the wound rather than through an external intervention. The body ultimately heals itself when the conditions for healing are well set. In the context of particular groups of young people, such conditions are built on cultural markers that are critical for the healing process to be enabled, as is the case, for example, in the context of Indigenous youth in residential services [65]. On the other hand, when the conditions for healing are not well set, the body not only fails to heal itself but also deepens the wound, and eventually that bandage we placed on the wound will no longer suffice to protect it from further injury. One might argue that many young people who have had extensive experience in residential settings eventually outgrow the bandage once they find themselves released from these settings and are in the world on their own. Without healing and without that bandage, the risk of further injury is great. As one young person puts it [37], p. 25:

> You start out with goals. You want to go to school, you want to look for work, you want to make friends. . .and then it slowly transforms from decent wholesome goals to you want to just screw school, I'm going to get drunk. I'm going to hang out with friends, going to try not to go to jail. All of a sudden, the moving stops. They pick you up and they drop you in life. It's like they literally pick you up, drop you on an island surrounded by all the shit you have to do for the rest of your life and they never taught you how to swim.

Healing takes time. It is not a change process but a process of unburdening. It requires that young people have opportunities to reflect on themselves, their lives, their relationships, and their ways of being in the world, as well as their futures, and that they be in control of that reflection. It is ultimately their own narrative, their own way of constructing themselves that matters. Goessling [58] suggests an approach to youth work in which "healing is produced both through praxis that fosters identity construction, hope, a sense of belonging as well as improved pathways to wellness". Drawing on Ginwright's [66] work on "healing-centered engagement", she argues that we must involve "the whole person by integrating identity, culture, civic engagement, spirituality and collective healing".

Our job is to encourage young people to engage their wounds and to start caring for those wounds on their own in ways that prevent further injury while slowly contributing to the healing process. Professionals are not the ones healing the young people. They are healing themselves, although they may assign different roles in that process to family, community, culture, spirituality, or professionals. Our task is to be aware of when we have been assigned a role in a young person's healing process and then to take up the role with commitment and attentiveness while maintaining humility around the fact that we are not in charge.

A good sign that we are not supporting a young person's healing process is when young people do not assign us any roles in that process. Interventions, including treatment interventions, that are initiated by professionals and imposed on young people have nothing to do with healing. High-quality residential care and treatment is patient—we wait for our task to be identified and we collaborate with those whom the young person has identified as being part of their healing process.

5. Wisdom

As much as healing is much more a function of the internal resources of young people than the externally imposed interventions of professionals, there nevertheless is a role for professionals, and especially youth workers, to offer something of their own to the young people. I refer to this as wisdom, although one might find different ways of articulating this. As discussed earlier, the here and now is often very important for young people in residential settings, largely because there is so little experience with spaces of kindness and relative safety. What happens right now is much more consequential to these young people then it should be. Under these circumstances, it is difficult for young people to think about their lives, or the social world they encounter, in ways that transcend immediacy and lend themselves to creating a vision for themselves and their social world. This is an opportunity for professionals to contribute something that most young people receive inadvertently in their everyday interactions with adults.

Wisdom is about the art of living, the art of thinking about living, and the art of imagining living differently. Interestingly, almost nothing we learn in our various training activities speaks to how we might transfer to young people our wisdom about life. And yet, without any engagement about life at a philosophical level, young people are asked to navigate all kinds of unexpected circumstances for which they are unprepared and have no reference point. Young people living in residential settings rarely can articulate the basic principles they use to make decisions, the factors they might take account of when dealing with a problem or the loss of a relationship, or the criteria they use to determine which steps to take now to secure the future they are interested in having. When asked about their role in making decisions about themselves and their own lives, one young person answered, "decisions. . .oh man, you don't get to make any for yourself" [37], p. 35. Although they are encouraged to have goals, to make good decisions, to work towards good outcomes and good relationships, they rarely encounter the wisdom necessary to sustain any of these things.

The idea that wisdom matters, and that the wisdom of elders is a critical component of the experiences of young people, has long been recognized in Indigenous communities. Indigenous-focused research that has explored the impact of having elders contribute to young people's understandings of themselves and the world around them has consistently demonstrated enormous value in the transfer of wisdom from one group to another [67,68], including in very specific contexts such as learning about sexual health and sexuality [69].

Wisdom is much more important for young people with limited social capital than it is for young people with high levels of social capital. This is because the latter group of young people can live their lives in sequence. They can do things that they dislike and even hate doing (such as getting up the morning to go to school or work), knowing that they will get to do things they love or enjoy as well (such as hanging out with friends, participating in organized sports, or visiting with family). For young people with limited social capital, such a sequence is often not possible. They cannot accept things they dislike or hate because they can balance that with things they like or enjoy, because there may not be access to such things in their lives. Instead, they must have a different way of working with the good and the bad of living life. To accept and fight their way through the bad, they need to be wise enough about purpose, the connection of what they are doing to other things in life, and a future that promises a reward (economic, social, philosophical, spiritual) at the end of it all. This is what wisdom gives us—it gives us meaning in moments when meaning is hard to come by in any other way.

It may be unfortunate that we must place a burden of accumulating wisdom on young people in residential care settings. They are children, after all, and should not be required to be wise. At the same time, quality care requires us to ensure that young people are equipped to live life not only in the moment (by responding to program cues) but also throughout the lifespan. Wisdom that grows over time, is shaped by experience, and is also impacted by the mentorship, guidance, and advice of trusted adults and elders is an essential ingredient in this process. At the macro level, young people benefit from having a vision of themselves and their lives that transcends their current circumstances and relationships. At the micro level, they benefit from being able to apply new knowledge about the art of living in ever-changing circumstances. For example, they must be wise enough to know when it is inappropriate to manipulate others and when that is, in fact, the right thing to do and reflective of what everyone does. They must be wise enough to understand the values and character traits they are told to adopt with enough nuance to navigate through complex scenarios. For example, it is sometimes appropriate and a matter of personal safety to be uncooperative and mistrusting of others—we might think of a sex trafficker seeking cooperation from a young person as part of recruitment into the abyss of sexual enslavement [70]. In fact, 2024 marks the 30-year anniversary of Lorraine Fox's [71] high-impact article "The Catastrophe of Compliance", in which she compellingly laid out the risks associated with training young people to become overly compliant. Even then, Fox argued that treatment had become far too synonymous with behaviour management, placing young people at risk from those aiming to exploit them. How, she asked, can we help young people differentiate between moments where compliance, or conformity, are appropriate and moments when they pose major threats?

I am not suggesting that sharing the wisdom about the art of living held by every youth worker is a replacement for treatment or for evidence-based practices. However, just like Trieschman, Whittaker, and Bendtro [72] wondered about the other 23 h in relation to residential care, we ought to wonder about the time we spend with young people outside of the implementation of evidence-based programs and measures. The hallmark of residential care, and indeed its greatest strength, is those moments of intimacy that arise multiple times in every shift (often, especially, the overnight shift) where youth workers and young people can sit together and wonder how the world works. These are not just serene moments; these are the moments that allow young people to grow the knowledge and understanding that will inform them for many years to come, especially when facing challenging and imperfect circumstances in their lives. Small [73] in reflecting on the 50th anniversary of "The Other 23 Hours", states that "treatment is best understood as multiple active processes of teaching and learning. The book makes it clear that our youngsters will bring diverse, multiple learning styles that will shape their experience throughout the milieu". Whittaker and his colleagues involved in the Consensus Statement of 2016 [11] provide for an updated and yet very much reminiscent statement to similar effect: "We view therapeutic residential care as something more than simply a platform for collecting evidence-based interventions or promising techniques or strategies. TRC is at its core informed by a culture that stresses learning through living and where the heart of teaching occurs in deeply personal human relationships (p. 97)".

6. Autonomy

Autonomy is often confused with independence in residential settings, which is unfortunate, because it means that these settings not only fail to advance the development of autonomy for young people but also that they actually slow this development. Independence is an awkward concept to begin with. Human beings are never independent; they exist in interdependence within their social relationships and their relationships with time, space, objects, spirituality, and other things [74]. In Indigenous cultures, this has always been obvious; hence, many Indigenous communities speak of "all our relations" as a way of capturing this interdependence [75]. Taken to its most complete manifestation, independence means a life of loneliness away from others and largely disconnected from the social world. Reeve and Cheon [76] demonstrate how autonomy-supportive pedagogies in school settings "produce a wide range of educationally important student, teacher, and classroom climate benefits". Additional research focuses on the ways in which autonomy-supportive practices, often drawn from self-determination theory, help to empower young people to find their own way to success and high performance, whereas controlling practices (reflective in treatment orientations based on externally generated modalities) often end up increasing feelings of disempowerment and resistance to change and growth [77].

Autonomy is an important concept that has never been meaningfully acknowledged in our psychologized, medicalized, and chemicalized ways of conceiving treatment in the North American context. The concept of autonomy occupies a central place in social pedagogic approaches to residential practices that are more common in European contexts. Autonomy is about our sense of self and its connection to the social world [78]. It is the concept that determines how we see ourselves as belonging, connected, and unique in the broader context of our interdependencies. Everyone develops an autonomous sense of self, but not everyone is aware or conscious of it. This is because not everyone needs to be. For those of us living in the relative privilege of full participation in our families and communities, it is less important to be consciously aware of how we are in relation to the social world. The social world will carry us when we do not know what to do or how to be because our social capital, the sum of all our different ways of interdependence, will respond when we are lost. For young people living in residential settings, this is not so certain. Many will leave those settings with fragmented social capital at best, and their connections to the social world are often tenuous. In fact, young people often find themselves living life independently against their will; they crave interdependencies, spaces where they can connect and belong, as well as spaces where others seek them out for connection and belonging.

When we think about what we do in residential settings, almost none of it aims to support young people developing their sense of autonomous self. We do not intentionally work with young people to find answers, however transitional those might be, to questions such as "Who are you?", "Who would you like to become?", and "How are you in relation to the world around you?" Quality of care in residential settings means caring for the whole person, not merely addressing problems identified by professionals and systems. Residential care is ultimately a life space, and part of life space intervention is building an orientation to spaces adjacent and beyond our own [79]. To this end, youth workers able to engage with young people such that their autonomous sense of self can develop further are furthering life space practices that were imagined by decades of residential care writing and research, including by the (North American) pioneers Redl, Bettelheim, Lewin, and others.

7. Four Concepts as a System for Life

Kindness, healing, wisdom, and autonomy are concepts that must be operationalized to secure high-quality care in residential settings. Residential settings are life spaces, or, expressed slightly differently, they are spaces in which young people's lives unfold. High-quality care means that we ensure that this setting facilitates life unfolding in ways that allow young people to live their lives in peace and confidence that new things are possible, new ways of being in the world are worth pursuing, and life itself can offer things worthy of pursuit. Our job is not to push young people into one singular and highly concrete way of being. In North America in particular, we have done this repeatedly, much to the detriment of many young people, and especially young people who understand their primary place of belonging as their communities, their identities, their cultures, and their land.

A core challenge in many jurisdictions around the world is that what we refer to as residential care and treatment settings encompass an enormous range of services and settings, as well as different types of organizational contexts. It is often difficult to have one way of ensuring quality across all these different types of settings and contexts. For example, in some jurisdictions, notably, across Canada and the United States, private for-profit residential care is common. Increasingly, such services brand themselves as treatment settings and lay claim to similar kinds of services as public settings, including claims to evidence-based practices. In reality, the claim to evidence-based practice is one that can simply be purchased on the open market by paying the registration fees for particular evidence-based practice packages. Regulatory frameworks are generally too weak to ensure that such claims are operationalized in meaningful ways. There are challenges related to whether a residential service serves primarily child welfare-involved youth who are placed in the service out of necessity and often in the context of a crisis, or whether the service has pre-placement elements and discharge-planning processes that involve integrated and meaningful work with families and communities and where the therapeutic milieu is just one of several interventions unfolding together. This diversity of services and contexts has major implications across multiple dimensions. For example, it is not always clear where our research comes from. In some cases, client data, outcome data, and follow-up data post-discharge comes exclusively from exceptionally well-integrated services that are connected to families and communities. Often, the critical research that relies heavily on the voices of "care survivors" who tell stories of abuse, neglect, and inadequate care reflects the experiences of child welfare-involved young people who were moved around placements with little or no meaningful treatment or even therapeutic orientation. Not surprisingly, we often end up comparing apples to oranges in the contested spaces of discussions on residential care and treatment.

I am proposing the four concepts of kindness, healing, wisdom, and autonomy as a way of bridging the uncertainties and diverse realities that pertain to residential care and treatment. These four concepts, when taken seriously and integrated along with excellent supervisory guidance, reflective time for practitioners, feedback from young people, and organizational support more generally, can ensure that no matter what happens with therapeutic outcomes or treatment goals, the quality of life for young people is one that is upheld through dignity and respect that are inherently embedded in each of the four concepts and in their intersections.

There are endless ways in which we can operationalize each of the four concepts. The ingredients of kindness, for example, are humility and patience, and anyone working with young people in residential settings, whether as a child and youth care practitioner or as a social worker in charge of case management, can exercise both humility and patience by reducing their own importance in the everyday experiences of the young person. However, kindness is not merely an interpersonal concept; it is the precondition for healing, and ultimately, we want young people not to get "fixed" in our settings but to find pathways to healing that are meaningful to them for years to come. That is the thing about old wounds—they reappear when you least expect them, and part of what we hope young people will find in our settings and in their relationships with us as caregivers is the wisdom necessary to respond when old wounds do reappear and the autonomy to do so in ways that reflect who they are becoming.

This, then, is the secret to, or the missing ingredient of, high-quality residential care and treatment. Quality is about the whole experience, not just the interventions and the changes that can be imposed on young people. Quality care reflects strong foundations for healing and constant capacity building for reinforcing trust in those foundations. The purpose of residential care and treatment ought to be relatively simple: We want young people to sooth their souls and to imagine life as worth living, however they might live it and whoever might become part of their story. These things are not entirely up to us to decide.

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Article

Everyday Care: What Helps Adults Help Children in Residential Childcare?

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Abstract: Over the last decade, there has been an increasing trend towards the use of 'therapeutic models' in residential childcare settings in the U.K. and elsewhere. While some have argued that these developments have been driven, at least in part, by free market funding environments and organisational survival needs, others have suggested that many of these models, despite some of their theoretical and conceptual differences, offer a useful approach. Drawing on findings from an ethnographic research project in a residential setting in Scotland, we argue that the underlying processes of implementing and embedding a therapeutic model can create conditions that are conducive to the provision of high-quality, effective, relationship-based practice, which has real benefits for children in their everyday worlds. Moreover, we argue that the model itself is somewhat beside the point. If residential organisations can facilitate safe, ongoing opportunities for staff to (a) think deeply about themselves and others (children and staff), (b) practice ways of being and doing, and (c) be seen and valued, then this can contribute to a practice culture and context in which they feel able to create genuine, caring relationships with children. We argue that it is within these everyday, genuine, caring relationships that children can recover from difficult experiences such as neglect and abuse. In this way, the 'therapeutic' focus should be primarily directed at the adults to enable children to get on with being children.

Keywords: residential childcare; therapeutic models; relationship-based practice

1. Introduction

Recent years have seen an increasing trend towards the use of 'therapeutic approaches' in residential childcare settings in the U.K. and elsewhere. Johnson and Steckley [1] suggest that although there are few models developed and designed exclusively for residential care, there has been a general shift in practice focus from behaviour management to a recognition of the value of relationally based practice and of the value of 'therapeutic interventions' [2]. Alongside this, organisations providing residential care for children and young people have drawn on these various models and approaches to claim and name their areas of expertise and particular practice skills. In part, these developments may have been influenced by the rise of free market funding environments and the pressure placed on care providers to demonstrate value for money; however, there is some suggestion that many of these models offer a useful approach despite some of their theoretical and conceptual differences. What is less well understood is what these different models offer, which is beneficial for children, young people, and adults living and working in residential care.

Despite recognition that children in the 'greatest amount of need' [1] are placed in residential care, there is limited research that explores what this form of care means to children, how it is delivered, and the immediate impact it has on their everyday childhoods. To date, much of the research undertaken with this population has primarily focused on current or future outcomes (often related to indicators of 'successful' adulthood). In addition, little is known about the day-to-day experiences of the adults providing care in residential settings [3]. Such limited understanding is particularly challenging given the level of scrutiny that residential care has been exposed to over the last 20 years. For example, The Scottish Child Abuse Inquiry [4] highlighted the dangerous and abusive practices evident in some residential settings over the last century. Contemporary residential care is, therefore, caught in the tension between the legacy of the past and the current demands for improved outcomes and better services for children [5].

The project on which this paper is based offered a unique insight into what occurs day to day in a residential setting. While there have been a handful of studies that have done this, there are none that have interrogated the new drive for 'therapeutic care' and how this translates into the everyday practices of frontline staff and the lived experiences of the children being cared for by them. Rather than being concerned with the long-term outcomes of care, this ethnographic study of a residential setting in Scotland explored the real-time experience and impact of 'therapeutic' care on current childhood. The overarching research question that the project sought to answer was 'what does "therapeutic care" look like in the everyday worlds of children and adults in a residential childcare setting'? As such, this study took a broad look at the experience of children and adults as both providers and receivers of care. This paper focuses on one key finding that emerged from the data relating to the perspective of adults. In doing so, it analyses the process of implementing and embedding a particular theoretical model and highlights key emergent themes related to the role, identity, and containment of adults in this setting.

1.1. Policy and Practice Context

In the U.K., residential childcare has a long and diverse history linked closely to wider societal changes in attitudes towards children and childhood [6]. For example, after World War II, the Curtis Committee (in England and Wales) and the Clyde Committee (in Scotland) reviewed the provision of care for those children who were unable to be looked after by their own families; the reports of these committees recommended reducing the size of residential care settings so that children were cared for in groups of 20 or less, thus replacing very large group living arrangements [6,7]. At the same time, the dominance of psychological and child development theories foregrounded the importance of the caring relationship in the 'healthy development' of children and further encouraged the move towards smaller group living arrangements such as 'cottage' models where children were cared for in 'family-like' groups [6]. Legislative changes in the second half of the 20th century increased the responsibilities of local authorities in relation to the provision of care for children in the U.K., while residential childcare was absorbed into the newly developing profession of social work (ibid).

During this time, several interacting developments combined to situate residential childcare as a less desirable choice for the provision of care to children, resulting in it becoming an option of 'last resort' [1]. For example, during the 1980s, ideological preferences for care within families coincided with a newly emerging neoliberal concern for the economy within the welfare state [6]. Alongside this were growing demands embodied in legislation and policy for children to be 'accommodated' within family homes [8]. The 1990s saw changes in the practice and understanding of social work following revelations of abuse both within families and residential childcare, with a concomitant increase in political interest in the field [6]. There has also been a sustained discourse on whether residential childcare results in poorer outcomes for children than other forms of out-of-home care, such as foster care, although the evidence for this is complex and inconclusive (for an overview, see [9–11]). Developments like these led to a more managerial and regulatory approach by the government to residential childcare, including a greater reliance on technical and procedural solutions within the policy framework [12,13].

Despite recent challenges to the 'last resort' narrative surrounding residential childcare, questions remain as to the extent to which it delivers what children need [14]. Children and young people admitted to residential settings are more likely to have had childhoods marked by complex trauma (including emotional, physical, and sexual abuse and neglect) as well as multiple moves within care [15]. Taken together, this can, for some, generate a range of pain-based and often challenging behaviours as a response. However, the relationships and experiences contained within a residential setting can support children in developing a positive self-identity, self-esteem, and self-respect [14], as well as enduring and meaningful relationships. The sociocultural and historical context for residential childcare is important when considering how services, practices, policies, and procedures have developed in this field. Such contextual factors have influenced residential childcare, which has seen '... regulation; value for money; risk aversion and evidence of outcomes for children' become the dominant discourses shaping the sector [16] (p. 658). Indeed, in discussing the rise of therapeutic residential childcare in Australia, Kor et al. [17] argue that, despite its benefits, relationship-based practice has been constrained by a focus on short-term outcomes as well as fears around the boundaries between personal and professional relationships for frontline practitioners. They highlight the vulnerability of both young people and adults in residential childcare settings where the practice is highly scrutinised and ethical dilemmas frequently arise. The vulnerability of adults working in therapeutic residential care has been further highlighted by Brend and Sprang [3], suggesting that consistent exposure to children's traumatic histories not only contributes to attrition in the workforce but also to a reduction in workers' capacity to '...fully engage in helping relationships with children in their care' (p. 155).

Parallel to demands for improved outcomes for children has been a related and growing interest in 'therapeutic' models of care [16,18–20], which call for workers to be 'caring' 'knowledgeable' and 'emotionally engaged' with children.

1.2. 'Therapeutic' Approaches in Residential Childcare

Therapeutic approaches to residential childcare practice are not a new phenomenon. Redl and Wineman [21] developed the 'life space' model to work with 'troubled' children and young people using the everyday group experience as a central tenet of therapy. This approach sought to move therapeutic interventions, based on psychological and psychosocial theories, out of the consulting room and into the actual, everyday 'life space' of the children and young people (see [22] for an overview and history of this approach). Currently, therapeutic models or approaches in residential childcare similarly appear not to imitate or replace individual 'therapeutic' interventions such as counselling; rather, they seek to embed therapeutic perspectives into the day-to-day practices contained within the residential environment [23].

In recent years, a number of therapeutic models have been developed and are becoming more widely used in residential childcare settings, including, for example, Sanctuary, Positive Peer Culture, Teaching Family, Stop-Gap, Children and Residential Experiences (CARE), Re-ED, and Dyadic Developmental Psychotherapy (see [19,20,24] for reviews of these). While distinct models are underpinned by different theoretical positions and are practiced in various ways, most recognise the potential impact of past experiences on children and argue that healthy and positive relationships are a means of addressing associated issues and promoting recovery. Echoing the position of Redl and Wineman [21], each model seeks to facilitate supportive relationships in an environment whereby everyday opportunities and experiences are 'therapeutic' in that they promote the healthy development and 'recovery' of children and young people. In an attempt to consolidate best practices in this field, Whittaker et al. [25] presented a definition of therapeutic residential care (TRC) that continues to hold sway within the sector. They suggest that TRC '... involves the planful use of a purposefully constructed, multidimensional living environment designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources'(p. 94). However, for some, the language of 'treatment' and 'mental health and behavioural needs' runs counter to the notion of a home as a site of everyday care and can devalue the roles of those who provide it [26].

While there have been some modest results recorded for a small number of therapeutic models [19,20,27], calls for more robust evidence of impact and effectiveness continue. This is somewhat paradoxical in that one of the drivers in the rise in therapeutic models is the increasing demand for 'evidence-based practice' in both the residential care and 'trauma recovery' sectors [27]. There are considerable barriers to obtaining the type of 'robust' evidence that is sought. For example, designing and implementing controlled trials in this field is fraught with logistical and ethical difficulties [28], which take resources, time, and effort to overcome.

However, there are decades of quality empirical evidence relating to factors that contribute to the 'healthy' and resilient development of children [29–31]. Central to much of this evidence is the place of genuine, responsive, and attuned relationships. Indeed, while James [27] argues that models are sufficiently distinct to prevent the formulation of a 'meta model', she lays out a range of features of residential care that are well evidenced within the risk and protective factors literature. Caring relationships are included in the list, and an examination of the other eight reveals most of them to be contingent on or required to support the development of relationships. Howe [32] (p. 278) argues that '. . . if relationships are where things developmental can go wrong, then relationships are where they are most likely to be put right'. Relationships that 'go wrong' are increasingly regarded as being the cause of 'trauma', and it is this trauma that residential care is tasked with helping children process, repair, and recover from.

In their critique of the concept of trauma, Smith et al. [26] argue that 'trauma informed' approaches to care (which many therapeutic models purport to be) do not go beyond what has long been accepted as suitable health and social care practice. Moreover, they argue that privileging a psychological worldview through a focus on trauma-informed practice devalues the highly skilled work currently undertaken in residential childcare. They go on to suggest that categorising experiences purely through a trauma lens may limit more positive and hopeful framings of actions and feelings. In trauma-informed models of care, relationships are reduced to a clinical tool used to 'overcome an individual's perceived deficits' [26] (p. 483) rather than being prized for their intrinsic human value.

We argue that any examination of everyday care in residential settings needs to take into account not only the models used, the nature of relationships, and the ways that past experience is approached; it also has to consider the multiple interacting relationships and systems within which everyday care is practiced in order to understand the processes by which that care has an impact on the recovery of children and young people—the ways in which it is 'therapeutic'. It is to this exploration of 'therapeutic' care that the paper now turns.

1.3. The Residential Setting and Therapeutic Model

The residential setting 'Kinbrae', used as a case study in the project, was situated in a rural location in Scotland. It offered residential care for 15 children across three houses. Each house was staffed by 12–15 residential care staff, including house managers, on a shift rota. Kinbrae looked after children between the ages of 5 and 18 who had typically been referred by local authorities across Scotland. The children were described as having experienced neglect and/or physical, emotional, and/or sexual abuse while living with their birth families. These experiences had created a home environment that was regarded as unsafe for children, and the impact of these experiences had resulted in many of the children displaying behaviours that were portrayed as damaging to the self or others. Most of the children were described as not having had their social or educational needs met in mainstream school. Taken together, Kinbrae was tasked with providing a safe, nurturing school and home environment where children could be supported to make sense of their earlier experiences, rebuild (where possible) relationships with family, and make new relationships with caring adults. During fieldwork, the children were aged between 8 and 14.

The organisation also provided an education service staffed by teachers and education support workers, although not all children who lived in the care setting attended the school and vice versa. Other members of staff included the senior management team, cooks and catering staff, cleaners, administrative workers, and facilities staff who looked after the buildings and grounds. There were also specialist consultants (speech and language, play therapy, and psychology) who worked directly with children and staff members and contributed to training, practice discussions, and other development activities. The organisation was selected because it had introduced a whole team training and supervision programme for a well-defined therapeutic model called Dyadic Developmental Practice (DDP), aimed at providing relationship-based care to aid the recovery of children and young people from the types of experiences (i.e., neglect and abuse) described above (citation not disclosed—this is literature that was produced specifically for the residential setting, and it has, therefore, been withheld to maintain confidentiality). It is important to note that, while it was the main model in use, DDP was described by staff members as not the only theoretical influence on everyday practice.

Dyadic Developmental Practice [33] was developed from Dyadic Developmental Psychotherapy, a therapeutic model based on the work of Daniel Hughes. It is underpinned by attachment theory and incorporates learning from other fields, such as neuroscience, and psychological concepts, such as intersubjectivity [34]. This approach seeks to help residential childcare workers connect with young people by encouraging rich and emotionally engaged relationships between all staff and young people within the setting using a variety of techniques [35]. For example, staff are encouraged to self-reflect at the start of shifts, to focus on the 'emotional tone' of the setting at change-over meetings, to take time to connect with each young person, and to adopt a general attitude of PACE (playful connections, acceptance of the child's inner world, curiosity about the meaning underpinning behaviour, and empathy for the child's emotional state) [34,35]. According to this model, it is the relationships with staff members (who provide the parent function) that facilitate the crucible of healing for the children [36]. Because of this, staff training and support (e.g., through supervision and other processes) are seen as crucial to success.

At Kinbrae, the whole team approach to training and implementation of DDP commenced approximately 9 years before the research fieldwork was undertaken. All staff, regardless of role, were expected to undertake DDP level 1 training. Frontline care and education staff and managers were then required to undertake DDP level 2 training and engage in regular, ongoing consultancy/clinical supervision with the DDP consultant, a qualified psychologist. Training and supervision were provided to small teams of workers who worked together regularly in the same house on the care campus or in the same class at the school. The training and clinical supervision sessions sought to not only develop the knowledge and skills of frontline workers but also to be reflective spaces where adults could talk deeply about their own experiences in life and at work. Indeed, as will be discussed later, the shared reflective content of both the training and the clinical supervision was seen by staff as fundamental to their practice and their ability to develop and maintain genuine, caring relationships. Based on data gathered in the project, the implementation and maintenance of the DDP approach are depicted in Figure 1 below.

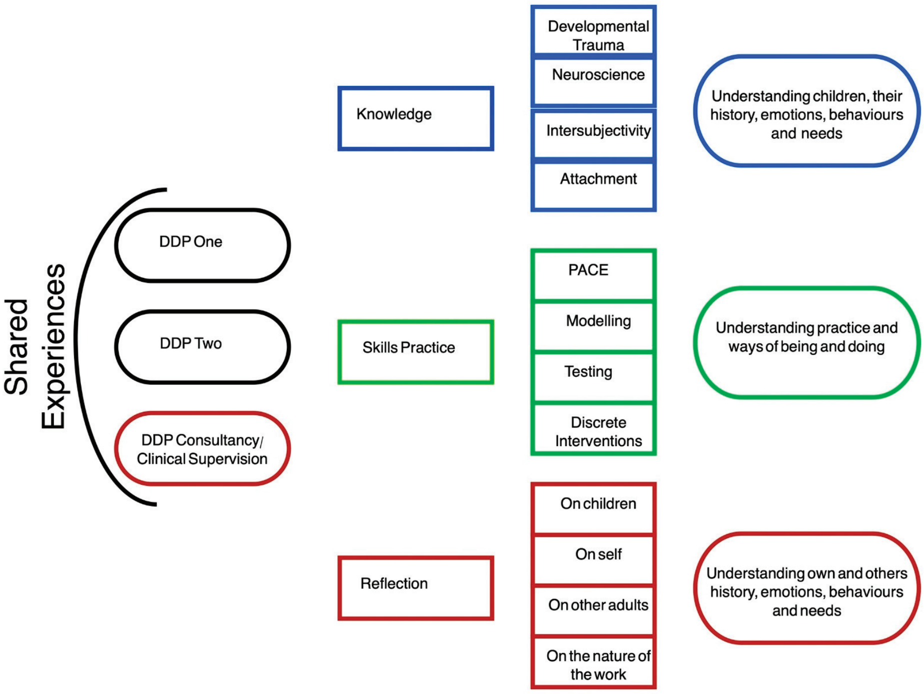

Figure 1. Diagram of DDP training and supervision model. Training levels and consultancy are depicted on the left as shared experiences that groups of staff undertook together. All of these included developing knowledge and skills and functioned as reflective spaces, with the consultancy being noted as especially reflective. Details of the types of knowledge, skills, and reflection are noted alongside the intended outcomes for understanding on the right. (Burns, 2021).

2. Methodology

In order to answer the central question posed by the research project ('what does therapeutic care look like in the everyday worlds of children and adults in a residential setting'), a range of ethnographic methods were employed. These had to be adjusted to accommodate social restrictions in place due to the COVID-19 pandemic, including collecting data in different phases, moving from initial, adapted, introductory online contact with all staff members, followed by online interviews, then in-person participant observation, and then concluding with semi-structured interviews. In phase one of the fieldwork, 30 min online 'orientation' interviews were held with 19 staff members between January and February 2021 in both small group and one-to-one formats. These adult participants volunteered to be interviewed following a meeting with the whole staff team. The interviews gathered initial data relating to how staff approached and understood their practice and what influenced it. Staff also shared views on the routines and rituals that marked everyday life at Kinbrae. Additionally, an hour-long, online, semi-structured interview was also held with a consultant specialist in Dyadic Developmental Practice. This interview was used to explore the background, development, and implementation of the model, including training and clinical supervision within the organisation.

In phase two (April 2021 to October 2021), 161 h of participant observation were completed. This dedicated time spent living as part of the group of children and staff allowed meaningful relationships to develop. Fieldwork primarily took place on the care campus across all three houses, and all staff and children (where parental consent was in place) were invited to participate. Alias et al. [37] (p. 9) suggest that '. . . the richest data typically hinges on the relationships created and maintained'. By allowing time to be given to getting to know the children and staff (and vice versa), we were able to set the fieldwork at the pace of participants and go some way to ensure depth to the data being collected. Details of activities, relationships, environments, and conversations were recorded in fieldnotes.

Between August and November 2021, 10 semi-structured interviews were conducted with key adults (frontline care and education staff, including managers and a senior manager) and two independent therapists (play therapy and speech and language). These individuals were selected because they represented a range of positions working at the organisation. The first author used the relationships that he had developed during participant observation to identify and recruit a range of adults who were willing to take part in interviews and then ensured a range of positions were represented in these. The interviews used an appreciative inquiry approach and Carter's [38] 4-D cycle: Discovery (appreciating the best of what is or what has been); Dreaming (exploring what might be); Design (co-constructing what the ideal should be); and Destiny (envisioning the future or what will be). The average length of the interview was 43 min. All interviews were transcribed verbatim for analysis.

Qualitative interviews (in the way they are described above) were not undertaken with children, but most (those who assented and had parental consent) took part in the participant observation. In both explicit and implicit ways, children declined to be interviewed in the traditional sense of answering a set of questions or discussing agreed topics. They were, however, open to wide-ranging conversations where they could influence and determine the topics for discussion and were particularly open to these when engaged in other activities. Such casual conversations, typically associated with ethnography and participant observation [39], were many and varied during fieldwork and were captured in fieldnotes. Activity-based methods of data collection were employed with some children. For example, an art-based activity was completed successfully with the support and collaboration of a staff member with specialist training in play-based activities. A total of 62 participants, 47 adults (mainly staff but also 2 social work students on placement and 3 independent consultants) and 15 children, took part. The children who took part were those for whom both parental consent and the assent of the child were confirmed.

As a method, participant observation does not follow the assumption of 'normal science' that one must detach oneself from the world to understand it. It is a key method in anthropology, a discipline that, more than any other in the human sciences, 'has the means and the determination to show how knowledge grows from the crucible of lives lived with others' [40] (p. 387). As such, the first author developed rapport and relationships with both children and adults in the setting. Geertz [41] argues that spending time in the field, getting to know participants, taking account of their social systems, and focusing on the everyday is a moral requirement, one that we would argue is even more pronounced when conducting research with children in this setting. While the first author used a reflexive diary and reflective discussions with the second author to consider his positionality and the ways in which this affected data collection and analysis, we also acknowledge the limitations of these tools as they are based on the assumption that both the self and the context are knowable and made transparent through their use [42].

Analysis was ongoing throughout the project, including initial analysis of events and activities as they were recorded in fieldnotes. Following well-established traditions in the analysis of ethnographic data [43], both authors regularly reviewed the data (fieldnotes and transcripts), discussed potential codes and emerging themes, and brought these initial ideas to advisory group members. The first author then returned to the field for further periods of data collection. Further thematic analysis began towards the end of data collection and was undertaken as described by Braun and Clarke [44] by familiarising ourselves with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and then producing a report. In reviewing the themes, we checked these against the original data to ensure fidelity.

Ethical Considerations

Ethical guidance from both The British Sociological Association and the Association of Social Anthropologists of the U.K. (ASA) informed each stage of the project. Ethical approval was granted by the (anonymised for peer review) General Ethics Committee.

Processes were developed to ensure ongoing, informed consent from both children and adults. Written leaflets were developed specifically for children, parents, and staff, respectively, which made clear the voluntary nature of participation. All discussions with participants prior to and during fieldwork reinforced this, and the first author returned to the subject of consent where any uncertainty or ambiguity arose. We remained open to the diverse ways children communicate, including verbal and non-verbal assent or dissent [45]. All participants were made aware of their right to withdraw consent at any point without having to provide a reason or explanation and the limits of confidentiality, including recognising each other's stories despite pseudonymisation and the requirement for the researcher to discuss any concerns for welfare or safety with a senior manager in the organisation were regularly shared. Because of the long-term nature of this research, some participants (especially the children) chose to opt in and opt out at different stages or during different activities, and the first author had to react and adapt accordingly.

Exiting the field can be a complex and ethically challenging process for anthropologists and the people with whom they work [46] and required even more careful consideration in this project, given that the children involved had varied and sometimes difficult endings to relationships in their lives. The first author provided a clear explanation of the time-limited nature of this project at the outset and returned to the issue of endings at appropriate times throughout. He worked with children and staff in the final stages of fieldwork to make appropriate plans for the end of fieldwork, including return visits to present and explain the findings.

3. Findings

While the study on which this paper is based took a broad look at the experiences of children and adults in this setting, we focus here on one key finding that emerged from the data relating to the perspective of adults on the processes of implementing and embedding a 'therapeutic' model and how these were translated by practitioners into what they regarded as 'therapeutic' care. Through analyses, what became apparent was that it was staff members' response to therapeutic approaches within these processes, as applied to themselves, which appeared to free them up to make sense of and support children and enable them to provide conditions for everyday childhood experiences.

3.1. Creating Caring Relationships

From data gathered in interviews as well as through observation, it appeared that, in many ways, the care provided in the everyday environment did not look specifically 'therapeutic' but rather very familiar and familial. Care happened within and rested upon genuine caring relationships. On the surface, it seemed that 'therapeutic' care at Kinbrae looked like 'good', everyday care, although this belies the complex sets of processes, environments, and cultures within which this can happen in a residential childcare setting.

The data showed that everyday care had many faces; it was not one thing but rather a range of different elements that were used in varied combinations depending on the individuals involved and the contexts and situations in which the care took place. To highlight this, during the analysis, we identified 22 sub-codes under the main theme of 'everyday care' where we attempted to specify exactly what types of care were evident in the everyday worlds of children in the setting. These included practical care, domestic activity, protection, boundary-setting, anticipation, facilitation, managing transitions, and relationships. Indeed, this last code relationship was the most densely populated, highlighting the centrality of relationships in the provision of everyday care. This is in line with the organisational ethos and the aims of DDP: that the adult–child relationship is the vehicle through which everyday care *can be rendered therapeutic* for children. Relationships were key in every aspect of care, as can be seen in the interactions in the following situation:

> *I position myself in the kitchen where staff and children and busily coming and going between there and other parts of the house. I watch as each child, in turn, arrives and tries to get access to the cupboard (a locked cupboard where a range of sweets, crisps*

> *and juice are held). Each child comes up against a patient Thelma who enforces a rule of 'healthy snack' first (fruit or a yoghurt) and, by my assessment, only one child (Brian) successfully negotiates his way through the healthy option to be offered something from the cupboard. Thelma seems so in control—funny, sweet, encouraging with the children, but also unmoveable on her rules as clearly stated. This is not the first or last time today that I will feel like I'm in a big family home*. (Fieldnote, 8 June 2021)

There are many ways to view this practice: as protective of the children's health and as mindful of their socialisation to rules and to food or as a display of adult power in an institutional setting with locked cupboards, for example. However, it is important to acknowledge the established relationships between Thelma and the children. What was evident in this scenario was how well Thelma knew each of the children and how well they knew her. There were in-jokes, laughter, feigned outrage, and blatant attempts at emotional blackmail. It felt familial because of the *nature of the relationships* that were evident. During fieldwork, these types of interactions were commonplace.

From the data, it was clear that the simple but effective power of these relationships and their impact on the children could not be taken for granted. Relationships were viewed as messy and complicated at the best of times, but particular challenges were faced by children and adults in this setting.

Similar to the findings of Brown et al. [16], adult participants identified the added complications that came from issues such as the political and public discourse around residential care, regulation and oversight of practice, and the complexity of relationships that extend into and out of the everyday care environment. All these factors contributed to a context in which, at times, adults felt worried about both the nature of their work and their relationships with children. Some of these complexities were evident in Mary's description of an incident in a public park where she and another worker had to prevent one of the children from hurting another:

> *I took the opportunity to chat to Mary about her experience last week and commented on the bruising that was visible on her arms. She went into some detail about the incident and talked about how stressful it was because it was in a public place and she and [another worker] Christopher had to 'safe hold' [one of the children] Daniel while some of the local teenagers and members of the public commented or filmed them saying things like 'that's child abuse'. Understandably, this makes her feel really bad and she is 'wary of wearing a lanyard or saying 'we're his carers' because a lot of the children don't like to be labelled/stigmatised in relation to their care situation'*. (Fieldnote, 7 June 2021)

Here, public discourse around childcare was experienced first-hand by those working at Kinbrae. It highlights the complexities that surrounded staff members' relationships with children, including the potential for stigmatisation arising from the very nature of the relationship itself and how it was viewed by the 'outside world'. These complexities extended beyond members of the public to the messages received by staff members from friends and family. In the example provided above, Mary was quite badly injured and had to receive a tetanus inoculation following a bite wound to her leg. She talked about how much she loved her job despite having to work hard to reassure her partner and other family members that she was safe at work and that the incident was not Daniel's 'fault'.

At Kinbrae, the data showed that much time and thought were given to relationships and the ways in which these could be genuine and meaningful for both children and adults, as well as the type of practice, culture, and support required to enable this. Quin, a senior manager, discussed the intensity of relationships and the concomitant emotions:

> *What I witness is, people invest a lot of themselves. Absolutely. And I think that does make it a lot more difficult, because I think there's not a switch off in the same way. Yeah, because I think it goes both ways. I think because of the intensity of time spent with the children, it can be really loving, beautiful relationships, or it can be incredibly challenging. So pushing you to your absolute limit [in] relationships in the same way that, you know, a parent who's got a child who's not coping particularly well and going*

> *through a lot, you know, when it affects them to the core [. . .] I think that's why the whole concept of love within residential care was one that always feels quite comfortable with me, because how can you spend so much time with people without developing some type of love for them, and developing genuine relationships with them? And if you develop genuine relationships, all these other emotions happen as a result of that.* (Individual Interview, Quin, 13 September 2021)

It appeared that, while not named explicitly, there was acceptance of the impact of having genuine relationships on the staff members and how this resulted in a sense of vulnerability. Quin went on to discuss the various support systems, or 'layers' as he put it, that were in place for staff, including one-to-one and group supervision, support from on-site consultants, and the training and clinical supervision provided to small staff teams by the DDP consultant (discussed further later). During participant observation and in the interviews with staff, these support mechanisms were characterised as fundamental to 'good' practice. What might be regarded as therapeutic mechanisms and systems helped to create a practice culture and environment where adults felt safe to create, develop, and maintain genuine, caring relationships with children. In effect, therapeutic relationships between adults were used to create a safe and secure environment for the children.

3.2. Creating Safe Spaces

Kinbrae had, over a number of years, invested heavily in DDP as a core therapeutic intervention. What was striking in our data were the ways in which DDP was understood and used by those who were trained in it. There were significant differences in how staff members discussed DDP, including fundamental disparities in its orientation; some staff members viewed DDP as a disposition (a way of being), while others regarded it as a discrete intervention (a way of doing):

> *TANYA: I think it's . . . it's not something that we do, it's something that we are [. . .] Yeah, so we don't say 'right, we're going to do DDP just now' we just do that all the time.* (Group Interview, Education Team 2, 16 February 2021)

> *And it works really well. Not all the time. Yeah, not all the time. But I think it works well. And everybody knows that you're away to do DDP, and some of them will stay in the background.* (Individual Interview, Duncan, 31 August 2021)

While DDP is described as an approach that seeks to achieve a team-wide attitudinal change [35], the contrasting views noted above show how the same programme of training and supervision can be understood and practiced in diverse ways within the same team.

Interestingly, in conversations and interviews, staff talked about the changes in process and practice culture that had resulted from the implementation of DDP rather than the specifics of the model itself. They identified the distinctive skills and abilities of the DDP consultant in the training and clinical supervision sessions, which were seen as creating a safe space for staff to open up and reflect honestly on their experiences:

> *And I think without [the consultant], yeah, [the consultant] is so important and what we're doing and, and not just the initial training or the level two training, but the sessions that we have with that as well. I think any gripes or anything always come out in there and don't get me wrong, it can be a really difficult session. Like sometimes I've left feeling upset before [. . .] and upset, but ready to start afresh almost. And that can just give you a better perspective on, I suppose it gives you a safe space to have things out. And so [the consultant] is a massive part in, I suppose helping us be in a place to support the children and recovery.* (Individual Interview, Philippa, 20 September 2021)

Philippa's account was representative of how most of the staff members discussed their experiences of training and clinical supervision. They regarded the DDP consultant as creating spaces where they felt safe to reflect honestly, to try out different ways of being and doing, and where they felt seen and valued. In many ways, what they described could be regarded as representing Roger's core therapeutic conditions [47]. These safe spaces and the kind of thinking, reflection, and acceptance that the consultant facilitated influenced other aspects of the working environment for the adults. This included the support and understanding that staff members offered to each other and a general recognition that, because of the complexity of the work, mistakes in practice were inevitable and that these could be acknowledged, learned from, and repaired without attributing blame:

> *I sort of think the training is part of it, but I think there also needs to be the right, the right culture to help people develop, and it not being, a, that sort of blame culture when something goes wrong. People make mistakes, people's buttons get pushed, you're in high intensity situations with the kids, sometimes. And they, things can go wrong, I suppose. But it's no, it's having that supportive environment and culture, I suppose. And openness with each other*. (Individual Interview, Ronnie, 22 September 2021)

Having the space to 'fail' and then to discuss and reflect on this in a supportive environment can facilitate transformations in learning and in practice [48]. Ronnie's example begins to demonstrate how some of the ways of thinking and being within the training and clinical supervision shaped the general ethos and practice culture. In turn, the 'everyday' permissive space and protective culture empowered staff and enabled them to trust the wider, more traditional processes of supervision and training. Most importantly, together, these elements appeared to contribute to an environment where adults felt safe developing deep relationships with children and were willing to try different approaches and ways of working with them.

3.3. Getting It Right?

Many of the staff discussed gaining confidence from the training and clinical supervision because they felt their practice was recognised and valued. Often this was through a process of affirmation, where training and supervision confirmed to them that they were doing the job 'right'. Having space to reflect on and consider not only what was being done to support children but also why staff members were responding in the ways that they did appeared to further enhance a sense of confidence and a view of themselves as skilled and knowledgeable practitioners. Staff were keen to have a clear sense that they were getting it 'right'. This was consolidated through a range of other supports, including formal and informal supervision and verbal and non-verbal feedback from the children in terms of their approach.

> **LEXI:** I think that's what I took out of it. Do you know what, after all, we must be doing an ok job?
>
> **TANYA:** Yeah.
>
> **LEXI:** and, yeah, there were bits you could take and go 'alright, ok, we could work with that' but, you know, it was more, you know, realising that you're actually doing ok

(Group Interview, Education Team 2, 16 February 2021)

The opportunity to continue to reflect and discuss practice in the clinical supervision sessions was seen as a way of continuing to feel confident in practice:

> *ANNIE: yeah, I think it was confirming, it's what we were already doing. But having, you know, [the consultant] then always keeping on top, and having these talks with [the consultant] you know, just reminds you and keeps you—'yeah, I am doing the right thing'—and it makes a big difference that you've got somebody that's, although, putting into words what you were doing before, we were doing all this but there's not a . . . a name for it. You know? And it's always nice to have that refreshing talk of why we're doing it, you know the reasons, and I like having the DDP [clinical supervision], you know, getting that every so often. It's good*. (Group Interview, Education Team 3, 17 June 2021)

This theme of 'rightness' was prevalent across conversations with staff, including opinions about 'being the right kind of person to do this work', 'doing the right thing', 'knowing the right thing to do', and 'feeling right when at work'. This concern for 'rightness' extended across practice and was not always related specifically to the DDP therapeutic model. Indeed, the 'right' practice was embodied in what could be regarded as traditional pedagogical approaches to residential childcare: head, hearts, and hands or knowing, being, and doing [49]. Pru and Florence, in their discussion below, highlight this idea of 'rightness' when thinking about who would first take Simone (child) in the car after a short car ban had been in place:

> *Pru was asking Florence if she should take her and noted that she wanted to and she 'felt like it was the right thing' because it would be her doing the run with her again since it was her and Simone the last time when there was an issue—that this would 'get that over with'. She asked Florence 'it feels like the right thing, but is it the right thing'? This was an interesting discussion where they were trying to work out together what would be the best approach and why*. (Fieldnote, 30 August 2021)

These types of discussions were frequent during fieldwork and highlighted the everyday ways in which staff reflected together on the best course of action and then followed this up by trying the approaches that they thought would work. When these were seen as successful or unsuccessful, further discussions and reflection would be used to try and determine why so that they could get it 'right' in the future.

Overall, then, it appeared that the processes that were instigated as a part of introducing and embedding DDP, such as creating safe spaces for honest reflection, opportunities to test out new ways of being and doing and recognising and valuing the work of adults, were important to staff and discussed by them more often than the specific knowledge elements of the DDP model, which is a point we take up in the discussion.

4. Discussion

Relationships are key to promoting the healthy development of children and aiding their recovery when they have experienced neglect and abuse [30–32], as highlighted by the data generated in our study. In the course of this paper, we have suggested that residential care is not simply focused on trauma and recovery but rather is a place where childhoods (and the play, friendships, talents, interests, and experiences) are also played out; it is a complex field where adults, as well as children, can be vulnerable [3,16]. Therefore, the provision of suitable, everyday care via genuine, caring relationships in this context is fraught with potential difficulties and barriers.

This complexity makes determining what is therapeutic (or not) about everyday residential care especially difficult as there are differences between and within residential settings, regardless of any model or approach that is employed [50]. For example, the values of care, comfort, and safety may be readily agreed upon by those working across this sector; however, Jakobsen [51] argues that values such as these are 'rationalised myths', which provide no insight into the everyday lives of children and young people (p. 225). Jakobsen [51] highlights differences in how such value conceptualisations are interpreted both across and within different settings, including those where staff are highly trained in particular theoretical models of childcare. Jakobsen's arguments are useful for beginning to think through how everyday care is likely to vary within and between residential settings. This creates a challenge to designing and implementing controlled trials in this field.

Another aspect of the complexity in residential settings arises from a context of different, interacting, and multi-level relationships. For example, Brown et al. [16] discuss how macro factors (such as the portrayals of historical abuse in the media or the individualisation of blame in childcare discourses) interact with micro factors (individual workers' conceptualisations of role and identity) to generate fear for residential childcare workers who are using relationship-based practice models and how this can impact on the everyday care that they provide. This vulnerability of adults and its impact on practice is further discussed by Kor et al. [17], while Steckley [48] highlights the difficulties that practitioners can have with both learning and negotiating personal and professional boundaries. At times, in line with Brown et al. [16], vulnerability appeared to occur as a result of outside pressures. This included being able to cope when children were very distressed or dysregulated and was acute when in a public space where the child and the adult were seen to be judged and not well understood. Staff members were also made vulnerable by the words and actions of their own family and friends, who they felt did not always understand the context of the work and who worried for their safety and wellbeing. Perhaps most profound was the vulnerability experienced through having genuine and deep relationships with children in the knowledge that the relationship could end or be disrupted at any point and where, despite a model of 'relationship-based practice' being employed, such relationships had to be navigated through the complex terrain of the personal and professional, the adult as a person and the adult as a staff member.

Arguably, the ways in which vulnerability is experienced and managed are determined by the ethos and practice culture of the residential setting. At Kinbrae, the organisation used DDP to change the practice culture and environment over a nine-year period. They were keen to develop an overarching model to help guide and shape their support of children and their vision for the service. While all staff spoke positively about the DDP model and training, the vast majority focused on the reflective spaces and support processes involved rather than the specific theories or skills promoted within DDP. The reflective elements of the training, such as when staff reflected on their own childhood experiences and relationships, as well as the safe spaces that were created in the clinical supervision sessions, were central to why they thought the DDP model was working well. Beyond this, they stressed the value of having opportunities to try out different ways of being and doing with children, both in training and in actual practice, and for their work to be seen and valued. Crucial to this was the need to feel like they were doing it 'right'.

These findings generate some critical questions about whether it was the DDP model per se or whether there were some underlying processes that can offer wider learning for the residential childcare sector, regardless of which specific model or models are being implemented. What was evident during this research was that close, genuine, meaningful relationships were permitted and encouraged to be formed between adults and children; time and thought were given to how these relationships developed; safety appeared to be created around these relationships in the full understanding of their complexity, knowing that difficult situations would arise and mistakes would be made; and adults were supported with the range of feelings that arose from these complex relationships.

Importantly, it was *how* this was performed that seemed to impact the everyday experiences of the adults and children. DDP offered a way to think more broadly about the place that staff wanted to work in and how they thought children would be best cared for. DDP appeared to provide a framework around which a set of training and supervision processes were implemented. However, the knowledge content of the training (attachment theory, neuroscience, intersubjectivity, and developmental trauma) could arguably be covered by other models, combinations of models, or through bespoke or ad hoc programmes developed locally. Rather, it was the development of safe, ongoing opportunities to think deeply about self and others and practice ways of being and doing and being seen and valued that appeared to create the conditions in which adults felt safe developing and maintaining genuine, caring relationships with children in this setting. Most importantly, it was these relationships and the everyday care that was provided in and through them that appeared to make a meaningful difference to children and young people. In this regard, the model and the practice that resulted were not directly therapeutic. Indeed, it appeared that the therapeutic elements of being seen, accepted, contained, and supported in a consistent and safe way were directed at and experienced *by the adults*, not the children. However, what this allowed was an environment full of adults who could offer everyday, family-like care in the most empathic and connected way despite the often rejecting and confusing protective responses from the children. The children were being 'super parented' by consistent and emotionally available adults. They appeared to be able to do so through the containing structures in place.

5. Conclusions

This paper has suggested that, in many ways, the specific therapeutic model employed by residential childcare is secondary to the facilitation of safe, ongoing opportunities for staff to (a) think deeply about themselves and others (children and staff), (b) practice ways of being and doing, and (c) be seen and valued. Arguably, these could be viewed as therapeutic conditions. These opportunities and processes can contribute to a practice culture and context in which adults feel safe and able to create genuine, caring relationships with children.

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Article

Navigating Fragmented Infrastructures of Care: Children's Sense of Home in Residential Education

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Abstract: Residential education often both challenges and reinforces the norms and systems supporting children and young people's need for homely environments. In this context, studies on pupils' sense of home when attending residential schools provide a ground for exploring broader infrastructures of care available to them as they move through different spaces. Drawing on autoethnography, life-story interviews, and semi-structured interviews, we illustrate how, for children within the Latvian residential school system, homeliness may be found at a relative's apartment, school bus or youth center affected by how each of the spaces relates to children's safety and control, privacy, community, identity, everyday life, and time. While normative discourses remain fixated on home as a family space where infrastructures of care can be limited, but educational settings emphasize control as a measure for safety without being attentive to peer-to-peer relationships, children's agency in achieving a sense of homeliness becomes fragmented and stronger in some places more than others.

Keywords: home; alternative care; residential education; care; infrastructure; agency; children

1. Introduction

Since their establishment, residential schools have both challenged the norms of what kind of homely environments children and young people should reside in [1] and provided options for filling gaps in care available in domestic spaces [2]. Nevertheless, the vision of how to provide positive homely experiences at the interstices between the residence of a child's caregivers and the school, if such a division exists for them, has been both changing and contested. 'It all starts at home' is a common phrase the staff of residential schools repeated when reflecting on societal problems during our research as well as during the first author's childhood stay at a residential school. This statement both describes home as a challenging environment, alludes to a perceived failure of home to provide a positive experience, and reifies a division between the private space of a child's home and the public space of an institution. This division, however, rarely reflects the lived experience of children themselves as they often experience constant transitions and transfers between home and institution, state official visits in their homes or parents being asked to appear in school, without even mentioning the movement of the children themselves. From the child's perspective, therefore, the meanings of home are not always that clear as experiences of home and homeliness are often fragmented and do not neatly fit into hegemonic positive definitions of home and family environment.

Drawing on autoethnography, semi-structured and life-story interviews in Latvia about periods from 1980 to 2020, in this paper, we explore the meanings and experiences children ascribe to home when attending residential schools. In trying to understand children and young people's experiences in multiply contested and often violent environments, our central research question is: what forms of agency are possible for children and young people in alternative care in constructing and experiencing homeliness within fragmented home and family environments? Theoretically, we draw on anthropological approaches to home, infrastructural approaches to care, and studies on domains and practices people ascribe to home to analyze how power relations, peer relations, and opportunities for different activities affect children's experiences of home in expected and unexpected spaces.

While residential schools have a long and complex history in Latvian educational and social support systems, they have not garnered significant scholarly attention either locally or abroad. To examine how it relates to the broader context of children's life outside the institution, we propose a synthesis between the infrastructural perspective on care and the subjective meanings of home that allows us to critically evaluate the impact different social structures have on the maintenance of care and creation of homes for children attending residential schools. By examining how young people navigate the intersections between homes, residential care, and education, we contribute to the study of children's sense of homeliness, the agency of children and young people, and broader societal infrastructures of care.

The Meanings of Home in and between Residential Education

In everyday use, home, housing, and homeliness host a variety of meanings. If people often use the notion of home to describe homeliness and belonging, critical approaches also recognize how the home is permeated by intersecting forms of power and gendered, aged, and kinship-based orderings of space and labor [3]. For example, in a collection on ethnographies of housing, anthropologists [4] treat it as a practice of housing that is "at once a built-shelter; a collection of relations, affects and moralities; and a node within neighbourhoods, communities and larger political-environmental regimes". In this perspective, the domestic and public spaces in and outside of residential education can both be viewed as nodes of different practices that aspire to produce relationships and spaces seen as appropriate for children and young people.

Relationship-building possibilities form a key role in shaping residential experiences. In their review article on positive peer relationships in alternative care, Haddow, Taylor, and Schwannauer [5] have shown that the ability to establish friendships during one's stay in alternative care institutions, such as residential schools, can have several measurable positive effects on adolescent life both in the institution and after it. In this context, particular attention should be paid to practices of care. According to [6], housing is sociomaterially constitutive of care not only through organizing domestic labor but through systemic arrangements of the housing system formed by materialities, markets, and governance. Thus, the arrangements in the governance of housing and residential patterns formed by policies and institutions affect what forms of care are possible in different spaces. In our case, we take this infrastructural lens on care to explore how it is related to experiences and meanings of home instead of housing. This allows us to observe how the infrastructural arrangements of homes and residential schools shape children's sense of home and their agency in affecting its aspects. From this perspective, it becomes possible to explain how children might feel at home in multi-sited and unexpected spaces due to feeling more comfortable in certain relations of care accessible in one space than in others. This also allows us to overcome the fixed concept of home (house) as opposed to other spaces, such as the street [7].

Not only due to differences in relations of care but also due to different forms of separation in time and space and the differing power relations forming domestic and educational spaces, residential education can produce fragmentation in experiences of home. In untangling such fragmentation, it is useful to build on approaches that have analyzed qualitatively different meanings people ascribe to home. For example, treating subjective understandings of home as based on practices, Pennartz [8] distinguished five main factors that his research participants most associated with home: "communicating with each other; being accessible to one another; being relaxed after having finished work; being able to do what one wants to do; and being occupied, absence of boredom". Also focusing on practices as strategies, Falk et al. [7] have distinguished three dimensions of the environment in creating a sense of home in residential care: (1) attachment to place, consisting of strategies for nesting and being in charge; (2) attachment to place, consisting of strategies for taking part in activities with others, expressing personality, and making friends; and (3) attachment beyond the institution, consisting of strategies for bridging the gap between past and present, and attending home someplace else. Similarly, during the experience of residential education, our interlocutors felt that their sense of home depended on such situations, strategies, and practices due to the interstitial nature of living in and outside of the institution.

Using a slightly different approach, Després [9] has categorized the meaning of home into six themes: safety and control, privacy, community, identity, everyday life, and time. While some of the themes correspond to the practices described by Pennartz, Després' categorization opens possibilities to analyze not only practices but also how broader socio-political regimes permeate these themes in our interlocutors' experience of home. Thus, in our exploration, we take inspiration both from Pennartz and Després, combining it with analysis of how intersecting forms of power and socio-material enablers of care in places where children reside shape their agency in finding homely situations in their life in and between residential education.

Residential schools in Latvia are called internātskolas, the term coming from the period of occupation by the Soviet Union (from Russian школа-интернат) and refers to an institution that is both an educational facility and a dormitory, which may also provide the pupils with additional support such as meals and clothing. This type of institution is not exclusive to Latvia or the Baltic region. Residential education has historically been used around the world both for educating the elites ([10,11]) as well as part of the colonial systems to re-educate the native population ([1,12–15]).

Examples closer to the research locality shows that most research in similar institutions has been conducted in Russia. Alleman [16] has explored how the residential school system is used as a tool of social reproduction in the Northern part of Russia, and in a similar vein, Khlinovskaya-Rockhill [2] in her exploration of childcare systems in Russia also explores the role of residential education. Current scholarship has also been focused on the culturally specific forms of residential education ([17,18]).

Nevertheless, the residential school system in Latvia is distinct from these approaches, as it does not deal with elite education or the assimilation of indigenous people. Therefore, we focus on the way residential education is proposed as a solution to a system where the resources available for caring for children and young people are limited and in time, the residential school system becomes self-sustaining regardless of the support mechanisms available to its inhabitants. Here, it is pertinent to remember that within the Latvian system, residential schools are not recognized as part of the alternative care system but only as educational institutions [19]. Within such a system, the children are not transferred away from their families as the state is neither able nor willing to take full care of them, but rather, they enter a system where they may return to their parental household only on weekends, only on holidays, or only between semesters, therefore making the experience of home unstable and fragmented. During the time of research, the total number of institutions kept shifting as the country was in the midst of a deinstitutionalization process which included a goal of closing down the residential schools, a goal that was never achieved. As there is no unified system within which the schools need to state whether or not they have boarding capacity, the number varies greatly. In my research, I came to rely on the data from the Ombudsman's Office of Latvia, which stated that there were 115 residential schools in Latvia on 29 April 2020.

As the institutions are employing creative tactics to avoid deinstitutionalization there is great variety in the names, sizes, and locations of the institutions. A residential school may be called "school with residential capacity", "centre of development", "school for children with special needs", or there may be nothing mentioning the fact the school has a residential capacity in its name at all. Nevertheless, they can be found in most regions across

Latvia, including in the capital city. Overall, despite being state or municipal institutions, the residential schools are ostensibly invisible to the official discourse.

Therefore, examining the context of infrastructures of care becomes relevant in understanding why children find meanings of home where they do. As argued by Massey, "in context of 'a place called home' both the geography (proximity, time space distanciation, etc.) and the content of the social relations themselves (full of the implications of sexism, or of the power relations of colonialism present or past, or of the relations of capital accumulation) must be taken into account" [20]. However, this process cannot be perceived as only happening to children as passive actors. As we illustrate later, children and young people redefine the notion of home and homeliness by establishing it in new and unexpected places. Thus, exploring the different ways children find a sense of home or its lack in residential education offers the possibility to analyze the ability of children and young people to create homes and respect the ways they choose to do it.

2. Materials and Methods

The data for examining residential school pupils' sense of home was collected by drawing on life-story interviews, autoethnography, and semi-structured interviews. The fieldwork phase took place from late 2019 until early 2021 and was significantly impacted by the presence of the COVID-19 pandemic. The project was part of a broader ethnographic research on the residential school system in Latvia, forming the first author's doctoral dissertation. While we build on more throughout fieldwork on the workings of the residential school system, the analysis is mostly based on an in-depth analysis of three individual experiences of attending residential education.

A key source of data was life-story interviews with two former inhabitants of residential schools, forming the opportunity to analyze how their sense of home was formed and changed over time. As argued by [21], the life story should be viewed not as either only the story of the participant or the information that has been craftily acquired by a researcher but rather as a result of coproduction between the researcher and the research participant where the participant is actively constructing the story as they see it. While a sense of home was not the major topic explored by the interviews, it inevitably came up as participants constructed their experiences of moving between caregiver home, residential school, and other spaces of importance as part of the formation of their self.

The participants of life-story interviews were recruited during the fieldwork on the residential school system in Latvia through personal contacts and residential school staff. This process relied on word-of-mouth as many of the former residential school inhabitants were rather reluctant to discuss their experiences. For this reason, I relied on my other research participants for introductions and contacts to gain access to the interviewees. The first interview was conducted with Antra (pseudonym), who was in her fifties and had studied in a specialized residential school geared toward children perceived as gifted but functioning similarly to ordinary residential schools regarding its residential capacity. The second interview was with Dzintars (pseudonym), who was in his twenties and had studied in a regional residential school that used to be one of the largest regional educational facilities, though it had already undergone several reforms and downsizing, which had left it as a shadow of its former self.

In both life-story interviews, I started out by establishing the starting point of the stories, which was the entry point to the residential school. After that, I allowed the research participants to continue to tell their stories the way they wanted. After they had finished their initial stories, I followed up with some questions that I developed during an interview and if they felt comfortable with it, I also proposed developing a participatory timeline as an additional tool to help them get their story across. In both cases, participants started with a short synopsis of the main events and later expanded on significant episodes or key points they wanted to make.

The other large data point was the autoethnography of one of the authors, Artūrs, on his own experience of inhabiting a residential school for his first nine years of education.

The primary objective of autoethnography is to establish a connection between the personal and the cultural field by situating the self within a social context [22]. This approach enables readers to gain insight not only into the data gathered from others but also into the inner world of the author. Our approach to the analysis of life-story interviews connects this study to the autoethnographic method, which is grounded in a similar interpretivist tradition, as the purpose of research is not merely to faithfully describe lived experiences but rather to focus on extracting meaning from them [23]. This approach rejects the positivist notion of maintaining an objective research stance and requires the author not only to narrate relevant experiences but also to maintain a critical perspective when selecting which experiences to describe and how to do it. In our case, the involvement of a co-author provided an additional critical viewpoint, which we represent in our writing by describing the autoethnographic data in the third person.

The data was collected by Artūrs writing his memories as he remembered them and identifying the important themes in them. The initial version of the story served as an entry point for our autoethnographic data. This was later complemented by the main corpus of the autoethnographic writings, which were produced later in the writing process and in relation to other types of data. Such an approach is characterized by Ellis, Adams and Bochner [24] as "therapeutic writing", which works to both help the author to come to terms with their experiences as well as to communicate their experiences to the readers.

Finally, to research the broader context of the residential education system and to include the voice of staff members from the residential schools, the project also included eleven semi-structured qualitative interviews with the staff, local officials, state officials as well as parents and family members of people who were living or had lived in residential schools conducted by Artūrs and his colleagues These interviews were conducted as part of the wider research project and included questions both directly related to the topic such as the everyday life in educational facilities and about the relations in the community as well as about more general themes relating to the wider research perspective on non-violence. Through the combination of the three data sets it was possible to break down information about both wider workings and perspectives of residential schools as well as experiences and practices within.

The research was conducted as part of a dissertation for which approval was received from the University of Latvia ethics committee. Names have been either removed or changed, aside from Artūrs, to protect the anonymity and confidentiality of the participants, while the details about residential schools were omitted to avoid potential harm to both the participants and schools. While our research and data are affected by Artūrs' insider perspective and our involvement in children's and housing rights as well as violence prevention advocacy, in this paper, we focus on analyzing the perspectives present in our data.

Data were analyzed using qualitative coding with a mix of open and a priori coding [25]. While the dissertation's chapter on which the paper is based used a different system of codes, for the purposes of the article, the data was coded for the second time to represent the different themes emerging in the context of participants' experiences of homeliness. The major themes brought out by analysis clustered the data by (1) pathways to residential school; (2) safety, control, and privacy; (3) community and identity; and (4) everyday life and time, bringing together [9] thematic categories of meanings related to housing in clusters of two.

3. Results

3.1. Pathways to Residential School

As described above, residential schools have been a part of Latvian care and education systems for a much longer period than we describe in this article. We concentrate on the way residential schools have worked from the 1980s to the 2010s with the aim to provide the readers with information about specific characteristics of the institutions in different time periods, which illustrate both the changes and the continuities within the residential education system. This is described mostly through exploring the life stories of three core participants who each entered the residential school during different time periods and in a different locality.

Starting with Antra, she lived in her residential school during the late 1980s during the Soviet Union's occupation of Latvia. In her story, her arrival in the residential school is the result of her own talent and the opportunities the school presented to her:

> I was about 4–5 years old, I was taken to a music conductor and found to have absolute pitch. [..] And I was taken to Z [prestigious Latvian vocational school for musicians]. But in that year, there was no building in Z, the accommodation building was under repair, because Z also was a residential school. Therefore, there was no admission that year for those who need an overnight stay. [..] And then there was the idea that they would go to [another residential school for musicians] and then maybe move to Z. But of course, once I got there, I stayed there.
>
> (Antra)

Later in her story, however, she also revealed that her continued education and life within the institution were connected as much to the specialized education available in the school as well as the challenges experienced by her family during her studies. The conditions at home were fraught with tension due to domestic violence between her parents, which eventually turned toward her. This setting created the conditions for not only entering residential school but also staying in it and prevented Antra from perceiving return to home as something that might bring her the support that she needed due to the often violent environment within school walls.

> From later classes I certainly remember everything that has to do with something, those moments, like not getting up in the morning, one of the teachers comes in and just turns the bed upside down or in the gym if the teacher does not like something and they just pull you down from the gym wall by your leg, or there is something else they don't like and they simply hit your legs with a fly swatter—that was normal, it was an everyday occurrence, nothing out of the ordinary.
>
> (Antra)

In turn, Artūrs had his years in residential school around the millennia, and for him also, the transfer to residential school was presented as an opportunity:

> At the time it was explained to us that as my sister was excelling in physical education, we should start studying in town to make sure she has access to additional support for her talent. What was less clear, was why I also needed to go with her as my physical achievements were virtually non-existent. Still, this was what my parents told me, and I believed them at the time.
>
> (Artūrs)

However, similar to the case of Antra, for Artūrs, the continued stay in residential school was also the result of the challenging conditions at home. Both of his parents suffered from alcoholism, and everyday life was often fraught with challenges connected to poverty, neglect, and violence. The last sentence from the excerpt is important here, as for Artūrs, these things were not the reason to enter residential school. As far as he knew, most of his peers in his home village lived in similar conditions, and he perceived the conditions at home as normal. Nevertheless, the conditions at the household were complicated enough that eventually, he also learned to recognize that neither school nor home provides a safe space for relaxation and enjoyment of the community.

Finally, Dzintars entered the residential school in the 2010s due to the economic hardship experienced by his family. Dzintars' experience took place after the financial crisis of 2007–2009 in times of deep-state austerity. Though school buses could transport children to and from school, their availability depended on the number of students and at a certain point, it did not cover the transportation costs:

> The thing is, we had a bus that drove us to elementary school. It was a school bus. It was a kind of private property of the school. There was a hired driver who drove the children. There was not enough of us at high school at the time and so we didn't have that bus.
>
> (Dzintars)

Here, we see that the entry of Dzintars into residential school is not necessarily the result of additional opportunities, nor is it connected to the same level of challenges within his family. Rather, for him, it is more openly connected to larger social processes, which stay obscured in the stories of Antra and Artūrs. Here, the home environment is not something that is necessarily experienced as fraught with danger but rather as remote, unreachable, and distant. This was the same argument that was often used by other research participants, as both school staff and state officials, often when discussing residential education, fell back toward discussing the significance of residential education regarding the physical distance between schools and the living places of pupils. Dzintars' choice to look for a home outside of his own family household was a result of having to stay within an institution, which again proved to be unsafe, as well as failing to provide him with options to spend his free time in a way he had hoped for.

All three pathways to residential school show that it is never a simple choice and emerge in the context of relationships in each family environment and broader social processes affecting access to education. In effect, these challenges to housing and relational permanence have strong effects on one's sense of home in how it fosters or aspires to ensure homely safety, control, community, identity, everyday life, and time to which we now turn.

3.2. *(Un)safe Homes: Resistance and Control through Hidden Kettles and Broken Flowerpots*

While children in most contexts are treated as in need of safety, control, and privacy, the amount of surveillance and opportunities for personal choice are highly dependent on one's caregivers and institutional practices. Due to this, safety and privacy were often ambiguous for both the residents and the staff members of the residential school. Both ones' home outside the school's context or the school were often contested as sites lacking safety and control.

> It also depends on the family. However, they cannot bring him home every night. It is exactly this rejection. Let's be honest: even the worst family is better [than residential school], except for one with violence in the physical sense, where children are beaten and young children are neglected, who do not have a chance of surviving as their parents are drunk and [the children] simply cannot protect themselves.
>
> (Gundega, principal)

This excerpt illustrates the often-contradictory view of the families of residential school pupils. Life within the family was perceived as being necessary for a child's well-being; however, it was exactly the question of safety where most of the professionals drew the line. For them, the main function of the institution was to provide safety for children in complicated conditions, therefore reflecting a long-running trend in former socialist countries where families are often described as "problematic" and seen as irreparable. A strategy of state institutions including residential school can then be to extract the child from a 'dysfunctional family' (*nelabvēlīgā ģimene* (*Nelabvēlīgā ģimene* is Latvian version of the Russian *neblagopoluchnaya semya*: "The term *sotsial'no-neblagopoluchnaya sem'ya* readily evokes the image of alcoholic, low- or no-income family, living in poor and dirty dwellings, with poor hygiene, diet and health, unkempt personal appearance, and a lack of material goods, good furniture or clothes". (Rockhill 2010).)) rather than provide support for the family. This also meant that staff saw pupils as 'damaged' and their care, therefore, was directed toward managing this damaged state. When the child enters the residential school, these preconceptions are already there, which often leads to either internalization of this feeling of being damaged, which is sometimes accompanied by angry rejection of the system that demands acknowledgment of their damaged state. Interview data with school staff, however, indicates that this usually results in achieving the opposite, as teachers and other school staff were more likely to see this as confirmation of their suspicions. This contributes to not only a lack of belief in the care provided by the institution but also significantly contributes to the insecurity felt within the walls of the institutions which are seen as threatening rather than comforting.

For children themselves, the idea of home, therefore, becomes complex as it becomes hard to pinpoint where exactly to locate 'home'—is it the institution, the place where they live with their parents or something else entirely? Adding to this, in both settings, the child may experience high levels of control over their life by others while lacking it themselves. Whether referring to the decisions of their parents to transfer them to residential school or the need to fit their daily lives within the daily schedules of the institutions, lack of control over their lives contributed significantly to the sense of uprootedness for research participants.

To overcome this and gain a sense of control, the pupils applied different strategies. Some were geared toward developing a sense of safety, control, and privacy within the institutional context. From Artūrs' experience, he can remember many instances where the destruction of doors, closets, windows, and even houseplants brought a sense of joy and accomplishment during the most boring and/or frustrating days. This was often not done openly but in a form of hidden protest that allowed to feel some agency in residential school. The results were, however, always tenuous, intermittent, and fleeting.

Another dimension that appears through the resistance to the rules of the institution is the tension between various levels of oversight.

> Q: You mentioned that there was no kitchenette for pupils at your time.
>
> D: There was no kitchenette. I had my own toaster or a kettle. [..]
>
> Q: Were pupils allowed to have these?
>
> D: Officially no. Unofficially, yes. The educators knew about it. But when the big inspections came, [the educators] knew, who had toasters and kettles. We were informed and we hid it all quite nicely.
>
> (Dzintars)

Here, we see an example of oversight and control that is simultaneously enforced and resisted by the residential school staff. The use of appliances such as a kettle may have been forbidden for numerous reasons, starting from fire safety and ending with their symbolic meaning, where the need for pupils to make their own food would indicate insufficient meals from the school, but the professionals who were working in direct contact with children were aware of how these requirements sometimes needed to be skirted in order to maintain what they saw as good care.

While it is not impossible to feel at home in a residential school or at one's caregiver home, children themselves enact upon their agency and resist the often violent experiences in their families and/or in the institutional setting. In Antra's case, a sense of homeliness was provided by an extended family member's home living closer to the residential school rather than her parents' home.

> Oh, also, I kind of lived with my grandfather's sister in [..], and on holidays I went to my mother's family. But since my grandfather's sister was in respectable years and she was not ready to take me home every day, they still chose the residential school. And then on weekends I went to her, and on holidays to my parents. Not to my parents, to my mom and foster father.
>
> (Antra)

Antra associated both her parental residence and residential school with difficulties as she experienced domestic violence from an early age, and when she was transferred to a residential school, the situation did not improve. Though she was no longer abused physically by her parents, residential school staff was still often violent toward pupils, which again prevented Antra from experiencing a sense of security and care. In contrast to Dzintars, Antra did not speak fondly about her residential school and home experience but rather turned toward her grandfather's sister as the key carer in her life while also talking about isolated cases of care in residential school by reflecting on educators, teachers, and staff she remembers positively. Although these cases were isolated and few, they illustrated another important component in the creation of a sense of home, which we look at in the following chapter, namely, establishing and maintaining a community that helps the individual child to grow and develop their own sense of identity.

3.3. Relational Homes: Building Communities and Identities at Unexpected Spaces

The need to have a space for communicating with others who are providing the child with support and encouragement was expressed by all research participants. However, the fragmented experience of home when attending residential schools, which was often the result of one's position in one's family and accessible communities, meant that the related identities the child associated with were often also fragile and threatened. Importantly, when residential school experiences were as traumatic as those at home, the children looked toward other spaces. While the interviewed staff revealed several cases when children ended up living without any adult supervision, it was assumed that children were avoiding home, not the institution. So, in their interviews, teachers from the institutions often referred to the residential school as an escape from the difficulties experienced by children at home, while the complications experienced within the residential school were treated as exceptions and not seen as connected to the reluctance of the children to engage with adults or official support systems. Our cases, however, make a case for problematizing both. Importantly, for Artūrs and his interlocutors, their sense of home was frequently found elsewhere, away from residential school or family home. Mostly, these were related to positive experiences of community and care.

In Artūrs' experience, the place where his parents lived was often unsafe and lacked a caring relationship. He did not have an extended family where he could look for an alternative care environment. Importantly, despite his stays at the school being longer than for some others, the school environment and community did not foster a sense of home either. He did not enjoy extracurricular activities and was either too scared or too angry to participate in any of the organized activities for a long time, showing unattached relationships with peers.

Children in his residential school formed relational identities divided into those living in the school (*internātnieki*) and those going home after their studies (*mājnieki*). Though there was quite a stable division between *internātnieki* and *mājinieki,* in some cases, this line could be crossed. Artūrs was one of the few children in residential school who not only crossed the line between both groups but was even able to sometimes visit his friends during afternoons. This did set him apart from other children staying in residential school as he never heard of anyone else visiting their friends at home.

In Artūrs' case, the alternative positive relationships were formed through friendships outside the residential school, allowing him to avoid constant presence in the 'abusive community' of the residential school and develop relationships that were based on trust and care for each other. While navigating the constant sectarian warfare of the residential school during afternoons, he had the alternative option of sometimes leaving all of that behind and visiting a friend to play video games. One of the possible explanations for his privileged status could be the fact that he entered residential school a year later, which meant that while most of his peers had already figured out how to persist in the abusive community of residential school, draw the battlelines and establish positions he arrived without all this knowledge which at the same time made his position deeply unstable.

It often made him the target of ridicule and bullying while also allowing him to craft relationships without falling back to the established antagonisms between *internātnieki* and *mājinieki*. Additionally, he never really fit in with the usual assumption about the *internātnieki*—he read too much and fought too little. All of this gave him the opportunity to build resources that would later help him to last through all his years in residential school.

If Artūrs found a sense of home in meeting his friends outside of the school, Dzintars found it at a youth center, which provided him with a space where he was listened to, able to express himself, and could relax, which was more challenging in residential school due to his experience of being bullied. In Antra's case, what made her grandfather's sister's apartment feel like home was not only the act of returning there on weekends but rather social relations that took place there and helped her to counteract both the physical (as her apartment was located in the same city as the residential school unlike her family residence) and emotional distance that characterized her experience in her parent's home and residential school. Antra also emphasizes the importance of "other workers" within the residential school context, pointing out that while interactions with teachers and educators were often complicated and sometimes violent, she found other adults in her life to be more friendly, such as school nurse, a cook, or a dentist. It is interesting to note that at the same time, this part of school personnel was regarded very low by state officials in their interviews. For them, the expanded technical and support staff of residential schools represented yet another problem in the form of additional costs, without realizing their potential role in the provision of a home environment for students in more ways than one. The relational aspect of feeling at home here is realized despite the lack of kinship relation or professional skills of the staff but rather established through a kind and supportive attitude forming an important part of the institutional infrastructure of care.

The experiences and practices described in this chapter show that in order to be able to establish a continuous community, it needs to incorporate both relational aspects, such as a supportive and cooperative environment, and activities that help the children to find meaning and fulfillment in the activities they are engaged in. The fragmented nature of the residential school environment meant that the activities that were available were often either relaxing but rather boring or exciting but potentially violent or dangerous. To counteract this, a different type of practices are necessary which we describe in the following section.

3.4. Everyday Homes: The Excitement of Spending Time in Transitional Spaces

As described above, everyday life in residential schools was often filled with boredom interspersed with episodes of violence and resistance for research participants. This meant that far from having a space where they could feel relaxed and not bored, they often experienced the exact opposite. In this chapter, we turn toward describing how alternative spaces were carved out by Artūrs and other research participants with the aim of establishing spaces that not only allowed them to survive but also to develop their skills and talents or to recuperate from the challenges, expecting them on both ends of the residential care continuum.

When relationships of care are not available in either one's caregivers' home or the institution, where can the child overcome loneliness and gain a sense of fulfillment? This question may seem irrelevant in the case of Dzintars, who, as we saw, did receive the most support and talked both about residential school and his parent's house as his home. But also, in Dzintars' case, the space external to the residential school or place of his origin becomes imbued with many of the qualities that are usually assigned to the home environment:

> Then every Monday afternoon after the school, I was a little late for evening learning. I had already told the educator that I would be a little late that I had to be there. Then was the first round [at the youth centre]. Then there were those two-hour evening lessons. Then we ate dinner and then I went out from about seven to eight. I went for the second round for a bit. We were basically

> the ones who stayed last, because for visitors it shuts down at nine, I think. But we walked away around 21.30. Sometimes because we just didn't have a choice, because until the last moment we sat there, worked, hustled, thought how to get it all done.
>
> (Dzintars)

Throughout the interview, Dzintars talked about his experience in his town's youth center fondly and considered it one of the formative experiences in his life, both because of the skills he acquired there and the sense of belonging and appreciation he experienced. But here, he shows that it was the ordering of time with meaningful social activity that was also crucial.

The second space that we see as constituting home for Artūrs during his residential school years was the buses. Despite the ever-changing experience of using public transport (different seats, other commuters, and different buses), there was always a certain comfort in stepping onto a bus, looking for a seat, (hopefully) finding one, and for around two hours not having to think neither of whether his parents are sober nor about whether he will get physically attacked or humiliated by peers.

Artūrs' experience during the bus rides illuminates the ways individuals from remote regions can exert agency on their isolation and creatively resist feelings of distance and isolation. By engaging in activities such as listening to music or reading, the space within the bus can be enhanced to become more comfortable and safer. This creates not only disassociation from the temporary setting of the perceived homely environment but also serves to reinforce it as repetitive and, therefore, somewhat stable. Artūrs' experience also illuminates the ways individuals from remote regions can exert agency on their isolation and creatively resist feelings of distance and isolation. While it could certainly be argued that Artūrs' engagement with books and buses and the subsequent sense of home is the result of loneliness and isolation, it also represents an active choice to craft a livable space in public, relatively unsupervised but also perceivably safer space.

What characterizes the spaces inhabited in both cases is their transitory character, as our participants were only expected to stay within them briefly and temporarily. Their experiences, however, illustrate how the experience of a homely environment may also be experienced in settings such as buses or youth centers. This characterization of home as transitory also helps to better understand the significance Antra assigned to the extracurricular activities during her school years, as during her interview, she spoke very highly about the hiking trips organized by one of the schoolteachers or the obligatory work component of the residential schools in the Soviet Union. For her the positive connotations of these activities not only arose from the ability to escape the control of the family and institution or the ability to create new and different relations. The significance is also tied to the way these events interrupted the daily life of residential school inhabitants and how their very form as somewhat disruptive activities allowed her to reclaim her agency with meaningful activities within transitory spaces even if the larger structures were still unchanged. This is represented by the story in an interview with one of the local deputies who explained how residential school children were taken on a trip to the nearest youth detention center with the aim of showing them what their future is going to look like if they misbehave. Extracurricular activities such as this one do not serve the purpose of reclaiming children's agency but rather in the opposite direction and remind them of the way the staff perceives them.

For Artūrs and Dzintars, the public space became most resembling homeliness. As the private space becomes associated with a lack of security and a sense of threat, they both found public spaces being somewhat regulated and safer than a room in a residential school or, in Artūrs' case, also home back in his village. Similarly, a bus to a friend's home was always transitory, which led to the development of a particular relationship with other human and nonhuman actors within the space. This makes the individual aware of the constant need to renew their relationship with things and people and, in the end, may not help to overcome the lack of trust and care that pushed them toward the alternative space in the first place.

4. Discussion

In this paper, we have focused on how children in residential education construct their sense of home across the domains of safety and control, privacy, community, identity, everyday life, and time. According to our analysis, the differently distributed infrastructures of care across family homes, residential schools, and different interstitial spaces create a fragmented sense of where homeliness can become located. In each domain, a different space may become more dominant in producing homeliness as the freedom to do one's desired activities and benefit from caring and supportive relationships when one's home does not provide it.

Our exploration of safety, control and privacy illustrates how residential schools struggle between establishing different levels of control aiming to ensure the safety of the inhabitants while trying to negotiate space for care and support, which the very same safety practices may ban. This leads to an unstable and fractured experience for the inhabitants, who end up living in a hyper-regulated and simultaneously confusing space to which they learn to respond through small acts of resistance, which further confirms the need for increased control. In this way, residential school becomes a mirrored image of the experience that the pupils already experience at home, where the adults entrusted with their care may end up harming them. Nevertheless, the schools are also forthcoming, and pupils experience a sense of homeliness through negotiating improvements in their rooms and receiving care from non-authoritative staff, like cooks.

When hyper-control rather creates a sense of insecurity and fosters space for violence, the children end up looking outwards for supportive and less restrictive relations, especially when relations with peers in school are frequently conflictful. This may be expressed through developing strong and supportive friendships, involving oneself in extracurricular activities or drawing on the extended kinship relations closer to school than one's kinship-based home. Thus, spaces like friends' homes and youth centers might provide better infrastructures of care than one's primary places of residence. This is crucial in the possibilities of feeling a sense of belonging in a community and navigating the school identities that might build on one strongly associating oneself with the residential school.

Similarly, possibilities to fill one's everyday life with fulfilling outside activities for our interlocutors were significantly associated with transitional and public spaces. The transitional space, like a bus drive, provides a means to feel a type of safety possible in public space, which nevertheless is without the often-unwanted surveillance or encounters present at a family home or the residential school. As argued by Inglis in his research on driving in post-war France, "[driving] makes it possible to be simultaneously at home and further and further away from home" [26]. While Inglis makes this statement about driving a personal car, here, this statement also applies to public transportation. This again shows that when we reflect on the sense of home for our three interlocutors, we must look past the places that are usually associated with home toward alternative places that allow participants to find the space necessary for a desired sense of control, privacy, caring and supportive relationships, and agency to spend one's free time where and how one desires.

Overall, we found multiple ways in which children had agency to navigate homely environments, but for our interlocutors, it was significantly higher in spaces outside of the residential school and one's family home. Both the positive definitions of home and family environment and some of the children's efforts to establish higher control were sometimes counterproductive in improving homeliness both at one's family home and in the residential school environment. Nevertheless, the small ways in which such a sense was established were also important. While our interlocutors attended residential schools at different points in time, their experience of it was mostly fragmented and sometimes problematic, but as our analysis shows—significantly different in terms of where they found homeliness. This means that the conditions also foster creativity at multiple interstitial spaces and offer opportunities to create homeliness in finding control, supportive relationships, and time and space even if infrastructures of care are lacking in multiple of them.

This, however, might not be the case for everyone. As a qualitative, in-depth study, our research focused on three specific cases and, therefore, is not representative of all residential school students in Latvia. Therefore, the interpretations within this article should be approached with caution when applied to other contexts, either in Latvia or elsewhere. Furthermore, the information was obtained from adult participants who had already concluded their study periods, which also should be taken into account when considering the connections of the discussed experiences with contemporary situations.

Finally, the study has not been focused on evaluating differences on the basis of gender or other structural factors, which opens potential avenues for future research. By including these variables, it would become possible to evaluate in what ways larger social structures affect the experience of home, homeliness, and home-making for children in residential education, especially if also connected holistically to other potential determinants. The inclusion of children currently located within residential schools also presents a potential for future research, simultaneously ensuring that their voice is heard and allowing us to gain perspective from participants who are currently residing within the institutions.

5. Conclusions

In the context of residential education, home is a notion that has a variety of strong normative assumptions since many participants' family homes are seen as lacking positive qualities of home while institutions often do not even aim to offer a homely environment. Our analysis shows that it remains important to critically assess both normative notions of home and children's experiences of home to evaluate alternative visions on improving children's quality of life in conditions of mobile and transitional experiences of being housed. Treating children's experiences of homeliness as resulting from homes as infrastructures of care reveals how relationships, materialities, and governance can intersectionally increase their caring capacities in multiple ways. Importantly, some sense of unhomeliness results from children's lack of agency in doing what and when they wish to do, finding relational spaces where to belong, and shaping their places of residence according to their will.

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Article

"I Don't Feel Like There's Enough Awareness about the Damage That Social Media Does": A Thematic Analysis of the Relationships between Social Media Use, Mental Wellbeing, and Care Experience

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Abstract: Social media (SM) has become an unavoidable mode of communication for many young people today, leading to increasing importance in exploring its impact on mental wellbeing. This includes exploring the impact on those who may be more susceptible to developing mental health issues due to adverse childhood experiences, such as care-experienced young people. This study consisted of 22 semi-structured interviews with young people from the general population ($n = 11$) and care-experienced young people ($n = 11$). Thematic analysis revealed varying effects of SM, including positive effects such as entertainment, inspiration, and belongingness. However, other findings indicated that the design of SM is damaging for young people's wellbeing. Age and developmental maturity appeared as key factors influencing the impact of SM on wellbeing, with the indication of further protective factors such as self-awareness, education, and certain SM design features. Specifically, care-experienced young people expressed how lived experiences of the care system can have both positive and negative effects on SM use while revealing the complex relationship between care experience, SM use, and wellbeing. These results can be used to inform SM design and policy and to provide suggestions for SM and wellbeing education among the general population and care-experienced young people.

Keywords: social media; mental wellbeing; young people; digital mental health; care experience; qualitative; multidisciplinary

1. Introduction

Social media (SM) platforms are prevalent in the lives of many young people, with research showing that 91–97% of 12–17-year-olds use SM platforms in the United Kingdom [1]. The definition of SM has been debated in the literature and a single, widely accepted definition is lacking [2]. In this research, SM is defined as an electronic platform that allows users to opportunistically connect, interact, and communicate with others. Two groups of young people in the stages of adolescence and early adulthood are explored in this study: those who are care-experienced and those who are not. With the high prevalence of SM use among young people today, it is vital to research the impact social media may have on their mental wellbeing. This is particularly important to explore with care-experienced young people as they are more susceptible to developing mental health issues and can be characterised as a vulnerable population [3]. Past research has offered largely mixed findings regarding wellbeing when investigating the impact of SM [4–6] and has mostly consisted of research with the general population, thus neglecting underrepresented populations such as care-experienced young people. So, gathering data from an underrepresented population will be beneficial to the academic literature in developing our knowledge of care-experienced young people's lived experiences while also hoping to empower these young people to make change and contribute to research. Furthermore, recent systematic reviews [7,8] have suggested the need for more qualitative, exploratory studies on social media and wellbeing, which supports this research's contribution. Therefore, these research gaps justify the rationale for this exploratory research and demonstrate the necessity to see if, and how, the needs of the care-experienced population differ to those non-care-experienced (as the care-experienced group is notably more susceptible to developing mental health issues), and the implications this has for SM design and policy.

Young people use SM regularly to confirm their role and position in friendship groups [9], and if access to SM is restricted, it is likely to produce anxiety in adolescents [10]. This is thought to occur mainly due to a phenomenon called FoMO (fear of missing out). FoMO is considered one of the biggest driving forces behind greater SM use among adolescents, with emotional investment in SM leading to anxiety about what they may be missing online when they are offline [11]. This results in increasing reliance on SM, greater use, and a higher likelihood of developing anxiety and depressive symptoms [12,13]. This is consistent with other research that outlines the relationship between SM use and dopamine. The persuasive design of SM (the high accessibility, nudges, and other design features that entice the user to keep checking the platform) causes a dopamine rush in the brain, leading to the feeling of reward and resulting in habitual behaviour [14].

Another aspect of SM that seems to have substantial impact on psychological wellbeing is feedback, often in the form of likes, comments, views, and other metrics visible on SM platforms. Li et al. [15] tested a large sample of young people and found that those who placed higher importance on peer feedback on SM posts (especially females) tended to have more symptoms of depression and low self-esteem, which is consistent with other research [16,17]. It has also been highlighted by researchers that SM profiles are often biased, only showing the positive side of life [18]; thus, comparing oneself to a seemingly 'perfect' other can result in reduced self-esteem and wellbeing.

On the other hand, alternative findings have suggested that SM can have positive effects on young people's wellbeing and self-esteem, with research findings showing that Instagram users had lower anxiety, depressive symptoms, and lower levels of loneliness [19]. This could be due to multiple factors, such as SM providing a safe space for the maintenance of friendships, wellbeing, and creating communities to feel a sense of belongingness and social support [20–23]. In addition, research has demonstrated other positive impacts of SM use, such as relaxation, entertainment, and escapism from daily stressors [24,25]. There have also been findings that suggest some aspects of SM design can reduce the anxiety around being judged negatively and therefore have a positive influence on wellbeing, including ephemeral features like SM 'stories' and SM platforms that show fewer feedback mechanisms [26]. Hence, the research is mixed, unclear, and primarily studies the general population, suggesting the need for more exploratory and detailed research.

For care-experienced young people specifically, research has found both advantages and disadvantages of SM use for mental wellbeing. Positive effects include the reduction of isolation and loneliness (especially for care leavers), providing social interaction and support, and creating a community that makes the user feel like they belong [27–29]. This is especially important for care-experienced young people given their increased reliance on peers for social support and community [27]. In contrast, there are challenges for care-experienced young people online, including a heightened risk of online grooming, heightened emotional responses to SM content, and concerns for unmediated contact with birth families and thus safety [27,30]. Therefore, SM can be both beneficial and harmful for care-experienced young people, but more recent research is needed to explore the reasons why this may be.

When exploring mental wellbeing in young people, it is important to note that adolescence is a key stage in vulnerability; therefore, age and emotional development may have a significant impact on how SM is affecting young people. Adolescence is a vulnerable period for many aspects of mental wellbeing, such as low self-esteem [31,32]. This is due to multiple social and developmental processes that occur during adolescence, like the heightened salience of social norms, importance placed on friendships, peer feedback and approval, identity development, and increased self-consciousness [33–37]. Therefore, adolescence is a key developmental period to research as it creates questions regarding young people's vulnerability in developing mental health concerns during this time and how this is impacted further by regular SM use, which can intensify the social and developmental processes mentioned [34].

Hence, the two research questions (RQs) of this study are as follows:

- RQ 1: How does regular SM use impact the mental wellbeing and self-view of young people, and how does this vary between young people who have and have not experienced the care system?
- RQ 2: How do adverse childhood experiences impact resilience to the effects of SM on the mental wellbeing of care-experienced young people?

The RQs were purposefully kept broad so as not to limit participants' answers, to allow them the freedom to expand on topics, and to discuss what came naturally to them. The aim of this study was to explore the effects of SM on young people's mental wellbeing to develop our understanding and make suggestions on how SM could be made a safer, more positive place for young people, whilst representing and sharing the lived experiences of an underrepresented population. Also, by exploring two participant groups, there is the further objective of investigating whether there may be differences in experiences of using SM and the subsequent effects on mental wellbeing between young people who have and have not experienced the care system.

2. Materials and Methods

This study used semi-structured interviews to allow for deep, personal exploration of, and discussion around, how SM influences young people's mental wellbeing. Twenty-two interviews were conducted online using Microsoft Teams. A two-group design was utilised in which 11 young people from the general population and 11 care-experienced young people were recruited, with the intention of exploring how their experiences of SM differed. Recruitment was achieved through snowball sampling and with assistance from Nottingham City Council. Twitter was used to recruit care leavers through searching the hashtag '#CEP' (which stands for care-experienced people) and private messaging potential participants who fell within the 13–25-year age range. Demographic details for the whole sample can be seen in Table 1.

Table 1. Participant demographics.

Demographics	General Population	Care-Experienced
Age range (*years*)	13–25	14–24
Mean age	17	19.52
Gender (*n*)		
Female	8	7
Male	3	4
Non-binary	0	0
Ethnicity (*n*)		
Caucasian	5	8
Black or African American	0	0
Latino or Hispanic	2	0
Asian	1	1
Other	3	2

Full ethical approval was granted by the Faculty of Medicine and Health Sciences Research Ethics Committee, University of Nottingham. Ongoing collaborations occurred with Nottingham City Council to ensure the appropriate safeguards were in place. Participants were required to have full parental or carer consent if under 16, or above if the carer felt it necessary, along with their own consent. Information sheets were provided via email and were available via the lead author's professional webpage. Participants were debriefed at the end of the interview, though they were also provided with the opportunity for continued communication via email for any further questions or signposting to mental health services, if required. Participants were frequently reminded of their right to withdraw from the research and the option to skip questions at any time.

All interview sessions occurred between June 2021 and May 2022, lasted 30–60 min, and were recorded using Microsoft Teams. The study began with the lead researcher explaining what would happen during the study, reminding the participant of their right to withdraw, and ensuring all participants were comfortable. After the interview had concluded, participants were thanked during the debrief and received an Amazon voucher as compensation for their time. Upon completion of the studies, transcripts were generated through Microsoft Stream and anonymised to protect participants' identity.

A discussion guide was used by the lead researcher, consisting of main questions and prompts. Key questions included broad questions regarding how SM made the young people feel, and then more specific questions relating to social comparison, peer approval, identity, and more. For the full discussion guide used for the interviews, see Appendix A. The guide was followed roughly and used to steer conversation back on track if participants became distracted. Terms such as wellbeing and identity were not pre-defined within the interviews, instead allowing participants to self-define and ask for clarification if required (see Appendix A for examples of clarifying terms). This approach enabled freedom of interpretation for participants and was aligned with the interpretivist approach of allowing definitions to emerge during data analysis, where concepts are influenced by the researcher's interpretation of the data [38].

Data were analysed using inductive reflexive thematic analysis to explore themes between participants, which allowed flexible engagement with the data [39]. The lead author conducted the analysis from an interpretivist positionality, with the second co-author blindly verifying the analysis. An experiential qualitative framework was adopted to explore the participants' own perspectives [39], and coding was performed inductively. The analysis broadly followed the step-by-step guide described by Braun and Clarke [39,40]. The lead researcher first familiarized themselves with the data by reviewing and checking all transcripts thoroughly, and then transferring each transcript to a Microsoft Excel spreadsheet. Initial codes were generated inductively to capture meaning, which were then organised in the spreadsheet. Initial groups were created by grouping initial codes according to similar concepts and patterns. The groups were then reviewed and developed into themes and subthemes, being named and defined in keeping with the phases outlined by Braun and Clarke [39,40].

Thematic analyses were conducted separately for both groups of participants. These were compared once themes had been developed for each to explore differences and similarities between them. The analysis process was completed using Microsoft Excel, creating an index system to track each code generated and to allow the corresponding raw data and participant to be easily located after the transcript had been copied to individual spreadsheets (for example, a code generated from line 50 of the transcript from participant A would be assigned the index A50). The lead researcher kept a reflexive journal throughout, as reflexivity is a crucial part of qualitative analysis due to researchers possessing unique positionality in relation to data interpretation [39,41]. This approach therefore enabled awareness of personal influences and is an activity that increases the confirmability and quality of reflexive thematic analysis [39].

3. Results

The reflexive thematic analysis led to the identification of four overarching themes and one group-specific theme. In addition, nine subthemes and six group-specific subthemes were developed. The themes and corresponding participant quotes can be seen in Table 2. When reporting the findings, some information is presented regarding the prevalence of some themes and subthemes among participants. It is important to note, however, that these proportions are just one indicator of prevalence across cases and are not intended to discount any other findings or the lived experience of the participants.

Table 2. Themes and subthemes found from the thematic analysis. Those placed under one participant group only refer to group-specific findings.

Theme/Subtheme	General Population Participant Group	Care-Experienced Participant Group	Illustrative Quotes
Theme 1	Psychological benefits of social media		*"Yeah, I find it entertaining and sometimes inspirational."*—Participant J (care-experienced).
Subtheme 1a		Belongingness and community for care-experienced young people	*"The communities on Reddit really helped me out because sometimes I post about, let's say, just a story or anecdote, and people will tell their own stories that are similar, and we'll just all bond over that."*—Participant AI (care-experienced).
Theme 2	The harmful design of social media		*"But I think when filters change your natural appearance, like maybe making your nose smaller, I think that can be quite damaging for, especially young people, because it's telling you that you need to look a certain way and that the way you are already isn't good enough."*—Participant L (general population).
Subtheme 2a	Encouragement of social comparison		*"I just think it makes you a bit weight conscious. But then you don't know what's real and you don't know what's fake."*—Participant AE (general population).
Subtheme 2b	Social pressure and identity presentation		*"It did affect me quite a lot… like I was trying to fit in with all this stuff on Instagram. Which is why I don't really use it much… I rarely go on it because it did affect my life and made me want to be this person that I really wasn't… I felt like it was wrong."*—Participant AD (care-experienced).
Subtheme 2c	Social media is addictive by design		*"Like when I see it [content] on Reddit, you can go down like a huge rabbit hole, so it can be quite tiring and exhausting to read all of it."*—Participant H (general population).
Subtheme 2d	Exacerbation of poor wellbeing or low mood and facilitation of negative experiences		*"That's one of the reasons I tried to stay off social media… I stay very anonymous because… the internet started this [bullying]… I think that was one of the reasons I've realized, if I go on social media, even if I was very anonymous… if they found me, they could target me, even with lots of privacy settings."*—Participant AH (care-experienced).
Theme 3	Age and emotional maturity		*"And I think we're at that weird age now where we're more aware of it and how social media, with the likes, how that affects people. All my friends say they don't care who likes it or how many [likes they get]. But for like 13 to 15, that kind of age bracket… I think they're a lot more aware, they're more aware of how many likes they have, and they can track them… I see how they get like that."*—Participant O (general population).

Table 2. *Cont.*

Theme/Subtheme	General Population Participant Group	Care-Experienced Participant Group	Illustrative Quotes
Subtheme 3a	Vulnerability of younger users		*"I think it's very much like what you see is what's going to go back into your subconscious mind... even if you think consciously, you're not really gonna absorb it, it's gonna be there. I think in recent years as I got older, I've realized that more."*—Participant AG (care-experienced).
Subtheme 3b	Age restrictions		*"Well, TikTok's awful, they don't do anything on there. My little brother and sister are on there and she has an account but it's private, so people don't see her videos, but it doesn't stop her seeing stuff that I see, and I'm nearly 25 and she's 11."*—Participant AE (general population).
Theme 4	Protective factors		*"I think we're told [in school] more about the consequences of using social media in a negative way. So, going to future employers... Are you being responsible on that? Are you posting appropriate stuff? I think we're told more about that as opposed to how we could be protected in a positive way on social media... I think there should be more taught about the protection rules on social media."*—Participant N (general population).
Subtheme 4a	Personal characteristics		*"There's always gunna be stuff that you wanna be like... but you have to be happy like as yourself [...] I feel like I have quite good self-esteem... like I'm happy with myself"*—Participant F (general population).
Subtheme 4b	Social media design features		*"Ever since they introduced the, you know, the posting photos where you don't necessarily get to see how many people have liked it. You can- the function where you can take that off- I love that so much because I feel like it takes the pressure off it."*—Participant AJ (CE). *"I think, definitely that [stricter rules]. There should be more of a control on bad comments and hate comments."*—Participant C (general population).
Subtheme 4c	Stakeholder responsibility		*"I don't feel like there is enough awareness. I don't feel like there's enough awareness about the damage that social media does [...] It's really difficult... I wanna say it's like a government policy that needs to be put in place, or maybe just... I don't know, re-education. It would be helpful if they had it in schools."*—Participant AJ (care-experienced).
Theme 5		Care experience, social media, and mental wellbeing	*"I know it [social media] does damage self-esteem. I've got friends that aren't care-experienced, right? And I know obviously it damages them. Although for us [care-experienced young people], I feel like it's going to be even more because we don't have that mother figure or father figure to constantly tell us every day "Oh, you look great. You look fine. You're absolutely fine" [...] I think it's made me rely on social media... like the purpose... that sense of belonging... because I haven't had parents, I haven't had that family life. So, relying on social media to essentially give me that is what I've been doing."—Participant* AD (care-experienced).
Subtheme 5a		Vulnerability and resilience	*"Just experiences and stuff just make you stronger, I guess... It just helps getting older too."*—Participant Z (care-experienced).

Table 2. *Cont.*

Theme/Subtheme	General Population Participant Group	Care-Experienced Participant Group	Illustrative Quotes
Subtheme 5b		Social media monitoring	*"Children that are in care much earlier and at a much earlier age are restricted from social media- there are pros and cons to that. Being disconnected from friends... being disconnected from what's going on around the world... and opportunities. A pro is that it can save you a lot of grief from affecting your mental health and body image or personality, the way you develop."*—Participant AG (care-experienced).
Subtheme 5c		Beneficial social media effects for care-experienced young people	*"One thing, yeah, this is more linked to my estrangement, but because of everything that happened I like to keep all my social media quite private. I don't really like letting people know where I am unless it's my close friends. Just for my own safety."*—Participant AI (care-experienced).
Subtheme 5d		Harmful social media effects for care-experienced young people	*"Uhm, I feel like it's the same for a lot of care-experienced young people. I do think it's hard... because I've never really felt like I've fitted in, I do feel like maybe there's something in that. I feel like I have to fit in some way, and I need to find my group of people."*—Participant AA (care-experienced).
Subtheme 5e		Education and support	*"We learn how to regulate our emotions from our parents, so therefore that's not been provided. Why aren't we learning about that when we enter care? Why aren't we learning about healthy relationships? How to use social media in a healthy way? How to deal with these difficult life transitions that our parents haven't taught us yet? The government and our corporate parent seem to fail at that again and again and it's just failure after failure after failure"*—Participant AB (care-experienced).

For ease of viewing and to see a visual representation of how the concepts are related, the findings are also displayed in a conceptual map in Figure 1 below.

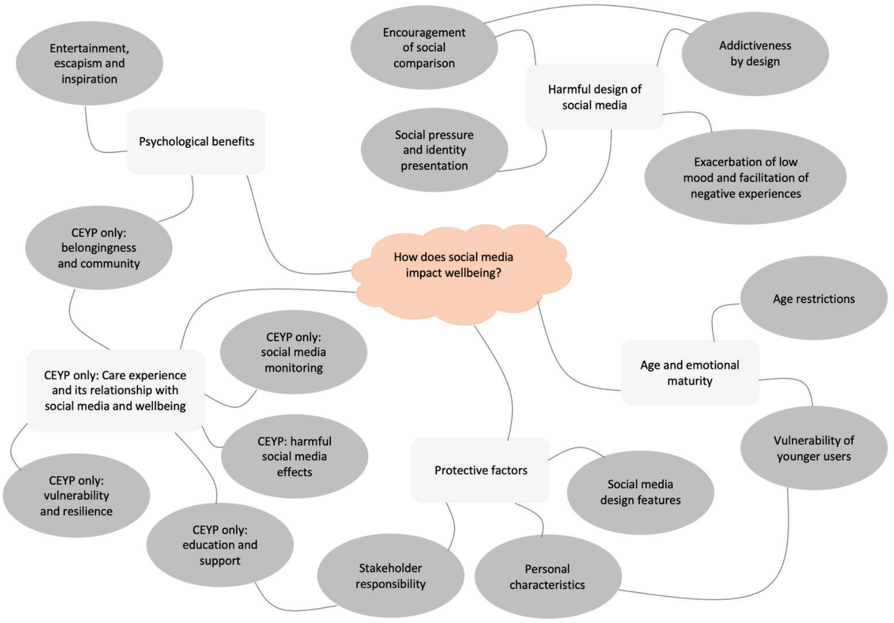

Figure 1. A conceptual map of the findings, with connecting lines showing how the concepts link (abbreviation CEYP stands for care-experienced young people).

3.1. Theme 1: Psychological Benefits of SM

All 22 participants agreed that SM can have positive effects on wellbeing in various ways, including the provision of entertainment and inspiration. SM was described as funny and uplifting and was used to communicate and joke with friends, all of which had a positive impact on mood. Positive, downward comparisons (social comparisons against others who are perceived as inferior [42]) also occurred, which resulted in either motivation or inspiration. Some participants mentioned using SM as an escape from their mundane or stressful lives to improve their mood. Others discussed the benefit of receiving supportive and complimentary comments from friends and family on SM, particularly on photos of themselves or posts about their achievements, which would boost their self-esteem. This was illustrated by participant O, who described the confidence boost felt when receiving praise from peers on SM:

> *"Me and my friends... we all kind of like comment on each other's posts like, oh "well done" if someone's achieved something. It gives you that confidence boost."*—Participant O (general population).

Group-Specific Subtheme 1a: Belongingness and Community for Care-Experienced Young People

This subtheme, specific to the care-experienced group only, highlighted the importance of gaining a sense of community, belongingness, and identity from SM. A total of 9 out of 11 care-experienced participants reported psychological benefits from using SM platforms—primarily Twitter and Reddit—to connect, make friends, and give and gain support from others who had also experienced the care system. Seeing relatable content from others who were care-experienced and seeing similar, validating experiences had a significant positive effect on participants' wellbeing. This enabled the young people to feel like they had somewhere to belong, as well as having a support network of other people who had been through similar life experiences. Using SM platforms for activism and to advocate for care-experienced people's rights was also positive for participants' mental health, as the young people felt it gave them a purpose and motivation. Participant AB described how they felt about the care-experienced community on Twitter and the influence this had on their wellbeing:

> *"I've found Twitter to be really good for my self-esteem... With the care experience community, it's really helped me find a community I can relate to. I like seeing people who I have that in common with and being able to see them do well... Just joining Twitter and being part of the care-experienced community has had a hugely positive effect on me, it's like empowered me... it's so nice to have that community and sense of belongingness. Like peer support and representation, it's so empowering."*—Participant AB (care-experienced).

3.2. Theme 2: The Harmful Design of SM

3.2.1. Subtheme 2a: Encouragement of Social Comparison

Around 82% of young people from both participant groups felt that the design of SM was harmful because it generally encouraged the users to compare themselves negatively against others through likes, comments, and other quantifiable feedback. Additionally, the participants felt that SM presented only the most favourable parts of a person's life, which naturally made them feel as though they were not good enough or missing out on a more exciting life. This resulted in feelings of 'FoMO', which had negative implications for mental wellbeing, illustrated by participant AC:

> *"Yeah... Instagram, for example. Twitter as well. You can always see what your friends are up to or people you're not so close with, you see that they're doing, like going on holidays or going to fancy places. Sometimes you just compare yourself and go 'I wish I was out, and I wish I was doing that really cool thing'. Yeah, because the self-esteem*

> *issue just kind of [makes you] wonder if you're, let's say, as high up in the social ranking as they are."*—Participant AC (care-experienced).

The idea that what is presented on SM is considered fake was expressed by participants, especially with the rising use of filters that change your facial structure and appearance. Some participants felt that filters were toxic and extremely damaging to self-esteem and wellbeing due to adding to the existing, toxic beauty standards that exist online, which young people compare themselves negatively against. Therefore, along with the already high beauty standards on SM to compare to, SM presents a world that is unrealistic and standards that are unattainable due to the ability to alter one's appearance without others knowing.

3.2.2. Subtheme 2b: Social Pressure and Identity Presentation

The second subtheme showed that young people feel pressure from SM to fit in and seek approval through likes and feedback. The young people reported feeling pressure to use filters like others to live up to the beauty standards online, which resulted in lowered self-esteem and self-view due to not feeling good enough without a filter enhancing one's appearance. For the care-experienced group especially, identity was discussed in detail and how this societal pressure via SM impacts upon identity formation. Approval was seen as important on SM for care-experienced people, so they were not seen as outcasts. This was a concern for some young people because they already felt different due to their care experience, so fitting in on SM was important for them. Likewise, multiple care-experienced participants mentioned the struggle they experience with identity and that SM does not help this struggle, but rather makes it more complex. This was mainly due to SM rapidly changing, with the trends and fashionable content ever evolving, which made identity formation complicated and subject to repeated and never-ending change. This was demonstrated by participant AA, who expressed their struggle with identity and the pressure they felt to fit in:

> *"I just never know who I am because I think now, especially with the internet. Like everything is so accessible and there's just so many different trends and different ways of being a person… I do think it's hard, because… I've never really felt like I've fitted in. I do feel like maybe there's something in that… I feel like I have to fit in some way, and I need to find my group of people."*—Participant AA (care-experienced).

3.2.3. Subtheme 2c: SM Is Addictive by Design

Participants from both groups agreed that SM was designed to be addictive for all users, but especially young people due to the peer pressure they face to fit in, linking to Subtheme 2b above. Participants noted that SM provides a constant stream of content and makes it easy to continue scrolling endlessly, as well as pushing adverts and content that are tailored to your interests, thus facilitating excessive and continuous use. Mixed with the FoMO felt by participants (as seen in Subtheme 2a), this resulted in addictive behaviour for many of the participants. This had a negative impact on wellbeing overall, making participants feel unproductive in other areas of their life and like they lacked control over their SM use. This can be seen below in a quote from participant AI, who felt the persuasive design of SM makes it difficult for young people to disconnect from the online world:

> *"The way TikTok is built is, it makes you addicted to it because it's all these really short videos. Obviously, it's made that way on purpose, but it can be very addicting and I can imagine it being even harder for a teenager to disconnect from TikTok after scrolling for an hour."*—Participant AI (care-experienced).

3.2.4. Subtheme 2d: Exacerbation of Poor Wellbeing or Bad Mood and Facilitation of Negative Experiences

When asked if SM was ever used for self-care, approximately 60% of participants expressed that SM use did the opposite and instead made them feel worse if they were already in a bad mood or were struggling with their wellbeing. This was primarily because of the negative effects SM had on mental wellbeing stated within this theme, such as negative comparison against beauty standards, which, if felt during an existing low mood, would only exacerbate the negative feelings, as participant AF demonstrates:

> *"I don't know if I necessarily would go to it [social media] if I was feeling down… I would be more inclined to feel badly if I was going on my social media, if I was already in a bad mood."*—Participant AF (general population).

Participants also highlighted (the care-experienced group more so) that SM facilitated and provided a platform for other negative behaviour, namely general negativity or trolling, cyberbullying, and ignorance about social class or people from disadvantaged backgrounds. The young people felt that SM contributed to negativity in society by allowing users to post harmful and disrespectful content. Some care-experienced participants mentioned feeling stigmatised after reading content regarding care experience (as seen from participant AC below), or anger from reading ignorant and insensitive SM posts about marginalised groups such as care-experienced people.

> *"I know there's been times where I felt stigmatized when I read things about care experience that've really got to me."*—Participant AC (care-experienced).

3.3. Theme 3: Age and Emotional Maturity

3.3.1. Subtheme 3a: Vulnerability of Younger Users

It was highlighted by 17 out of 22 participants that the younger generation are now growing up with SM and perhaps face more pressure to use it more often, leading to conversations around the importance of age. The older participants, aged 18 and above, reflected on their SM use during adolescence and conveyed that they felt much more vulnerable when they were younger towards the psychological effects of SM. This included feeling more pressure to fit in, negatively comparing themselves more to other peers, feeling a stronger need to receive likes and approval due to peer pressure at school, and having a stronger influence on identity. Some participants compared this to what they see now in younger siblings or friends, who appear much more impressionable and vulnerable on SM during their young age.

The older participants expressed concern over the rising use of SM among very young users, as they only realised the detrimental effects of SM after they became older and more self-aware. Therefore, being older was found to be a protective factor against the negative effects of SM as self-awareness, reflection on usage, and confidence increase with age (more on this is discussed in Theme 4). Some participants also found that their sense of identity became more stable as they grew older, which resulted in feeling less pressure to change themselves or how they present themselves online.

3.3.2. Subtheme 3b: Age Restrictions

Despite the young people in this research having little to no knowledge of SM policies or rules except age limits and general data protection regulation (GDPR), once the Age-Appropriate Design Code [43] was explained by the researcher and discussed with the young people, participants agreed that SM was not abiding by these rules because it was so easy to see inappropriate and harmful content as a young person. It was also highlighted by participants that SM need to do better at both enforcing policies and removing harmful content.

In addition, participants felt strongly that age limits on SM need to be reassessed and better enforced, as participant J illustrates here:

> *"I think for some social media platforms that [age limits] should be enforced better because you wouldn't want a 12-year-old on there because there's some weird stuff on there. That's the same for Instagram as well because that might affect their mental health… It should be like 14 in my opinion because we get more mature around that age."*—Participant J (care-experienced).

It was agreed among all participants that age limits are important in protecting young people online, although despite their importance they are easily avoided by young people. The participants explained that it is easy to enter a different date of birth when creating a SM account, rendering age limits useless. Despite many of the young people admitting they have entered incorrect dates of birth in SM platforms before, they went on to discuss the importance of age limits due to the damaging and subconscious impact of SM on young people's mental wellbeing. Regarding the re-assessment and enforcement of age limits on SM, some participants felt age verification or parental approval could be used to improve the safety of young people. However, others felt this was controlling and not the correct way to resolve the issue. Others felt that emotional maturity was important to consider when re-evaluating age limits, as young people mature emotionally at different rates. Thus, an umbrella age limit would not suffice because it does not consider individual developmental and emotional maturity.

3.4. Theme 4: Protective Factors

3.4.1. Subtheme 4a: Personal Characteristics

A total of 18 participants across both groups reported that having the ability to self-regulate emotions helped protect them from negative mental health effects when using SM regularly. This included acts that primarily involved self-monitoring, such as actively deleting content or apps (as participant AA expresses below), deactivating accounts, or avoiding certain content on SM. Interestingly, some care-experienced participants reflected on their difficulty to self-regulate due to their past trauma, which, in turn, exacerbated the negative impact of SM. Other personal characteristics also helped to protect mental wellbeing, with the young people highlighting that high levels of confidence, self-awareness, self-esteem, and self-worth all act as protective factors. This was mainly because these young people only felt the effects of SM on a surface-level and, due to their strong self-concept, did not feel their mental health was impacted negatively by what they saw on SM. General awareness that SM was not an accurate portrayal of life was also highlighted as a protective feature.

> *"I used to use TikTok... but I had to delete it because it was just addictive [...] I've not been very well... all I could do is lay in bed. I was just scrolling through social media and I just- it was making me so depressed because I just saw everyone going out and doing things... But it was like everyone was just living their life and I was stuck at home. And that's when I ended up deleting TikTok, because I was just so miserable about it in the end."*—Participant AA (care-experienced).

3.4.2. Subtheme 4b: SM Design Features

This subtheme was highly significant in terms of prevalence, with 91% of participants discussing the role of SM designers in protecting young people from online harm. Participants highlighted the current design features that act as protective factors as well as potential design features that would aid this further. These included the ability to privatise your account to protect oneself from negativity or mentally triggering content, being able to block or report to remove harmful content, hiding likes to reduce the pressure to self-compare, the encouragement of honest and transparent content, and being able to tailor content to one's interests. All these features protected the participants from the negative effects on mental wellbeing by increasing feelings of safety and reducing the natural tendency to negatively compare oneself to other people's successes.

Whereas participants were glad these protective design features exist, the young people also mentioned that the design of SM could be improved further to protect them from harm. These suggestions included using better technology to improve the speed of detecting and removing harmful content, encouraging more age-appropriate content, using trigger warnings on all sensitive content, and taking action to reduce the addictive design of SM. This is illustrated by participant AB below, who felt that SM companies are irresponsible by not providing these design features that could protect young people from harm. Participants felt that if SM designers incorporated these suggestions, then SM would be much less likely to have a negative psychological effect on young users due to increasing the chances of protection from possible harm.

> *"And all the like glamorization of self-harm... I mean I get why young people do it, it's a coping mechanism, but it's social media's responsibility to take that stuff down. They should be better at detecting this harmful stuff and taking it down faster. You know what's been really good for me, I find trigger warnings really useful but again that's not social media policy, that's the users discretion. I just think social media has a lot to answer for."*—Participant AB (care-experienced).

3.4.3. Subtheme 4c: Stakeholder Responsibility

Participants explained that they had limited knowledge of any mental health policies or guidelines on SM. Therefore, the young people believed they should be educated more about SM, mental health policies, and any potential effects of SM on their mental health to prepare them. A total of 19 participants across both groups felt that if they were educated in these aspects, they would feel more protected and less likely to suffer any negative emotional effects. This education was felt to be the responsibility of educators, such as the government and schools. It was highlighted that current school curricula focused on teaching young people how to use SM for employment benefits, how to be cautious about what to post due to future employment, and the importance of privacy settings. Whereas participants acknowledged the importance of these aspects, they also believed that education and awareness about the potential psychological effects of SM is a crucial step in teaching young people how to use SM safely and to manage their emotional wellbeing, as demonstrated by participant O:

> *"I think it should be made more aware like in school, they should have that message put across saying "look, it doesn't matter... you can't make someone like your post."*—Participant O (general population).

As well as education, participants felt that SM companies and the government need to improve current policies to keep young people safe because they are currently failing. Participants felt that little is being done to protect young people online and that SM companies and the government need to take accountability and more responsibility for young people's mental health, through both education and improving SM platforms. Furthermore, it was highlighted that more funding and resources are needed for young people's mental health; however, SM companies are profit-focused and unwilling to spend money on design improvements that could help young people's mental health. Therefore, SM companies need to reflect on their priorities and focus more on protecting the mental health of young generations. This subtheme is represented well by this quote from participant AD:

> *"I sometimes feel as though they [social media policies] are not fit for practice really. Social media companies should be held more accountable too... for example, Snapchat, Instagram, they give you the filters to put on, you're given that, they provide them. So, it's not like you're having to go to another app to get that filter and then upload it to your snap. You can just do it on the actual platform. I think it's wrong. Yeah, they shouldn't be allowing that to happen."*—Participant AD (care-experienced).

3.5. Group-Specific Theme 5: Care Experience, SM Use, and Mental Wellbeing

3.5.1. Group-Specific Subtheme 5a: Vulnerability and Resilience

This first subtheme consisted of 10 out of 11 participants explaining that vulnerability starts at an elevated level in care experience due to the trauma and difficult life situations they have been through. However, this vulnerability made the young people feel more resilient to life challenges over time. Some participants believed that their increased resilience was due to time, experience, and age, whereas others felt it was due to the care experience specifically. For example, having to move around frequently in care made the young people feel more resilient and more capable of surviving change and challenges.

Experience of the care system also resulted in validation for some participants, regarding their experiences with birth families and other trauma. One participant reported that their stable care experience in foster care, of which they admitted the stability was rare, allowed them to feel safe enough to find and establish their identity, which was beneficial for their resilience and mental wellbeing.

3.5.2. Group-Specific Subtheme 5b: SM Monitoring

The second subtheme reflects on how care experience differs to the general, non-care-experienced childhood experience, drawing on the effect of the young people's SM use being strictly monitored or completely restricted throughout their childhood by carers or social care staff. Approximately 64% of participants reflected on the advantages and disadvantages of this experience. Advantages included feeling safer and less at risk from dangerous behaviour, feeling protected from the negative effects SM can have on mental wellbeing, and feeling less obsessed with the need to be on SM all the time. Care-experienced young people who had strictly monitored SM use now believed they were less fixated on approval from likes and other SM features, which was beneficial to their mental wellbeing. On the other hand, participants reflected on the disadvantages of having a strictly monitored childhood. The primary disadvantage was the frustration caused by the exacerbation of feeling different and missing out on a regular childhood. Participants conveyed that it was already difficult to lead a 'normal' childhood while in care, so the strict monitoring of SM and mobile phone use made it even harder to fit in with other children. Whereas participants showed awareness of the importance of monitoring care-experienced young people's SM for safety reasons, they were frustrated that this was necessary in the first place because it made them feel like an outcast.

3.5.3. Group-Specific Subtheme 5c: Beneficial SM Effects for Care-Experienced Young People

Comparably to Subtheme 1a, the feeling of belongingness, community, and support gained from SM use had a significantly positive impact on mental health and wellbeing. Being able to find similar communities and relate to other people had a positive impact on the self-esteem, identity, and general wellbeing of care-experienced young people. It was also highlighted by participants that care experience results in moving around regularly and thus it is important to maintain contact with foster carers, siblings, or other people they formed a close bond with. SM can therefore be useful when wanting to maintain contact with these individuals.

The care-experienced participants also gained validation from SM by connecting with other care-experienced people online, which has helped to validate some participants' experiences of care and trauma. The importance of private accounts for safety reasons was also discussed by participants, with some reflecting that this SM feature is more important for people who have suffered trauma or have a complicated family background, so they can remain safe. Moreover, some participants use SM to advocate for and raise awareness of care experience and as a source of information about care experience. The ability to do this has had a positive impact on mental health and identity and has been an outlet for some of the participants to share their care experience with the hope of helping others. Participant AB described how impactful the care-experienced community has been for their wellbeing, often serving as a coping mechanism to avoid relapses of depression:

> *"I think for me, the use of social media for activism and advocacy has been massively impactful on my mental health [. . .] When you're in the care system, I felt completely fed up with the world. I thought everybody in the world was evil and like I'm just gonna be traumatised for the rest of my life [. . .] I guess being empowered by other care-experienced people online, seeing what they're doing to help others in the community, empowered me to get into activism and advocacy. And that is genuinely, I've got to say, it's probably one of the biggest drivers in getting my mental health to stay stable for the first time ever. And the reason is, is it gives me that control back and that ability to go actually "that's not*

> *OK" and kind of fight for something and it gives you purpose to get up in the morning. And, you know, times where I do feel like I'm slipping back into the depression, I feel like I can't, almost, because I have somebody to fight for now that doesn't have a voice. That's been hugely impactful on my mental health."*—Participant AB (care-experienced).

3.5.4. Group-Specific Subtheme 5d: Harmful SM Effects for Care-Experienced Young People

This subtheme was substantial in size when considering the number of codes generated, with contributions from 7 out of 11 participants. Participants mentioned that being in care had made them more vulnerable, especially when younger, which, in turn, made them more vulnerable to the generic negative effects of SM. Some participants acknowledged that care-experienced people are highly susceptible to developing mental health issues or may already have mental health concerns themselves, so the increased vulnerability mixed with the societal pressure to use SM regularly is worrying when considering how SM can have a subconscious, negative impact on mental wellbeing.

It was also argued that avoiding mental health triggers in real life was mostly achievable, whereas this was difficult on SM due to the lack of control around what kind of content is viewed. Again, similarly to Subtheme 4a, older participants reflected on their own struggle to self-regulate their emotions due to their trauma, which they also saw in other care-experienced young people online. This made the young people feel more vulnerable online and feel that the risk of revealing too much or getting into dangerous situations was higher than that of the average population. Moreover, some participants felt more vulnerable because they lacked parental reassurance, support, and comfort from loved ones during childhood when on SM and facing challenges.

The care-experienced young people conveyed that they feel different due to having different family lives compared to their peers, which was heightened when comparing oneself to others online. Participants had already experienced many life obstacles and felt that, when compared to other young people online, their life was not worthy to share. The feeling of FoMO was thought to be more severe for care-experienced young people due to having to grow up quickly in care, as well as not having a regular or common upbringing and everything that comes with that adversity. Participants additionally revealed that SM expectations are even more unrealistic for care-experienced people due to obstacles they face, such as a lack of financial stability, a lack of familial support, and general limiting personal circumstances. Participant AJ specifically described how going to university was thought to be unattainable due to being a care leaver and the obstacles they face:

> *"I had this goal in my head for so many years that I would get to university and that was my goal. But it was so unattainable for a care leaver, I don't know a single care leaver who's gone to university... I know probably two or three girls out the whole of the UK."*—Participant AJ (care-experienced).

The final care-specific negative effect revolved around the pressure to find or create a stable identity. Being in care often resulted in an insecure identity and a lack of belongingness for some participants, which was worsened when comparing to other people's 'perfect' lives on SM, so it was generalised by participants that this population feel more pressure to find an identity. Whereas this could have a positive effect if the young person found care communities to relate to on SM, it could also have a negative effect if an identity or community was not found. For example, one participant reflected on their unhealthy reliance on SM to find a purpose and sense of belonging in life because they do not receive that from family (see the illustrative quote used for Theme 5 in Table 2).

3.5.5. Group-Specific Subtheme 5e: Education and Support

This subtheme was primarily formed from ideas from older participants, with their age and experience being a key factor in their reflection on this topic. These participants reflected on their damaging SM use, including seeking out damaging content on SM for attention both before and during their care experience and wishing they had received more support from social care services. In addition to more support, participants felt that care-experienced young people should be taught to develop their emotional life skills as well as being taught how to use SM safely, so they are more prepared to deal with the psychological challenges that come with regular SM use. An example of these emotional life skills would be working on emotion and self-regulation, so they can learn how to effectively deal with the flood of emotions that come with using SM during adolescence.

It was pointed out by participants that the use of SM is increasing, so social care services need to stay up-to-date, work with this—and not deny or completely restrict it—and help young people prepare for this, especially for when they leave care and must deal with the consequences alone (as expressed by participant AH below). Participants believed this education and support around SM and mental wellbeing would ideally be balanced between keeping the young people safe while still granting them opportunities and trusting them to explore their interests. Likewise, any communication surrounding this education and support should be open, enable trust, and yet set boundaries to maximise comfort for everybody involved.

> *"We can't run from social media and I think that everyone's just put their heads in the sand [. . .] You know, we need to consider contact, we need to consider support for birth family, better ways they can reach out later in the child's life. [. . .] I think the care system needs to catch up with social media, it's getting more complex every day. It's becoming more of an integral part of people's day-to-day life, especially after lockdown. And actually, we're not going to be able to stop it. It's like a tsunami coming. . . you're either going to learn how to work with it or you're going to run."*—Participant AH (care-experienced).

4. Discussion

This detailed study offers a range of findings that contribute to our understanding of how SM impacts upon the mental wellbeing of young people from the general population and care-experienced young people. As well as this insight and development of knowledge, the widespread findings contribute to the existing literature in the multidisciplinary fields of psychology, sociology, and computer science and communication while also providing novel contributions from an underrepresented population (care-experienced young people). This discussion will explore the themes found from the reflexive thematic analysis and implications for real-world improvements to mental wellbeing.

4.1. Psychological Benefits of SM

The first theme found conveyed multiple emotional benefits of regular SM use, which were consistent with previous research [24,25] and provides one potential answer to RQ1. The care-experienced young people involved in the research expressed the importance of using SM for belongingness and to find relatable care-experienced communities, which expresses the importance of providing a social platform for young people from a minority group, such as those who have lived experience of the care system. These findings are consistent with existing literature that demonstrates how care-experienced young people can have trouble feeling a sense of belonging due to their past trauma and non-traditional family background [44]. This research also supports broader research that suggests young people who have low self-esteem may think of SM as a safe place to maintain friendships, which allows them to gain support and attention from others [20].

4.2. The Harmful Design and Consequences of SM

The second theme produced from this research conveys the numerous ways in which SM platforms can have a damaging impact on the self-view and wellbeing of young people, again providing more answers to RQ1. These primarily consisted of discussing the harmful impact of SM design (addictive in nature, with design features that encourage negative, upwards social comparison to others and subsequently result in reduced wellbeing and self-view). As well as these design features, SM in general also created prominent levels of social pressure to fit in with others and seek approval, especially in the form of SM likes. These findings are consistent with past literature, including research that has found SM design to be persuasive and thus often results in FoMO [12,14], that peer pressure is a key driving force in online behaviour [45], and that SM use can often result in upwards social comparisons and self-criticism [46].

These findings are also consistent when considering the developmental period of adolescence, as during this period there is a heightened salience of social norms, and more importance is placed on peer feedback [33]. Care-experienced young people primarily felt pressure in a unique way compared to the other group, as they felt pressure to 'find' an identity when on SM. This is consistent with psychological theories regarding identity. For example, Erikson's [36] stages of psychosocial development suggest that identity is formed through life stage 'crises' in which identity clashes with confusion, and successful transitions are required to form a stable identity. So, a key period of instability occurs before adolescents form their identity, which causes vulnerability due to constant psychological and physiological changes [47]. As a result of this, any threats or stressors during this period of development can have worsened effects on identity [48]. Therefore, as care-experienced young people are likely to have experienced stressors, neglect, or trauma during their childhood, they are likely to struggle with an unstable identity [44].

The final subtheme in Theme 2 describes how SM can exacerbate poor mental health or low mood while also facilitating negative behaviour, such as cyberbullying. This was most relevant to the young people who were prone to low mood or for those who have existing mental health issues, as SM added to those existing feelings and exacerbated them by presenting a 'perfect' façade and encouraging negative, upward social comparison (as also suggested by Reinecke and Trepte [18]). The care-experienced participants agreed with this but additionally discussed the extra barriers care-experienced young people face due to their lived experiences of trauma and having such different lived experiences and opportunities compared to the average young person. Therefore, this supports the literature that shows care-experienced young people are more susceptible to developing mental health issues [3,49,50], which can be heightened further due to SM use.

Nevertheless, this finding also conveys that young people who may be prone to low mood or mental health issues can find that SM exacerbates this feeling and thus could be harmful for mental wellbeing. These concerns align with recent suggestions from Choukas-Bradley et al. [34], who proposed that the design features of SM (namely the 'perfect' and idealised content and the quantifiable and comparable feedback such as likes) significantly overlap with the social and developmental processes occurring in adolescence, such as the salience of peer feedback, social pressure, and heightened self-consciousness. Along with additional gender pressures for girls to look an ideal way, these conditions create the "perfect storm" for exacerbating body image concerns, which may extend to further mental wellbeing issues for some young people [34]. Thus, this finding and the consistent previous literature suggest that SM design may be harmful particularly for young females, as well as for those who may be prone to negative social comparison styles or mental health issues. Unfortunately, only a slight gender difference was apparent in this analysis which was not significant enough to warrant a separate theme. Therefore, while this study provides some support for this, more exploratory research focussing on gender is needed.

4.3. Age and Development

The third theme conveys that age and development are highly significant when considering the impact of SM on mental wellness. Older participants in this research (aged 16 plus) reflected that when they were younger, they did not realise the harmful impact that SM was having on their sense of self and general mental wellbeing. To support this further, the younger participants (15 years and under) reported predominantly positive effects of SM. It is impossible to say whether this is because they were simply not impacted negatively by SM, or whether any negative impacts were subconsciously occurring and would only be realised later as suggested by the older participants. If the younger participants did mention negative effects of SM, they reported not being significantly affected by them, in that they were able to 'brush off' whatever the feeling was (i.e., the impact was fleeting). Although, the older participants reflected on how damaging SM had been for their wellbeing when they were younger, suggesting that this may be a subconscious effect. Therefore, this finding adds to the importance of considering age and development (and subsequent vulnerability) when designing SM and creating policies and guidelines around SM use for young people. Moreover, it suggests the need for improved education and awareness of the potential emotional impact of SM on young people.

The second subtheme within the third theme was centred around age limits and restrictions. Participants felt that age limits were easily evaded, should be increased, and did not consider the importance of emotional maturity. Thus, this suggests that age limits on SM need to be reassessed. Despite this, the participants discussed how they had easily managed to evade age restrictions themselves to either join SM platforms when below the age limit or to view adult-restricted material. This suggests that participants may not honestly have believed that age limits can keep young people safe and that perhaps the design and protective measures on SM sites need to be reassessed considering the significance of age, emotional maturity, and developmental stages, rather than simply enforcing stricter age restrictions. Likewise, the participants had not heard of the Age-Appropriate Design Code, but once this was explained to them, they agreed that SM platforms are not adhering to these rules; hence, it needs to be enforced more effectively. This finding also shows that more education on existing policies to keep young people safe is needed to raise awareness among young people and how to protect mental wellness online.

4.4. Protective Factors

The first two subthemes within this theme describe two key protective factors that helped to safeguard young people from the damaging effects of SM. These factors were split into two categories: protective factors that were personal in nature and protective factors that stemmed from the design of SM platforms. Personal characteristics included self-awareness, confidence, high self-esteem, and self-reflection. In other words, having a strong self-concept seemed to protect the young people from taking part in behaviours or thinking styles that would contribute negatively to their emotional wellbeing. SM design features, such as hiding likes and private accounts, were also key in protecting young people's mental health online, as other research has similarly found [26], and hence should be strongly considered by researchers, SM companies, and other stakeholders like policymakers and educators.

In addition, this study found that young people felt that the role of protecting their mental health online fell into the hands of others as well as themselves, although this view of responsibility differed fractionally between participant groups. The non-care-experienced young people focussed more on the role of schools and other educators to protect their mental wellbeing online, suggesting the need for more education and awareness in school curricula around the relationship between SM and mental wellbeing. Alternatively, care-experienced young people focussed more on the responsibility of social care and policymakers, understandably due to their experience with social workers and, perhaps, the law and advocacy. Another potential reason for the focus on policymakers was due to care-experienced young people having an externally controlled upbringing, often led by social care professionals (SCPs) and governed by strict rules and guidelines. Consequently, while the focus varies for the two groups slightly, this finding conveys that there is an important responsibility from everyone involved in a child's safety to protect them from online harm. This finding supports recent internet safety laws which recognise the responsibility of SM companies and other stakeholders to keep young people safe online, such as the Age-Appropriate Design Code and the Online Safety Bill, which will make SM companies legally responsible for preventing online harm [43,51].

4.5. Care Experience, SM Use, and Mental Wellbeing

This final theme draws on the data gathered from the care-experienced group only and describes how young people feel care experience directly affects both SM use and mental wellbeing, and how these two factors are linked. The first subtheme provided insight into how care-experienced young people feel more vulnerable, especially when younger and in the initial stages of being in care. This is consistent with the literature and psychological theories that suggest care-experienced young people are more vulnerable due to trauma and deprivation [52,53]. However, the participants expressed that they had developed into more resilient individuals with time and experience due to their lived experiences of the care system. This can be linked to the literature on ACEs (adverse childhood experiences), in that these events can make a young person more resilient through the development of healthy social relationships and experiences after surviving their individual trauma [54]. Thus, this provides an answer for RQ2 of this study. Likewise, another finding further conveyed that some participants found that being in care had validated their lived experiences of trauma, which had helped them with their mental recovery. This is a useful finding for the future of children's social care, suggesting that trauma-informed practice and the acknowledgement and validation of a young person's trauma can be beneficial to wellbeing.

The second subtheme in Theme 5 conveys how differently care-experienced young people's SM is monitored during their childhood compared to non-care-experienced young people. As many care-experienced young people are not brought up in a traditional family unit, their experiences with the online world and typical parental monitoring differ significantly. This research found that care-experienced young people felt the strict SM monitoring from social workers had both advantages and disadvantages, concluding that a balanced approach is optimal. Therefore, this implies that professionals need to acknowledge the effect strict SM monitoring is having on care-experienced young people and work towards a more balanced approach to enhance and protect mental wellness. For example, this approach could maintain the aspect of safety and boundaries, while working to minimise the monitoring strategies that make care-experienced young people feel like an outcast. This finding is consistent with a report by Anderson and Swanton [55] of the Glasgow City Health and Social Care Partnership, in which these issues are also identified, and similar next steps are suggested.

The third and fourth subthemes within this theme outlined the care-specific positive and negative effects of SM on mental wellbeing. Primarily, the positives were the importance of SM for community, connection, and belongingness (as also expressed in Theme 1) and SM communities providing validation of lived experiences and mental wellbeing issues. This is again consistent with work by Stein [28] who found that care-experienced young people feel isolated once they leave care and thus turn to SM for support and community, as well as findings that have shown that SM has been beneficial for social interaction, support, and belongingness [27,29]. Therefore, this finding provides further support for the mental and emotional benefits of using SM for social connectedness, especially for those who struggle with identity.

Regarding negative effects on mental wellbeing, the care-experienced group highlighted again what has previously been included in other themes, namely that care-experienced young people are more vulnerable compared to others due to their lived experiences of trauma and neglect, they are more sensitive to FoMO and negative comparison, and they feel more pressure to find an identity because they are largely unsure of who they are during this developmental stage. All these factors align with the literature on care-experienced people stated previously and provide further support for the argument that care-experienced young people have notably unique needs, as their lived experiences can intensify the impact of SM on mental wellbeing. Therefore, SM platforms and policies need to listen and adapt to these needs going forward to protect care-experienced young people's mental wellbeing.

The final subtheme in Theme 5 is a desire expressed by the care-experienced young people in this research: that they believe more education and support is needed for care-experienced young people to increase awareness of potential mental wellness effects from SM use. Not only is more education and support needed for these young people, but this needs to be carefully balanced between maintaining safety while not limiting opportunities. This is coherent with mediation suggestions from Livingstone et al. [56], who suggested more digital literacy training for parents, carers, and young people themselves to maximise online inclusion and opportunity, while increasing awareness of online risk. Thus, this study conveys that the views, needs, and desires of young people who are often underrepresented in research aligns with suggestions from leading academics too, showing that the opinions and voices of young people are important in research and should be considered by all stakeholders involved in keeping young people safe online.

4.6. Group Differences

The differences between the two participant groups are subtle. Most underlying concepts are similar for both groups, but the differences lie in the level of impact. For the care-experienced young people in this study, their lived experience of trauma and barriers that come with non-traditional upbringings exacerbate the impact SM can have on mental wellbeing. This has been demonstrated through both positive and negative aspects of SM. Therefore, it can be recommended that care-experienced young people have differing psychological needs that need to be met and adapted to by SM companies, the government, and SCPs, that are not yet being fulfilled due to the damaging effects discussed in this research. However, it is important to note that damaging psychological effects also occurred for young people from the general population, thus suggesting that SM companies and other stakeholders need to improve SM platforms for all young users if they wish to prioritise and protect youth mental health.

4.7. Implications, Recommendations, and Limitations

This research has several important implications for the future of SM design and policy. The first theme suggests that SM stakeholders need to acknowledge and prioritise the beneficial features of SM, such as those that encourage entertainment and inspiration. Equally, SM companies should acknowledge the benefits of platforms that enable underrepresented groups, such as care-experienced young people, to form communities for support and guidance, which this study has shown to be significantly beneficial for mental wellbeing. SM companies should also work to enhance the design features that protect young people's mental health, such as hiding likes, the accurate tailoring of content, and good privacy settings (see Theme 4).

Secondly, SM companies have a responsibility to reflect and act upon how their platforms are impacting upon young people's mental health and implement appropriate changes. It is apparent from this research that SM can have a damaging impact on self-view and general wellbeing. From the harmful consequences found, it can be concluded that SM designers should be held accountable and make a firm commitment to improve current algorithmic and design practices to prevent the encouragement of unattainable and biased beauty standards (particularly regarding filters and editing) and readdress the persuasive design of SM to reduce the addictive behaviour many young people are experiencing and the subsequent negative impact on wellbeing. Moreover, this study has conveyed the differing needs of care-experienced young people and young people who may be more prone to negative social comparison. Thus, this implies that these young people may need additional support both online and offline to lessen the negative impact SM may have on their wellbeing.

The third theme found in this study conveys the importance of age and individual development of young people when considering how SM affects mental wellbeing. Therefore, from this finding, it can be recommended that the implementation of the Age-Appropriate Design Code needs to be more seriously enforced and adhered to by SM platforms. In addition to this, SM designers should take these considerations into account and focus on providing more age-appropriate content. For example, rather than using age restrictions that are easily evaded by young people, they could incorporate content-filtering and other measures to protect younger users from seeing harmful content.

Similarly, from the information gained from Theme 3, it could be suggested that the realisation of SM having a negative impact on the sense of self during formative and important developmental years only occurs during older adolescence, once the 'damage' has already been done. Therefore, this implies that more education on the potential impact SM could have on wellbeing is needed during younger years of childhood and in early adolescence to raise self-awareness. This way, the young person can gain autonomy and may be able to recognise the impact of SM before it has damaged their sense of self and increased susceptibility to the development of mental health issues. This is also consistent with suggestions from Theme 4, in which having higher self-awareness can protect younger users from harmful impact. So, the encouragement of education and learning how to accept oneself and develop confidence is important for young people.

The final insight gained from this study is the glance into care-experienced young people's lived experiences of care and how this can affect mental wellbeing and SM use. The findings convey the differing needs of care-experienced young people both in their general wellbeing, their wellbeing on SM platforms, and the way SM use should be monitored throughout childhood by SCPs. This study has shown that the effects the average young person feels from SM are amplified for care-experienced young people due to the lived experiences they have had and the extra barriers they face. As a result of this, both SM designers and policymakers need to consider this impact and work to create an online space that is safe and mentally positive for all users.

One limitation of this study is the small sample size. Whereas the sample size is average for a qualitative study, it can be considered small when reflecting on the transferability of the findings to wider populations. Likewise, there was a bias in the gender of participants, with more females being recruited than males, and some differences in ethnicity, thus limiting transferability and the comparisons made. The recruitment method may also have resulted in a biased sample. As stated, Twitter was used to recruit older participants through the hashtag '#CEP' (care-experienced people). Although this was an effective way to recruit care leavers, many of the young people who used Twitter and the CEP hashtag were advocates for care-experienced people's rights and were active members of the community. Therefore, it is understandable that a key finding of this research relays the voice of this online community, in that connection and community is an important part of SM use for care-experienced young people. Whereas this may be true and transferable for many others, it can be considered biased due to how the sample was recruited.

5. Conclusions

In summary, this study used a semi-structured interview technique to gain detailed information into how SM affects young people, both from the general population and those who are care-experienced. Reflexive thematic analyses were completed for the two groups of participants, which were then compared to explore the differences between groups. The findings conveyed that young people could feel emotional benefits from regular SM use, such as entertainment and escapism. An insightful finding from the care-experienced group was the value of using SM for social connection and community to feel a sense of belongingness, which enhances mental wellbeing. On the other hand, SM design was criticised by the young people in this research for its addictive design and apparent encouragement to compare oneself negatively against others. This conveys the need for the SM industry to better adhere to responsible practices that prioritise user wellbeing and safety and the need for active steps in SM design and policy to reduce exposure to harm [5].

When looking at how young people could be protected from negativity online, several factors emerged. Firstly, age and development were shown to be significant factors in how SM impacts young people, thus suggesting that SM stakeholders need to consider this in design and policy adaptation. Furthermore, participants highlighted design features of SM that were beneficial in protecting youth mental health, which provides implications for SM companies. Along with these, recommendations for more education were provided to improve young people's self-awareness and digital literacy, as strong self-concept was shown to be another protective factor. Finally, findings around care-experienced young people's lived experiences of care and the impact this has had on mental wellbeing and SM use provide useful and novel insights that henceforth lead to recommendations for future SM design, policy, and SM monitoring.

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Appendix A

Discussion guide for the interviews.

First, there will be an introduction from the researcher, saying something like this:

"Hello, I am Cecily, and this interview is part of a study I am doing about how social media makes us feel and how it may affect young people's mental wellbeing. All your answers will be anonymised, so no one will know they come from you, and you can withdraw at any time without any explanation if you ever feel uncomfortable. You can also skip questions if they make you feel uncomfortable too. There are no wrong or right answers, I'm just interested in hearing your opinion and your experiences with using social media."

There will then be an icebreaker, where the researcher will ask the following questions:

	Questions
1	Do you use social media and how much?
2	What type of social media do you use?
3	Do you have a favourite and least favourite social media site?
4	Do you use different social media sites for different purposes? i.e., Instagram for photos, Twitter for news etc.

After this, the main part of the interview will start, with the following questions:

	Questions [Category]	**Probes**
1	How do you feel social media impacts upon your wellbeing? [Things like self-esteem, mood, wellness, confidence etc.]	Do you feel it has a negative or positive effect? Can ask them what their definition of wellbeing is and how social media use affects this
2	Do you find yourself comparing yourself to others? Is this in a negative or positive light?	How does this make you feel about your own self-image and worthiness? Do you feel inspired/positive when you compare, or do you feel less worthy/negative? Why do you think this might be?
3	Do you feel other people's approval is important when posting things on social media? If so, why do you think this is?	How do you feel when looking at feedback on your posts? How do you feel if you receive a lack of feedback or likes? What level of importance do likes, or other feedback have for you?
4	How do you feel social media affects your identity and who you are as a person?	Do comments or feedback ever make you feel like you should change your personality or what you wear or how you act? Do you ever adapt your personality to 'fit in' with what you see online? If so, why? Do you feel like you have a different personality when you're online compared to offline/in-person?
5	Can you tell me a story about a time social media made you feel unworthy or not good enough?	Why do you think it made you feel that way?
6	Can you tell me a story about a time social media made you feel uplifted or positive about yourself?	Why do you think it made you feel that way?
7	Do you ever use social media purposefully to help look after and improve your well-being? For example, if you're feeling low one day, do you use social media to help you feel better? If so, how?	Do you think social media could make this easier in any way? Or have any other features that would make this better?
Break (if participant would like one)		
8	Do you know any policies and guidelines that are in place to make sure social media isn't harming young people's wellbeing?	If they don't understand what a policy is, explain in simpler terms.
[After discussing current guidelines briefly and in simple terms]		
9	Do you feel like these are enough to make sure young people don't let social media make them feel bad about themselves to an extent where it's damaging their mental health?	If not, do you have any ideas on how you would change them or new ones that you'd like to see?

For care-experienced participants only (remind participants that they do not have to discuss things that make them upset or uncomfortable, and remind them of their right to withdraw, stop, or take breaks):

- How do you feel your childhood and being in care has affected your social media use?
- Do you think your personal experiences have made you tougher and able to cope better with any negative effects? Or do you feel your experiences have had a more negative effect on how social media makes you feel?
- Why do you think this is?

Finally, the researcher will ask if the participant has anything else they would like to add. Then, participants will be thanked for their time, and asked if they have any further questions. The interview will then end.

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Does Group Size of Provision Matter for Children Who Experience Residential Group Care in Scotland?

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Abstract: It is widely recognised that trauma-informed care is fundamental to meeting the needs of children who experience residential care. Service design is central to this, and the aim of this article is to illustrate the experiences of 13 young people who have lived within group care settings, to highlight how a service's capacity can impact on children's needs being met. Using findings from a PhD thesis engaging 18–29-year-olds in Scotland, the research used a mixed methodological approach of questionnaires and semi-structured interviews to elicit young people's retrospective care experiences. The findings show that the number of children within a setting can adversely affect the feeling of being emotionally and practically supported, resulting in some children feeling that their needs were not fully met. This will offer insight to practitioners, managers and decision makers who are engaged in the delivery and development of children's services. Background: The United Nations Convention on the Rights of the Child (UNCRC) articles 3, 9 and 20 and Scotland's Independent Care Review state what children should expect from authorities and services responsible for providing alternative care. The ambition for Scotland's children is that they "grow up loved, safe, and respected so that (they) realise their full potential". For those who spend a period of their childhood growing up in residential care, they should experience a relational, trauma-informed and caring approach from staff.

Keywords: residential care; relational practice; unmet need; group size; lived experience; practitioner research

1. The Needs of Children and Implications for Trauma-Informed Care

On 31 July 2022, 12,596 children were "looked after" in Scotland, a reduction of 5% on the previous year. Looked-after children are defined within the Children (Scotland) Act 1995 [1], as children under the care of their local authority. While the number of children affected is the lowest it has been since 2005, and the majority of these children will be cared for within a community setting (90%), 10% are looked after within residential accommodation [2]. Children may become looked after on meeting the criteria set out in the Children's Hearing Scotland Act [3], under Section 67. Grounds for a child to be referred to the Children's Reporter, looked after and the subject of a supervision order include the presentation of needs and risks that seriously impact on the child's safety, health, or development.

The number of children who are referred to the Children's Reporter has also decreased by 67%, reducing from 31,371 to 10,494 from 2012–2022 [3]. Within this data a distinction is made between referrals on offence grounds (23%), where a child has been referred to the children's reporter or the courts as a result of committing a crime, and non-offence grounds (77%), where a child is referred due to care and protection concerns. However, this distinction is not clear, and it has been argued that differentiating between welfare- and offence-related needs is unhelpful as they are one and the same child [4,5].

Children may become looked after because they experience some form of abuse or neglect, require specialist care because they have additional needs, are illegally trafficked

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or are unaccompanied minors, or as a result of being involved in the criminal justice system [2]. While there is no national study of Adverse Childhood Experiences in Scotland, in a study of children within secure care, Gibson [6,7] found that 68% of children looked after within this form of residential care came from families who experienced relative poverty and the children's exposure to adverse childhood experiences was reflected in heightened levels of ACEs scores. On moving to residential care, the adversity and trauma previously experienced may be further exacerbated as children may experience placement instability, breakdown, and loss. Additionally, Steckley [8] (p. 1651) states that not living with one's family can result in feelings of "fear, rage, shame and grief" for children, which may result in intense feelings and emotions that can be expressed, misplaced, and repressed. While not specific to residential care, Gobbels-Koch [9] highlights a link between childhood maltreatment and the increased incidence of suicidal ideation and behaviour among children, young people, and adults internationally who experience care. The Scottish Government's [10] (p. 90)"Keeping the Promise" implementation plan highlights that "being 'trauma-informed' means being able to recognise when someone may be affected by adversity and trauma, and collaboratively adjusting ways of working to respond in ways that supports recovery, does no harm and recognises and supports people's resilience". Trauma-informed services that cater for children therefore need to be "structured, organised and delivered in ways that promote safety and trust and aim to prevent retraumatisation" [10] (p. 90).

2. Residential Care for Children?

Residential care for children is an integrated part of children's services in Scotland [11]. Care can be provided by the third, statutory, and private sectors and the form of care may be children's residential houses, residential schools, or secure accommodation [12]. Whittaker, Holmes, del Valle and James [13] (p. 6) state that these are therapeutic specialist houses where children are cared for; however, while they share some characteristics, they "vary greatly in treatment philosophies and practices including their purposes and the intensity and duration of interventions" they provide. Despite this, Johnson and Steckley [14] highlight a consistency in Scotland's residential childcare in that a relational model is the approach used. Welch, Fowler, Ross, Withington and McGhee [15] (p. 8) indicate that "availability, seeing the young person as positive and trustworthy, offering 'parental gestures', continued transitional support, support above and beyond paid duties, feeling valued, and being there for the long-term" are features of practice that is relational.

A recognition of the centrality of relationships is rooted in Scotland's national trauma training programme for staff [16]. Being trauma informed in residential care means recognising the commonality of trauma and adversity and how this can impact on individuals. The approach supports recovery and provides opportunities to avoid re-traumatisation by promoting safety and agency. Johnson [17] speaks about the importance of "predictability, structure and routine" to the healing process within group care settings. However, he also highlights that there are a number of events and interactions, such as aggression or self-harm, which may trigger children within residential care [17].

Care planning is a core component of effective trauma-responsive practice [17]. The Looked After Children (Scotland) Regulations [18] set out the responsibility of local authorities to ensure that a child's plan is prepared after an assessment has been undertaken. Local authorities have corporate parenting responsibilities which are set out in law, and there is an expectation that corporate parents have the same aspirations for looked-after children that they would have for their own children [19]. This statutory duty for agencies to work in partnership and coordinate activities may be delegated to services responsible for the day-to-day provision of care for children [19].

The National Practice Model framework, Getting It Right For Every Child (GIRFEC), was introduced in 2006 and underpins Scotland's assessment and care planning process [10], and the child's plan, in addition to reflecting the assessment, must identify outcomes that ensure the child is able to achieve the GIRFEC wellbeing indicators of Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included. Under legislation, for children who have been looked after on their 16th birthday, corporate parenting responsibilities continue until the child or young person's 26th birthday.

More than 75 years ago, the Clyde Report (1946) stated that residential care homes should house less than eight children [20]. The Care Inspectorate [21] (p. 18), the body that regulates and inspects residential care establishments, recently produced a report that states their "scrutiny evidence and data suggests that people living in smaller care homes often experience better care", with children reporting a desire to live in settings with no more than four beds, which is consistent with other findings [15]. This paper will consider this further by exploring whether group size mattered for the 13 young people who engaged in this study.

3. Research Design

The research began with a literature review into successful transitions, initially exploring adolescence to adulthood, for children who experienced residential care. Smith [22] highlights that transitions are emotional, experiential, and structural, which led me to widen the focus of the research to transitions in their widest sense. As evidence reflects that children and young people with residential-care experience have poorer outcomes in relation to employment, training, education, health, homelessness, early death, criminal involvement, and early pregnancy than most of their peers who are both looked after and in the wider population [23–26], my aim was to consider the care experience in totality. To view this holistically, the study needed to consider the entire care experience, exploring before, during and after journeys for children who lived in residential care to try to understand contributory factors more fully.

There is very little research into residential care in Scotland; research can be limited to government-funded reviews to improve practice [24–26], researcher-led studies exploring outcomes [23,27], research which includes those with lived experience [28,29], research related to relationships [30,31], restraint and containment [8], and trauma [17,32]. Practice-led research is largely limited to CYC-net and CELCIS and rarely takes the form of a PhD thesis. This PhD thesis aimed to add to this body of knowledge by engaging with young people with lived experience of residential care in the belief that their knowledge and expertise would add to our understanding of the entire residential care journey. Although we know poorer outcomes continue, despite legislation and social policy to redress imbalance [33], we do not have a good understanding of what supports effective transitions. The data were gathered for this purpose but provided qualitative information on the residential care experience which informs this paper.

Knowledge and understanding differs depending on the theoretical approach adopted by the researcher. Social constructionist theory indicates that meaning can change over time, space, and context [34]. Grant and Osanloo [35] highlight that with qualitative studies—i.e., the approach I was required to employ to ascertain narrative accounts—commonly, the theoretical framework emerges within the data-analysis stage of research. The study used for this paper used grounded theory which involved identifying and integrating "*categories of meaning*" [36]. This method was used to code and categorise the data into initial themes of "family and gender", "chaotic lives and negative assumptions" and "emerging adulthood and identity". Chaotic lives and negative assumptions was a theme for young people before, during, and sometimes after their experience of group care.

4. Methods

The approach taken within the PhD thesis was a mixed methodology which combined a short one-page questionnaire with semi-structured interviews. The methods were selected to elicit demographic information and narrative retrospective accounts from 13 18–29-year-olds with experience of residential care in Scotland. The approach relied on recall as some of the participants had left residential care many years before the interviews took place. The questionnaire asked participants for their age, gender, and ethnicity, before requesting information on entry, exit, number of placements, relationships, and the participant's understanding of the explanation for why they were received into care.

The interview schedule consisted of the following questions:

1. Did you feel ready to leave care?
2. How did you know you were ready?
3. Did your experience of residential care help to prepare you for the transition to adulthood? In what way?
4. What does being an adult mean to you? If necessary, prompt re role transitions, responsibility taking, decision making.
5. At what age did you feel like an adult?
6. Did you feel that you were supported if things didn't go to plan?
7. How and who provided you with support?
8. What role did your family play in your care experience?
9. Did you feel there was a stigma of being in residential care? Why do you think that is?
10. Did you leave care with qualifications? What were they?
11. Have you revisited formal education since leaving care, if so at what age?
12. Do you feel that you've achieved successful outcomes? What does successful outcomes mean to you.
13. What successful outcomes have been important to you?
14. Is there anything you feel you missed out on?
15. What could people have done to make your experience better?
16. Is there anything else you'd like to say?

These were designed to answer the research questions:

1. 'What are the early childhood experiences of young people who are placed in residential care in Scotland?
2. To what extent are young people supported to understand these experiences?
3. To what extent do young people get what they need from residential care?
4. To what extent are young people prepared for leaving residential care and what supports a successful transition.
5. Does the theoretical framework of emerging adulthood add to our understanding of their transition to adulthood?' [37].

5. Data Collection

The data were gathered between May 2017 and September 2018, pre-dating the COVID-19 pandemic. Recruitment was through a gatekeeper within an advocacy organisation who played a considerable role in supporting me to gain access to young people. It is recognised that recruitment of young people with experience of this setting is particularly challenging [38,39]. I aimed to recruit between 20 and 40 young people, a representative sample of around 4% of the children who are accommodated within children's houses over a one-year period [40]. Recruitment challenges resulted in 13 young people being interviewed.

Participants provided informed consent for all elements of the research, and they received both verbal and written information which included contact details for support services. Interviewees completed the questionnaire, which also served as an icebreaker, before the interviews commenced. Interviews ranged from 12–52 min; the average interview was 25.43 min. Interviews were recorded on a Dictaphone from the outset as discussions began when participants had begun to complete the questionnaire. Interviews took place at a time and location convenient to participants; the researcher travelled to offices, quiet coffee shops, and third sector services to undertake interviews. Ethical approval for the PhD was gained through the university research ethics committee and participants were given a £10 Amazon voucher for taking part in the study.

As I am a practitioner–researcher with 25 years' working experience of residential care for children, Reid, Brown and Smith [41] suggest that I shared an identity with participants. My practitioner experience as a residential child and youth care worker and residential house manager combined with my social work training, meant that I did share an insider language that made it easy for conversations to flow, and my "emic" perspective appeared to enhance relationships with participants. My 20 years as a residential manager made me consider my positional authority. While all of the participants in the PhD study were born in Scotland and described themselves as white Scottish or British, I identify as a Black Afro-Caribbean Scot, I am female and middle aged. My insider relationship was invaluable in enabling me to engage effectively with my gatekeeper [42]. The data have to be considered in this context as I believe these connections and relationships afforded me a unique opportunity in what is an under-researched area of practice outside academia. "You know what I mean" was frequently said within interviews, suggesting a shared knowledge and understanding from the perspective of participants.

6. Demographics

Data collected show the demographics of participants (Table 1). The group consisted of six girls and seven boys and the age range selected was informed by legislation in Scotland that supports care leavers up to the age of 26, and emerging adulthood transition to adulthood research, which reflects 18–29 year olds [43,44]. This range was determined by one of the purposes of the PhD thesis, which was to explore transitions from adolescence to adulthood. This range also allowed me to consider how experiences and perceptions of adulthood changed over time.

Table 1. Pseudonym, age, number of placements and Local Authority.

Pseudonym	Age on Admission to Care	Residential Care Admission	Age on Leaving Care	Age when Interviewed	Number of Placements	Local Authority Area
Luna	13	13	18	19	4	LA1
Lisa	12	16	16.5	22	6	LA2
Carol	6	12	18	24	4	LA3
Tania	0	13	17.5	20	18	LA3
Kevin	10	10	18 *	22	2	LA1
Bruce	Unknown	12	18	18	5	LA4
Mark	15	15	17	19	2	LA5
John	12	13	20	20	2	LA3
Hamish	9	14	19.5	29	51	LA1
Liam	11	11	21 *	27	15	LA1
Tina	3.5	7	19.5	20	14	LA3
Amy	15	15	16	24	5	LA6
Bob	6	12	18	27	2	LA7

* denotes moving on from a supported carer and not group care.

The Chart indicates that the young people who took part in the study came from seven of Scotland's 32 local authority areas. The time young people spent within residential care varied considerably, from 6 months–12.5 years. The mean duration of residential care placements was 5.3 years, while the median duration was slightly higher at 6 years; this differs slightly from the statistics in the table as nine young people moved on to supported accommodation or supported care placements. Three children entered residential care before the age of 12 years old, while most of the group entered as teenagers. Four young people experienced 14 or more placements. This data is consistent with the findings of [45].

7. Results Section

7.1. The Journey to Residential Care and Placement Stability

The Care Review [26] highlighted that multiple transitions may be "accompanied by feelings of loss, sadness, anxiety and a lack of security" [26] (p. 56). Within this study, young people were more likely to experience multiple placement breakdowns when they were placed within family-type placements, contradicting the continued view that family environments are the best place for children to grow up) [26]. Although less frequent transitions largely offered greater stability for young people in the study, Kevin spoke about how the transient nature of relationships impacted on his mental health (Kevin, Interview five).

Consistent with other studies reflecting the prevalence of ACEs for children within residential care [6,7,17], the young men experienced up to five adversities while the young women experienced between three and four. Devaney, Frederick and Spratt [46] highlight that children may find it difficult to cope with a high number of adversities over time. The number, however, does not reflect the impact or nature or the resilience of the child who experienced the adversity [47]. Most participants shared experiences of adversity that included poor parental mental health, familial criminal justice activity or imprisonment, substance use amongst parents, domestic violence, and issues of abuse and neglect within the family.

Amy spoke about her physical journey to the residential placement, during which nobody spoke to her or explained where she was going or why (Amy, Interview twelve). She feared that she was going to be beaten with coat hangers due to urban myths about residential care, and her way of trying to gain control over her life resulted in her refusing to eat (Amy, Interview twelve). She expressed a lack of insight shown by professionals and felt that it would have been helpful if staff had put themselves in her shoes. The Secure Care Pathway and Standards [48] Standard 13 states "I know the details of where I will stay, and I have access to information which explains daily life there. Every effort is made to visit before going to stay". These co-produced standards resulted from children sharing experiences similar to Amy's where they were deceived or kept in the dark about their intended destination.

7.2. Perceptions of Residential Care for Children

There is a lack of understanding about residential care—this is consistent within secure care [49]—and a need to disperse historical urban myths and reconstruct the narrative which has centred around residential care as a choice of last resort [50]. In part the stigma may inadvertently result from research illustrating poorer outcomes [26,28,38]. Information reflecting the fact that children placed in residential care have more complex needs without critically evaluating and analysing can exacerbate this view [51]. Within the study, only two participants went to a residential house as their first care placement and both of these young people experienced good outcomes overall (Kevin, Interview five; Mark, Interview seven). Most within the study could be described as high achievers when using educational outcomes as a measure [52], although Kevin stated that because he was doing well at school his emotional needs went unchecked. This finding is consistent with Duncalf [45] in her study of care leavers aged 17–78, suggesting that educational attainment develops over time. Nine out of thirteen participants went to college and three university. Matheson and Connelly [53] highlight that poor educational outcomes are not inevitable, and with supportive, stable placements trajectories can improve over time [54].

7.3. Placement Stability

Participants experienced between one and 50 placement moves. Although these figures are not unusual [26,45], there is an assumption that the placement instability is experienced within the group care setting. Amy describes a very swift transition during her initial period within residential care. Arriving at the children's house late at night she was taken to a dark room where she slept on a sofa bed before being moved in the morning. A smaller setting may have afforded staff the opportunity to familiarise Amy with her surroundings and explain the process [15], but Amy was moved to a house where she lived with five other children without any preparation. Placement instability is described as being in-built to a service viewed as a last resort [50].

Placement instability, reflected in moves in living arrangements, was also evident in many children transitioning to new schools. Seven of the participants spoke about changing educational provision; six of the group spent a period of time within specialist education provision while the remaining seven were sustained within mainstream secondary education. Dixon and Stein [55] note the instability of movement from family and community and the subsequent impact on unfulfilled educational, developmental, and health needs. Within the study, it appears that almost half of the participants had additional support for learning needs that may have been exacerbated by a lack of secure educational provision. The young people also spoke of difficulties being supported after school with homework or access to a computer (Kevin, Interview five).

While movement in education provision was not always viewed positively and may impact on educational attainment [27,54], Hamish said that he moved to a better area and school when he moved into residential care (Hamish, Interview nine). He felt that he missed out on the opportunities afforded his peers, such as school trips, saying "they would get to go snowboarding and France and quite fancy things so I used to think that I was missing out because you can't do that when you have eight other kids to consider" (Hamish, Interview nine).

7.4. The Number of Children within the Residential Placement

The number of children within the residential house was mentioned by a further nine participants in the study. They expressed feeling that the ability of staff to meet their emotional and practical needs was affected by the number of children in the placement and this view is reflective of contemporary experiences of children shared in research and as part of a Care Inspectorate review [15,21]. The Care Inspectorate [21] (p. 19) found that smaller houses were viewed as supportive of the ability of "people to form positive, worthwhile relationships with staff and other young people". Smaller houses were seen as more homely and settled and more conducive to time to oneself. This reflects what the Care Inspectorate describes as a "domestic model" [21].

Within the study, the young people shared their experiences of the group living situation, which was viewed more negatively, both by the young people themselves and their wider social network, than familial-style care settings. The young people associated living within residential care with failure. Tania stated that she lived within a residential house when she "was too much for the foster carers" (Tania, Interview four). Placement breakdown was associated with self-blame rather than an inability of adults or the system to meet children's care needs. Perceptions of children as either dangerous or in danger is pervasive in welfare provision for children [56]. Lisa talked about assumptions made by people that she had possibly committed murder to be placed within a group care setting (Lisa, Interview two). Negative stereotypes were expressed by 11 out of the 13 participants, resulting in many blaming themselves for being in care.

7.5. Comparisons with Peers

Children made comparisons between themselves and multiple peer groups, comparing themselves to brothers and sisters, friends at school, and those within their household group (Luna, Lisa, Kevin and Hamish, Interviews one, two, five and nine). Normative sibling rivalry can be exacerbated when children have the complexity of being members of multiple comparison groups. Klass [57] highlights that parents can differentiate their children, for instance as the pretty or clever child. Isaacs [58] states that sibling rivalry can be viewed as universal and a valuable developmental opportunity where children can learn to problem solve and manage conflict. Within a residential setting, where children are unlikely to be related to each other, organisational processes and bureaucratic constraints may limit children's opportunities to learn from each other.

7.6. Living with Children Who May Have Experienced Trauma

When living in a group setting with unrelated individuals, even as a result of entering care for your own safety, which was the case for five young women in the study, the residential care setting can be experienced as hostile and unpredictable. Children may have limited control or respite from other children or adults and re-traumatisation may occur when behaviour is a reminder of past experiences or events. Kevin noticed "people's behaviour being so radical because they were seeking care and attention by doing ridiculous things that was getting them into trouble" (Kevin, Interview five). Pain-based behaviours are a way for children to express their pain [59]. Kevin stated that because he did not make demands on staff or act out, his emotional needs were not met as staff attended to self-harming behaviours. Johnson, et. al. [32] highlight the prevalence of self-harming behaviour within residential care, and the distress that it causes to both the individual and others within the setting. Self-harming and acting-out behaviour impacts on the availability of staff to the wider care group [32,60].

Hamish said that his behaviour mirrored people's expectations of children who live in children's houses. He said: "I kept lashing out at people as well, so it was a self-fulfilling prophecy" (Hamish, Interview nine). Goffman [61] distinguishes between social identities, which are shared, and social alliances. All of the young people who took part in the study defined themselves as care-experienced. Goffman states, "the stigmatized individual may exhibit identity ambivalence when he obtains a close sight of his own kind behaving in a stereotyped way" [61] (p. 131). Unlike Hamish, two of the other participants spoke about trying to distance themselves from the stigma associated with residential care by avoiding their immediate peer group and associating with children and young people outside the care system (John, Interview eight; Kevin, Interview five).

Luna found it difficult to live away from home in a residential setting and found the house "a really hard place to live" (Luna, Interview one). While she recognised that there were worse places, her emotional needs remained hidden. Luna spoke about struggling to form relationships with other children due to the fear that they would move on. This view was shared by many participants and Kevin spoke about a lack of felt security despite remaining in the same placement for eight years, due to the transitions experienced by other children and staff (Kevin, Interview five). Young people seemed to be so accustomed to others coming and going that despite placement stability there was a fear that they could be moved at any time.

A lack of a consistent staff team was reflected within the Care Review [26]. Three participants spoke about shift working and its impact on the group living experience. While children may need to navigate differences in parenting styles within a family, within a group care setting the presence of multiple adults may result in the need to adapt to what may be changing rules, expectations, and demands. The size of the staff team will invariably affect the impact of this. Kevin and Hamish viewed the impact of three shift changes daily as disruptive (Kevin, Interview five; Hamish, Interview nine). A lack of consultation and discussion around staff movement also caused anxiety and exacerbated a sense of insecurity (Kevin, Interview five). Only three young people in the study formed friendships with peers that continued after they left care (Luna, Interview one; Bruce, Interview six; Mark, Interview seven). There was a fear of forming friendships when relationships could be fleeting.

Bob struggled with how staff prioritised their duties (Bob, Interview thirteen). He stated that when he wanted to speak with his keyworker they would ask him to wait and would prioritise administrative tasks; emotional availability is likely to be affected by the demands of the shift [60]. This left him feeling unsupported and disempowered when preparing for meetings or time with his family. Staff members have to prioritise needs and, while relational models of practice are crucial to meaningful engagement, not all children may receive this prioritisation well [32].

7.7. Relational Practice

Every young person in the study experienced positive child–adult relationships before and during their time in residential care and beyond. Liam spoke about the ongoing support he continued to receive from his former keyworker, who was like a father to him; they had had a constant relationship for 11 years (Liam, Interview ten). Tina's experience was similar in that her residential worker was viewed as a mother and the relationship had continued and was enduring for 12 years (Tina, Interview eleven). Characteristics of beloved staff included active listening, and being present, caring, reliable, and stable. These traits are consistent with findings elsewhere [15]. Unsurprisingly, children didn't get on with all staff, but John reflected that this could be down to a number of things including personality (John, Interview eight). However, for Hamish and Tina, screening should identify staff that should not work within residential childcare. Hamish reflected on a time when he had briefly moved on from a placement. He said "there was one staff member who took a grudge. I don't know if she felt I'd betrayed her or abandoned her or whatever, but she was horrible after that. . .another lassie about a year later had a similar situation. . .and she got the same treatment" (Hamish, Interview nine). Kilpatrick, Berridge, Sinclair, Larkin, Lucas, Kelly and Geraghty [62] indicate that staff's own life experiences and the stresses of the job may impact on their receptiveness to those within their care. Relationships within this setting are complex and "blocked care" can be evident when stress can affect a staff member's capacity to be empathetic and the propensity to sustain loving feelings [63].

The young people's relationships with non-residential staff lacked consistency, as highlighted by Lisa and John's accounts. John said, "I went through eight social workers in five years which isn't ideal. It's having to get to know someone else, someone else who knows everything about you and someone else making decisions and you probably don't want them making those decisions" (John, Interview eight). Lisa said, I "had thirteen social workers in four and a half to five years or so. . . I never had that one person I could talk to" (Lisa, Interview two). Hamish reflected an understanding of social work and the social work system. He said, "you understand a bit more [as you get older] . . . I found out that my last social worker had 28 cases. . .no wonder she had such a shit time" (Hamish, Interview nine). A high caseload impacted on his ability to receive the support that he needed.

Developing trust, for children who may have experienced trauma or adversity, can be challenging, so consistent, reliable relationships are crucial. Tania said, "I didn't trust people because I was always getting told lies. . .so I didn't really. . .build relationships with all the staff" (Tania, Interview four). For Kevin, an inability to trust resulted in him feeling alone "even now being surrounded by friends and stuff" (Kevin, Interview five). In a study by Gabriel, Keller and Bombach [64], adults displayed emotional and social scepticism towards both others and themselves, and this continued for years on leaving care. Lisa felt she missed out on having the emotional support from that one person, the stable parental figure you could confide in. Someone "that would cuddle me when I was crying or understand when I was upset" (Lisa, Interview two).

7.8. Familial Relationships

Family relationships with brothers and sisters were important to all of the young people within the study, except Amy (Interview twelve) who was an only child. As children, they experienced a sense of loss on going into care. Hamish spent a short period of time placed with his brothers in foster care, but only Kevin experienced a period of time in residential care with his brother (Hamish, Interview ten, and Kevin, Interview five). This broke down when the brothers' sibling rivalry was seen as problematic, resulting in the brother being moved on (Kevin, Interview five). Membership of a sibling group gives children a unique identity, so separation can have a significant impact. Luna's experience, in which her brother continued to have regular contact but the relationship with her sister was confrontational, would indicate the complexity of relationships (Luna, Interview one). Almost half of those involved in the study had brothers and sisters who had no experience of care, but it is difficult to ascertain if this is consistent with other findings as data is not collected nationally.

Ibsen and Klobus [65] describe fictive kin as nonrelative relationships that are kin-like in nature. Two of the youngest participants in the study spoke about ongoing mental health concerns despite the development of a consistent fictive relationship with an adult while they lived in residential care (Kevin, Interview five; Tina, Interview eleven). Miller, Wakefield, and Sani [66] link positive mental health with multiple group identities including family, school, and peer. This was an area that was lacking for most of the participants, with few experiencing positive affiliations as they had moved away from their family, community peer group, and, for all but one, their local school. The strongest indicator of good mental health in 13–17-year-olds has been highlighted as a positive association with one's school [66].

7.9. Group Care Norms

Liam stated that the children's home, with five other children, provided him an opportunity to opt in or out of daily routines such as eating at the dinner table (Liam, Interview ten). While he viewed this as agency, if he had not subsequently experienced a supported foster placement, this may not have been part of his life experience or accepted familial norms. For Kevin, bureaucracy within his residential placement had an impact on his ability to integrate within the local community. He said, "my friends [weren't] allowed to stay over at my house. . .when they [came] in my house, they [had] to sit in a reception room, [as] they weren't allowed to come through and sit in my bedroom" (Kevin, Interview five). It is difficult to envisage how individualised care planning approaches can be consistent within a setting housing five or seven other children, such as the setting where Kevin lived. Kevin spoke about how this affected his experience of childhood as he felt different to his peers. He also reflected on practices that were risk-focussed, such as visits to the beach which needed to be supervised or have a trained lifeguard on hand (Kevin, Interview five). A blanket approach resulted in staff being unwilling to give him train fares for fear that the money would be misappropriated or spent on alcohol (Kevin, Interview five); a smaller milieu with supportive opportunities may have resulted in different childhood experiences. Tina also spoke about institutionalised practice that became internalised as norms such as having a sanitary bin in your ensuite, or toiletries and razors stored centrally within a locked cabinet (Tina, Interview eleven).

7.10. Positive Experiences

While outcomes studies illustrate that residential care-experienced young people are more likely to experience homeless and unemployment, have higher early mortality rates, poor mental health, increased risk of contact with the criminal justice system, an increased risk of early pregnancy, and low educational attainment [24,39,67], this is not the experience of the young people within this study. Duncalf [45] also illustrates that residential care-experienced care leavers were more likely to describe their experiences as "mainly positive" than those who experienced foster care and less likely to share this experience as "mainly negative". Research illustrates that multiple caregivers are able to provide the nurture and support that children and young people need [68–71], and all of the young people in this study benefited from the love and care they received from staff whose job it was to look after them. More positive experiences may partially be explained by the participant recruitment process, as all but one of the participants had ongoing contact with an advocacy agency which engendered positive wellbeing support.

Tina spoke about what could be considered a well thought-out preparation and planning experience for moving on from her residential house (Tina, Interview eleven). Preparation begun at the age of 15 years old, when a plan was formulated and tasks were gradually introduced to promote selfcare skills such as tidying her bedroom, laundry, setting an alarm and budgeting, shopping, and cooking (Tina, Interview eleven). Appropriate support was provided through a whole-team approach, including the house cook.

Mendes, Standfield, Saunders, McCurdy, Walsh, Turnbull, and Armstrong [72] state good transition planning should begin between the ages of 12 and 15 years old, with a holistic approach required. The young people within the study spoke about barriers to preparation including the number of children to staff ratio, and most of the residential houses ranged in resident group size from 6–16, making it difficult to prioritise individual needs. Young people found it difficult to experience the quality time required to make this preparation meaningful (Liam, Interview ten; Bob, Interview thirteen; Luna, Interview one). In contrast, the study group spoke about beginning preparation for leaving care within supported carer or accommodation placements; however, these were not experienced until young people were 16 (Lisa, Interview two; Bruce, Interview six; Mark, Interview seven; Amy, Interview twelve) or 18 (John, Interview eight; Liam, Interview ten; Hamish, Interview nine). These experiences are despite local authorities having a statutory duty to prepare children and young people for leaving care.

8. Limitations of the Study

This study offers insight into the lives of thirteen young people with experience of residential care. A single agency was used to recruit participants, with one exception where recruitment resulted from word of mouth. Recruitment of young people who have left care is challenging as they are likely to be disengaged [39]. A single recruitment source may have limited the experiences of participants as they were all actively involved in the children's services sector in an advocacy capacity and had support networks in place. This also restricted eligibility, as most children and young people who accessed the agency did not have experience of residential care. Attempts to recruit young people outside this agency proved unsuccessful, resulting in a low response rate.

The small sample size may not be representative of the wider residential care-experienced population, making it difficult to draw conclusions from the study. Additionally, retrospective accounts rely on recall and, as children may have experienced traumatic experiences and shared their stories repeatedly over time, the accuracy of recall can be high but complex [73].

9. Future Research

The primary function for data collection was to gain a better understanding of the journey before, during and after residential care. The purpose of the PhD thesis was therefore not to ascertain children and young people's experiences of the limitations or benefits of group size. However, this was an area that was discussed by 11 of the 13 participants and provides a starting point for this discussion. Future research should focus on this experience of residential care with particular attention given to provision for smaller group sizes. This would provide us with a clearer picture of the impacts of group size and placement capacity.

10. Conclusions

This paper shares the experiences of thirteen young people who spent a period of their time in care within residential care. Many experienced a number of transitions before entering residential care, reflecting rejections from family-style settings. Urban myths and a lack of understanding about residential care can result in children and young people feeling anxious when entering this type of placement and stigma can be associated with this form of care. There is a lack of understanding more widely about Scotland's relational approach in group care.

Placement instability was experienced by most young people in the form of their own moves, moves of peers, or staffing moves or shift changes. This affected children's ability to form relationships for fear that they would be transient, but all of the young people in the study were able to form a meaningful relationship with a significant adult. Children, young people, and staff may move from one setting to another, affecting people's ability to trust and form meaningful relationships for fear that they will be transient. One young person, who had experienced a stable eight-year placement, lived in fear that his placement would come to an end as a result of the instability of others. Despite this, the young people within the study all had a significant adult who had played a positive role in their life.

The group size was mentioned by almost all within the study. Consistency and felt security within a larger group setting were seen as being difficult to achieve as staff responded to the needs of children who required their immediate attention. Childhood experiences were impacted by residential care bureaucracy and young people felt that their developmental, practical and emotional needs went unmet. The group achieved good outcomes educationally, but this success was also viewed as masking unmet emotional needs. Only one young person within the study was prepared for a time when they were no longer going to be in care and others saw a lack of preparation resulting from staff to child ratios, administrative priorities, and the needs of the residential group. Most young people experienced additional support if they moved on to supported accommodation.

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Article

Charting the 21st Century Rise of For-Profit Residential Child Care

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Abstract: This article explores the increasing prevalence of for-profit residential care, with a particular focus on Great Britain, while also drawing on the international evidence from the Global North. Comprising a critical review of the published evidence (both academic and grey literature), the article seeks to examine what might explain the rising prevalence of and the possible associated impacts of the increase in for-profit provision. The findings indicate that the rise of for profit-companies among residential child care providers appears to have occurred by default, rather than explicit policy design. Our analysis also highlights gaps in the knowledge base about the quality of care and whether better quality is associated with the type of provider. Furthermore, the relationships between provider, quality, cost and outcomes are unclear. There are inconsistencies in the evidence base, with different conclusions being reached. However, available evidence tends to suggest the increased prevalence of for-profit residential child care providers has had an overall negative, rather than positive, effect. The best case in favour of the continued use of for-profit residential care is currently a non-moral pragmatic one: that in countries with medium and high prevalence of the use of residential child care, it would be hard to sustain care systems if for-profit providers were to suddenly withdraw or be withdrawn.

Keywords: out-of-home care; residential child care; privatisation; private equity; transnational corporations; for-profit care providers

1. Introduction

Over the last decade, increasing questions have been asked about the increasing prevalence of for-profit residential (group) child care providers in Great Britain, which sit among wider concerns about moves to privatise elements of its child welfare services [1] These concerns are shared in a number of other countries of the Global North [2–5]. In Great Britain, the concerns recently generated an investigation into the levels of profit-making in placement provision by the Competition and Markets Authority (CMA) [6]: this is a non-ministerial Government Department in the United Kingdom which oversees markets' operation. These sit among a set of wider challenges in finding suitable residential placements available for young people with high-level and complex needs [7].

This article contains a critical analysis which charts and explores the rising prevalence of for-profit residential child care provision in 'Great Britain' (GB) (GB refers to Wales, Scotland, and England; the United Kingdom (UK) refers to these three countries as well as Northern Ireland), with a particular focus on England. The article explores the potential reasons for this rising prevalence and assesses what is known about its impacts. It places these in a wider international context by exploring similarities and divergences in the residential child care sectors in other post-industrial countries of the Global North.

The findings indicate that the rising proportion of for profit-companies among residential child care providers appears to have occurred by default, rather than explicit policy design. Our analysis highlights gaps in the knowledge base about the arising quality of care and whether better quality is associated with the type of provider. Furthermore, the relationships between provider, quality, cost, and outcomes are unclear—there are inconsistencies in the evidence base, with different conclusions being reached. However, the currently available evidence does tend to suggest that increased prevalence of for-profit residential child care has had an overall negative effect. Thoughts on implication and future policy directions are offered in the Discussion and Conclusion sections.

2. Materials, Methods and Concepts

This article is based on a critical review of evidence exploring the following questions:

- What is the evidence for the rising prevalence of for-profit residential child care provision in GB?
- What might explain the rising prevalence, and what is known about its impacts?
- What evidence is there of similar or divergent developments in other countries in North America and Europe?

As in other countries, residential child care provision in GB may be provided by 'private' for-profit companies, non-profit 'voluntary sector' charitable organizations, or by state ('local authority') providers. The balances between these three types of provision have changed historically in light of social policy and political developments [8]. For-profit companies providing residential child care have usually included small, generally family-run companies which own one or a few facilities and medium-sized firms which own several. However, in GB and internationally, both have been superseded by the entry of larger corporations into residential care provision. These corporations tend to purchase large numbers of residential care facilities and frequently also deliver other public welfare services alongside activities in the non-public economic sphere [3,6,9].

Given the focus on GB, and England in particular, the analysis for this article began via analysis of government statistics and data on the residential child care sector in England as well as the recent CMA report which explored profit-making in placement provision in GB [6]. Additional literature was identified by a hybrid strategy of reviewing key index literature which was known to the authors with relevant data within it; backward and forward citation searching from this literature; and a search of Google Scholar and of the Social Science Premium Collection database via ProQuest using the search string "residential AND child* OR youth AND private OR profit". Inclusion was based on relevance to the questions set above. Any sources considered were in the English language only and no date restrictions were applied, though the vast majority of literature retrieved was post-2000.

We suggest three moral positions towards for-profit residential child care provision. The first is a principled objection position that profiting from the care of vulnerable young people in out-of-home care is morally wrong in all circumstances. The second is a pragmatic position that for-profit provision can be morally justified but only if it provides clear advantages over non-profit provision. The third is what we term a market-orientated position that market mechanisms and competition between suppliers of residential child care provision will drive down costs and improve its diversity and quality. The underpinning moral justification for a market-orientated position is, we suggest, identical to a pragmatic position but differs in assuming that the entry of for-profit provision will lead to lower-cost and better-quality services if market mechanisms operate correctly. A pragmatic position would, however, premise the use of for-profit provision on the conditionality of clear evidence of its advantages.

The remainder of the article outlines the context of residential child care provision in Great Britain and charts the rise of for-profit provision in the three constituent GB countries. It then explores the potential GB-specific reasons for it. Second, the article places this evidence in a wider North American and European context by exploring similarities and divergences in this area. Third, the article explores underpinning reasons for the rise in for-profit residential child care provision across countries as a wider phenomenon of global capital entry into public welfare service provision in post-industrial countries in the 21st century. The discussion summarizes the findings and considers proposals for addressing emergent concerns.

3. Results

3.1. Evidence from Great Britain

3.1.1. The Great Britain Context for Residential Child Care

Compared to other countries in the Global North, GB falls into a low utilization category of residential child care: a little over 10% of all placements are in the sector in Wales, Scotland, and England [6]. This compares to close to, or more than, 50% in Spain, the Netherlands, Germany, and Finland, and over 90% in Portugal [10]. The lower use of residential child care provision in GB means it is principally used for young people over 10 and young people with higher-level care needs [11]. The majority of children in state care in GB are in family-based foster care, and there have also been concerns about the increasing presence of for-profit and private-equity-backed for-profit fostering provision [6]. At the same time, demand for residential child care placements has been rising over the last decade as the numbers of children in state care in Wales and England have been on a rising trend [12]. One feature of this over the last five years has been large increases in the numbers of teenagers with highly complex needs who require care placements: a shortage of appropriate local provision has seen a number of young people being placed in unregulated placements and at significant distance from their home areas [7].

3.1.2. The Rise of For-Profit Residential Child Care Provision in Great Britain

The United Kingdom is an independent state which is made up of Wales, Scotland, Northern Ireland, and England. Since the 1990s, some policy-making powers have transferred to national Parliaments in Wales and Scotland and a national Assembly in Northern Ireland. These bodies can legislate on matters in their respective countries which are not 'reserved' to the UK Westminster Parliament's exclusive jurisdiction. Legislation and policy which relates to children's social care and work is *not* reserved to Westminster. Therefore, the national Parliaments and national Assembly are able to develop country-specific legislation and policy in this area. One consequence of this has been an increasing divergence between the four constituent countries of the UK since the late 1990s in social care and social work legislation and policy.

There has been a substantial increase in the proportion of all care placements provided by for-profit providers in Wales, England, and, to a lesser extent, Scotland, over the last two decades [6], (see also Table 1, below). Though UK Government statistics on for-profit residential child care provision have not been consistently published, the data that have been nonetheless demonstrate a marked increase in for-profit provision residential child care, as well as for-profit fostering services, in the last 25 years in England. The overall prevalence of *all* for-profit placements in England increased from 28% [13] to 38% of *all* placements in just over a decade [14]. The rise in for-profit residential child care provision specifically has been ever starker. In 1998, just 12% of residential child care provision in England was for-profit [15]; the latest Government statistics show this is now 80% of all residential child care provision [14]. The recent CMA analysis reported that for-profit providers now supply a similar proportion of residential placements in Wales (77%), with a notably lower but still substantial proportion (35%) in Scotland [6].

Table 1. Proportion of children in RCC in England in for-profit RCC in England, 1998–2022 (Sources: [13–15]).

	All Children in RCC	Children in for Profit RCC	Percentage of Children in RCC in for Profit
2022	14,150	11,280	80%
2010	8190	4490	54%
1998	6650	770	12%

It is notable that the initial surge in for-profit prevalence in England occurred at some point between the late 1990s and 2010 under left-of-centre ‘New Labour’ Governments. Supporting this contention, in 2013, a (Conservative) cabinet minister, who at that time had overall responsibility for children’s social care in England in Prime Minister David Cameron’s first Government, stated there had been a decline in local authority residential child care provision from 61% in 2000 to 35% six years later [16]. Since 2010, under successive Conservative-led Governments at the UK level, there has been a further marked rise in the numbers of children and young people in for-profit residential provision, reflecting both growing numbers of older children within the care system as well as the ongoing growth in prevalence of for-profit providers.

3.1.3. Great Britain Specific Reasons for the Rise in For-Profit Residential Provision

Successive UK governments from 1979 embraced the entry of for-profit providers into publicly funded welfare services. A UK landmark was the NHS and Community Care Act 1990, which introduced a purchaser–provider split, paving the way for the development of an internal market within the National Health Service (NHS) and commissioning arrangements for services in regional government local authorities. This change, supplemented by subsequent legislative and policy reforms, has seen governmental bodies in the UK retain overall statutory responsibility for the delivery of public services while the services themselves are frequently contracted in from for-profit providers. New Labour Governments from 1997–2010 extended the use of market mechanisms within public service delivery, and these were further embedded in children’s services under right-of-centre governments from 2010 [1].

The rise of for profit-companies among residential child care providers since 1998 appears to have principally occurred by default, rather than explicit policy design [17]. Instead, broader market-orientated reforms in other areas of public service delivery provided encouragement to for-profit companies looking for additional areas of public welfare provision to expand into. Within child welfare services, placements were the first area of children’s social care services to be significantly outsourced from the late 1990s. Subsequently, the Cameron Governments (2010–2016) indicated their warmness towards increasing for-profit provision in child welfare services more broadly. This included, in the mid-2010s, proposing to open up child protection services in England to for-profit providers, rowing back after significant public opposition [1]. The first Cameron Government had previously commissioned a report lead authored by a firm specializing in private health care market analysis [18], which adopted a strongly market-orientated position in laying out models for greater for-profit involvement in a range of children’s services provision in England. With respect to residential child care placements, the report contained the claim that in England, there had “long been a particular concern over the conflict of interest that exists due to local authorities both commissioning and providing placements for children” [18] (p. 119). It also reported the claim that “Outdated costing, sequential decision-making, rigid contracting mechanisms and burdensome tendering processes” with respect to residential child care provision [18] (p.120) were problematic. The experience of Scotland—where there is a lower proportion of for-profit residential child care, as well as a formal ban on for-profit foster care providers [6]—and Northern Ireland—where the proportion of for-profit residential child care provision has remained minimal [19]—provide points of contrast within the UK. These contrasts strongly suggest that within the UK, regional conditions, though not necessarily formal policies, have facilitated or inhibited the development of for-profit residential child care provision.

The decision of local authority and voluntary sector providers to leave residential child care provision in large numbers in Wales and England from the late 1990s also merits consideration. The following appear significant. First, local authorities and voluntary sector organizations had to make large cuts following UK government ‘austerity economics’ plans from 2010 [20]. Residential child care provision has long been noted to be considerably more costly than family-based placements [11]. While recent attention has focused on the excessive cost of for-profit placement provision to local authorities [6,21], this has only become a significant policy concern in recent years. In the early 2010s, when local authorities and voluntary sector organizations were looking to make savings, reducing direct provision of residential child care facilities would have been initially attractive given the capital investment, interest on borrowing costs, and high ongoing running costs associated with it.

Second, national policy makers have engaged in marked criticism of state ‘failures’ within child welfare services in England while encouraging for-profit provision. Conservative governments from 2010 have removed some regional statutory children’s services from direct local authority control due to alleged inadequacies in their performance [1]. Poor individual-level service performance has thereby been linked to its management within state (local government) organizational structures. By contrast, examples of inadequate or dangerous child welfare service provision by for-profit companies has either passed without public comment from senior policy makers, or has been presented as an individual issue, rather than a systemic one linked to the modus operandi of profit-making firms in welfare provision (e.g., see [22], Column 138).

3.1.4. The Impact of For-Profit Provision in Great Britain

We turn to examine whether there is evidence of the increasing prevalence of for-profit provision having positive impact on residential child care provision in GB, as the moral justifications for both a pragmatic position and a market-orientated position require.

The Quality of For-Profit and Public Residential Child Care Provision

There is little research comparing the quality of different models of ownership of residential child care provision in GB. One of the few studies to do so is over 25 years old, and the authors were also at pains to emphasize that their study was not a strictly comparative one (there was much more local authority than for-profit provision in their sample) [23]. The authors did, however, find that young people had better experiences within for-profit provision and that staff morale was better. The authors suggested this finding could be explained by the private residential homes’ greater focus on a treatment regime which was underpinned by their greater distance from children’s home communities. It would be unwise to draw wider conclusions from a single, dated, indirectly comparative study conducted before the rise in prevalence of larger for-profit companies had occurred. However, the study did illustrate the possibility that for-profit provision could provide better quality of specialized residential care provision and suggests a possible reason why policy makers may have believed at this time that the expansion of such provision could prove beneficial.

In a contemporary context of high prevalence for-profit provision in GB, one concern about its prevalence has been exactly that it is associated with young people’s placement at distance from their home communities. In 2010, the UK government introduced statutory guidance for England giving local authorities a ‘sufficiency duty’ to maintain an adequate number of placements for children and young people to be placed locally [24]. However, a recent study [25] found that the increasing prevalence of for-profit providers in foster care and residential child care was statistically significantly associated with the placement of fewer children in their local authority area, though they did not establish a causal link.

There is also no recent evidence that for-profit provision is better quality as judged by other criteria. An organization principally representing for-profit providers of children's homes in Wales and England has stated that there is no systematic difference in quality between for-profit and other ownership types of residential child care [26], a claim repeated in the recent CMA market analysis (2022) [6]. It should be underlined that this claim is not that for-profit provision has improved the quality of residential child care provision, only that it is, on average, no worse.

Even this more residual claim is questionable according to current evidence. There have been a number of concerning reports by the independent non-ministerial government inspectorate of children's homes in England, The Office for Standards in Education, Children's Services and Skills (Ofsted), concerning for-profit facilities. Ofsted inspect children's homes against a range of domains to review the quality and safety of care provided to young people in a particular residential child care facility and provide an overall rating of the home based on a four point scale ('outstanding', 'good', 'requires improvement to be 'good', and 'inadequate'). Recent journalistic investigation reported that, of the private children's homes whose most recent Ofsted inspection reports they had examined, 114 had been found to be 'inadequate', 20 of which were linked to private equity firms [27]. It should be emphasized that is not only for-profit children's homes that Ofsted inspections of children's homes have raised concerns about. However, in-depth analysis has established that for-profit residential care facilities are less likely to receive better Ofsted ratings. Bach-Mortensen et al. [28] found, based on detailed analysis of all Ofsted ratings of children's homes in England from 2014–2021, that for-profit children's homes were statistically significantly less likely to receive better ratings across all the domains Ofsted inspects against compared to state and voluntary sector provision. They also found that for profit providers were 1.44 times more likely to have violated a legal requirement than local authority providers. In a separate study, the same authors [25] also found that the rise in for-profit provision in both foster and residential child care has been associated with a statistically significant decrease in placement stability, where placement stability is defined as the proportion of children who have been in the same placement for at least two years.

Such findings could be influenced by wider contextual factors such as placement and commissioning decisions to place or move children which are beyond an individual provider's control. For example, sequential placement decision making could mean children are placed in for-profit provision only after local authority placements have been unsuccessfully tried, influencing some of the negative differences identified. However, this is a speculative claim which, at least currently, lacks empirical data to support it.

Costs

We turn now to consider evidence of the impact of for-profit residential child care provision on its cost. This section focuses on GB, although similar issues are evident internationally (c.f. [29]).

Concerns about the high cost of residential care are long-standing, and particularly the difference in cost between residential and foster care [30]. During the intervening period, there have been attempts to better understand the costs of different placement options and explain variations. Knapp and Fenyo (1989) [31] included indirect costs in their analysis and indicated that this approach reduced the difference in costs between foster care and residential care. However, it should be noted that cost comparisons between different placement types (i.e., foster versus residential) are largely unhelpful, given they are such different provisions, with very different running costs. It has been argued that it is preferable to relate the costs of placements to the needs and circumstances of children, the quality of care they receive, and the outcomes achieved [32]. It is only by comparing costs and outcomes that we can identify which services (placements) provide the best use of limited resources [33].

In the late 1990s, concerns were raised in England about the delivery of (cost) effective children's social care and unexplained variations in the costs of services [34]. This was also at a time when the number of children in England being placed in care was going down and the total expenditure was increasing, with no explanation for the increase in unit cost per child or whether resources were being used effectively [32]. These concerns led to the commissioning of a national research initiative with the inclusion of an economic component in all studies [35]. Of relevance, one of the studies focused specifically on the leadership, management, and resources in children's homes [36]. They sought to understand the variations in costs of different types of residential provision and identified that these could be attributed to a range of factors including the needs and characteristics of the children, the staff-to-resident ratio and the provision of 'packages of care' (including education on site). They also identified geographical variations with higher costs being associated with provisions in the South of England [36].

Since the early 2000s, unit costs of different placement types have been published in the UK; these are usually based on a nationally applicable average for either foster care or residential placements, and a range of approaches have been used. The variability in approaches (for example, the use of either top-down or bottom-up methods (a top-down approach to unit costing assembles all the relevant expenditure of providing a placement and divides this by the number of children in receipt of that type of placement. A bottom-up approach identified all of the constituent parts of the delivery of a service (i.e., placement) and assigns a value to each)) and what components have been included in unit costs makes comparisons difficult [37], although some sources do distinguish between local authority provision and the for-profit sector. However, like-for-like comparison of the costs of residential placements by different providers has been an ongoing point of contention. Hicks and colleagues (2009) [36] reported that children's homes provided by the 'non-statutory' sector were more expensive than those in local authorities, but that the difference was not statistically significant. Furthermore, Ward, Holmes, and Soper (2008) [32] identified substantial variability in the costs of residential placements and offered examples of for-profit, specialist provision, such as therapeutic settings that include psychological services as part of the placement, with high staff-to-child ratios having the ability to skew the budget for children in care in a local authority. More recently, Stanley and Rome (2013) [38] reported that the cost of homes provided by the for-profit and voluntary sector (based on the prices paid by local authorities) was substantially lower than the annual unit costs published by the government: GBP 2841 [USD 3570] per week compared to GBP 3282 [USD 4124]. The most recently published unit costs [39] indicate the opposite of the findings from Hicks et al. (2009), reporting a higher weekly unit cost for local authority residential care (GBP 5045) [USD 6340] than for private and voluntary homes (GBP 4332) [USD 5444]. The fundamental issue with these comparisons between providers is that without necessary transparency in the calculations and assumptions underpinning the calculations, it is impossible to determine whether the differences are real or just a result of different methodologies [37].

The reported costs of placements and cost comparisons is, however, only one element of considering the role of privatisation. To understand the cost-effective delivery of services, we need transparency in the amount of profit that is being made and how that profit is being used (e.g., is it released in dividends for shareholders, or is it re-invested in improving service provision?). Notably, the CMA investigation [6] (pp. 9–10) identified significant cause for concern with respect to large, and excessive, profit making across GB in the for-profit residential child care sector:

> *For the children's home providers in our data set we have seen steady operating profit margins averaging 22.6% from 2016–2020, with average prices increasing from GBP 2977 [USD 3741] to GBP 3830 [USD 4813] per week over the period, an average annual increase of 3.5%, after accounting for inflation.*

In summary, there are still substantial gaps in the evidence base about the value for money of different types of residential provision, and in particular associations between cost and quality. There is also concerning evidence that lower cost provision in the for-profit sector is likely to be related to factors such as low pay and poorer training and development for staff—factors that impact negatively on the quality of provision [10]. Consequently, there is now a growing number of local authorities in England that have established plans to open in-house residential homes to meet the needs of their adolescent population [40], a divergence from the previous impetus to close local authority children's homes that has been prevalent during most of the 21st century in GB.

3.2. International Evidence

The paper turns to place these developments within an international context by describing the rising prevalence of for-profit residential child care provision in other countries of the Global North. It then examines reasons for the growing involvement of large for-profit companies in public service delivery as a phenomenon in post-industrial countries in the 21st century.

3.2.1. International Evidence on the Prevalence of For-Profit Residential Child Care Provision

Though data on for-profit residential child care prevalence are not available for all countries, there is clear evidence that Wales, Scotland and England are far from unusual in seeing the 21st century rise of for-profit child care. There is also some evidence of variation at the country, and sometimes regional government, level. We use the descriptors 'high prevalence' to refer to countries where the majority of residential child care provision is for-profit, 'medium' to describe those where it is 25–50%, and 'low' where it is less than 25%.

Those countries with high prevalence for-profit provision include Ireland (67%), where for-profit provision has significantly increased in the 21st century [2]. Finland and Sweden have, respectively, a little over 80% and a little under 80% for-profit residential child care provision [5]. In Canada, there are large variations between regional government areas: in some, such as British Columbia, there is high prevalence for-profit provision [41], and it is also widely used in Ontario [42], though data on its exact prevalence could not be found. There is a lack of data on national prevalence of for-profit provision in the USA, but concerns have been raised about private-equity-backed firms' involvement within the 'troubled teen' residential industry, as well as in foster care provision, since the late 1990s [4].

In contrast, Norway falls into medium prevalence, with 45% for-profit provision, while Denmark falls into low prevalence (22%) [5]. Quebec, another regional government district within Canada, only possesses state-run residential child care facilities [41]. In France, only 5% of residential child care provision is for-profit—the vast majority is provided by non-governmental non-profit organizations, alongside approximately 15% state provision [43]. Portugal has no for-profit provision—the vast majority of residential child care is provided by non-profit charitable organizations alongside a small number of state providers [44]. This is despite the fact that the residential child care sector also provides the vast majority of out-of-home placements for children in state care in Portugal [44].

There are indications that the increasing prevalence of for-profit provision occurred from the late 1980s onwards in Nordic countries [3,5]—a decade earlier than in Great Britain—albeit with a similar process of increasing prevalence in the 21st century. Gilligan [2] suggests the shift to high prevalence for-profit provision in Ireland has occurred over a similar period. Meagher et al. [3] also document how in Sweden there have been shifts in the organizational form of for-profit residential child care provision from small, private, often family-run firms (in the late 1980s and early 1990s), to medium size companies (in the 1990s to 2000s), to large companies from the 2000s. Although timescales may differ internationally, the shift over time towards large corporations' entry into public welfare provision, associated with both private-equity-owned or -backed companies and transnational firms, appears to be shared in higher prevalence countries [4,6,45]. We turn now to explore the politics and economics behind such developments in more detail.

3.2.2. Factors Underpinning the Entry of For-Profit Firms into Public Welfare Provision in the Global North

As in GB, the rise of for-profit involvement in residential child care provision in the Global North more generally has been part of the expansion of neoliberal principles which have also underpinned the growing role of for-profit actors in public welfare provision more broadly. In the 1970s and 1980s, market-oriented reforms were introduced in response to what was deemed an ineffective and expensive public sector (e.g., [46]). The spread of pro-market ideology was accompanied by regulatory changes that allowed for-profit actors to enter emergent 'care markets' [3,46]. Underpinning this spread was also ideational change away from egalitarianism in favour of ideals of "choice and diversity" alongside the increased political influence of private welfare-providing companies [47], who also took advantage of the slow response of the non-profit sector to increased welfare demands [48].

The three most prominent aspects of the rise of for-profit firms in public welfare internationally are the growth of outsourcing to for-profit service providers, the corporatization of the sector, and the rise of private equity involvement.

Outsourcing to for-profit actors has sometimes been a response to understaffing in social services, especially child welfare, through the use of for-profit staffing agencies—a costly and potentially problematic solution [49]. Foster care has also seen marketization in a number of countries, whereby public authorities contract non-state, including for-profit, foster care agencies to recruit and support foster families, often in response to a shortage of foster care placements [50]. Further, social services in some countries have moved to hire private consultants in child protection investigations, which determine what kind of measures are needed to protect the child, i.e., involving them in the exercise of public authority. The latter may have important implications for children given that private consultants handle investigations differently compared to municipally employed social workers [51,52].

Another important aspect of the ongoing for-profitization of public welfare delivery across countries is the increasing corporatization of the sector. Large companies increasingly invest in health and social care services (e.g., on elderly and childcare, see [3,45,46,53]). Often, these large corporations offer a broad range of services, may run multiple subsidiaries, and operate across national borders [45,46,54]. For example, 70% of the private care market in Sweden is owned by the five largest international chains, with services relating to disability, addiction, health care, and child welfare [55]. Some care corporations are owned by private equity firms, and some are listed on the stock market. Notably, there is a rise in transnational corporations—the significance of which still needs investigation [56]. Typically, care corporations start in elderly care or personal assistance and later move into other fields, including residential childcare.

Similarly to the situation in GB, internationally scholars have explained the expansion of for-profit social welfare providers through macroeconomic goals of reducing budgetary deficits, driving cost-saving public sector reforms [57,58]. The rise of for-profit provision is also associated with New Public Management policies and popular ideas about the importance of consumer choice, competition, and attracting private capital for ensuring high-quality provision, diversity, and efficiency, along with legal changes allowing for-profit companies into the market [3,5,59]. The rise of for-profit hospitals in the USA, UK, the Netherlands, and Germany was shown to be linked to improved access to state subsidies and reimbursement by the state [60]. Another factor was probably the increased workload in social services and stricter professional requirements for staff employed by municipalities in child protection [51,52]. The high turn-over of staff and deficit of workers with specific qualifications meant that state-provided services were overstretched, which created gaps in provision which for-profit providers moved into.

The expansion of large corporations is also associated with regulatory changes and increasingly complicated procurement procedures, which disadvantage smaller operators [5,46]. However, it appears that the ongoing ownership shift to for-profit actors has occurred without explicit public policies aimed at for-profitization of this scale: for-profit companies were expected not to replace but to complement existing public provision [3,48].

The controversial involvement of profit-seeking corporations (for example, due to high profits, care scandals, impact on the social work and related professions, and high transaction costs) has become a matter of public concern and part of political agenda [45,46]. Some scholars see the roots of these issues in that care markets operate as "quasi-markets" rather than conventional markets, where private providers were given access to what used to be a state monopoly. The state purchases services on behalf of end-users, leading to the lack of real consumer choice, high transaction costs, and varying care quality [45,61]. As already noted in a GB context, the cost and quality of these services are hard to measure and compare, and information is often asymmetrical—the purchaser has only limited information compared to the end-user and the provider (who may therefore be tempted to misrepresent their activities and retain the contracts despite inferior service provision) [45]. It is notable that the voices of those people accessing for-profit welfare services rarely appear to be foregrounded in policy-level discussions about different ownership types within public welfare provision: this is despite the ideological focus on 'consumer choice' and 'consumer preference' as a basis for moving away from direct state provision.

Another concern related to changes in ownership structure and the corporatization of the care sector is the change of treatment ideas and consequently the nature of provided services, such as the shift from the family-like model of care, giving priority to small-scale establishments with a family logic of care, to a professional model allowing large-scale establishments prioritizing evidence-based, standardized interventions [3,46].

The rise of private equity involvement in residential child care provision is also part of the broader transnational trend towards increasing private capital investment in public welfare services since the 2000s. Private equity acquisitions have grown dramatically across countries and sectors—elderly care and nursing homes [48,62–68], health care operators such as hospices [54], hospitals, outpatient care, including emergency care [69] and GP practices, specialized service providers in ophthalmology [70], dermatology, gastroenterology [11], special needs services such as autism services [71], and others [72].

As is also the case with for-profit outsourcing companies and care corporations, private equity funds are believed to have moved to invest so widely in social welfare services because of unfavourable economic conditions elsewhere and, at the same time, new, neoliberal regulatory/legal reality that removed relevant restrictions for private capital. The economic downturn and low interest rates have encouraged private equity funds to seek new investment targets to ensure guaranteed returns on their capital (steady income from government contracts). Given the changing demographics, the aging population, and the growing need for long-term care for an even larger population with severe morbidities, health and social care services may promise reliable revenues, especially where funding is likely to come from public budgets. The increased rate of diagnosed mental health and developmental disorders has also boosted demand for sometimes life-long support services, inviting private equity firms into the sector (e.g., for autism, see [71]).

With regard to the effects of these cross-border trends, studies are not conclusive. Despite the common public perception that private equity firms prioritize short-term revenues over the interests of their customers or employees, studies provide mixed evidence (for a brief overview, see, e.g., [66]). Companies may use the economies of scale and achieved efficiencies to redirect released savings towards hiring better-skilled staff and improving the quality of services. They may also supply finance capital to help expand services where demand outstrips supply [71].

Companies may also choose to focus on short-term revenues and consolidation [69,73] and engage in cream-skimming, e.g., by profiting from the acquired properties of care homes, raising rents and fees, and cutting on the labour costs [48,63]. Scholars raise questions about the implications of private equity acquisitions for workforce size and composition [65] and the nature and extent of provided services [70]. Some researchers argue that private equity acquisitions have negative effects on competition in healthcare and social care markets and ultimately on costs and the quality of care [64,72,73]. Some segments have seen reductions in service provision following private equity acquisitions [71].

Yet recent research shows that the reality is complex: data are often insufficient but suggest that for-profit ownership can have "nuanced effects" on the extent of service provision [71] and some benefits for service recipients [54,67,72]. One study finds that the intensity of profit-making incentives varies among non-public providers and shows that private equity firms and publicly traded companies deliver lower quality care compared to private limited liability companies and non-profits [74]. Another study explains the varying impact of private equity acquisitions on nursing home customers through the competitive sensitivity of players, as well as the concentration of markets where the buyout occurs [66].

Overall, building on evidence from countries like the US, Sweden, Germany, and Canada, scholars argue that the ownership of care homes under private equity finance is increasingly opaque [62,64,71,73]. A large number of private equity deals remain unreported and operations are left unreviewed, sometimes in the context of no minimum provider service standards (as in the case of autism therapy in the US); this has resulted in calls for greater transparency and more rigorous regulation and oversight [62,64,71,73].

4. Discussion

Increasing for-profit residential provision can be linked to intersecting political and economic factors. Neoliberal ideology has accentuated the deficiencies of state-delivered services and the a priori belief in the comparative efficiency, quality, and 'choice' of for-profit provision. Policy makers have not tended to explicitly encourage the entry of for-profit companies into residential child care. Instead, a broader pro-marketisation policy agenda has encouraged their entry into adjacent areas of public welfare service delivery, from which they have subsequently moved into residential child care.

Macroeconomic policies to reduce national budgetary deficits have periodically seen large cuts to public sector funding, including child welfare services [20,58]. The resultant need for state and voluntary sector organizations to find cost savings has encouraged their withdrawal from direct provision of costly care services, including residential child care, even if, in the medium term, there is some evidence that such withdrawal can increase state costs due to excess profit-making and above-inflation placement price rises [6]. The microeconomic decisions of large corporations entering residential child care can be explained by the attractiveness of public welfare services offering comparatively high investment returns alongside low risk: continued demand for health and care services is certain and ultimate legal and practical responsibility for welfare services is retained by public authorities.

There is some divergence in the prevalence of for-profit residential child care in post-industrial countries. It is hard to discern an obvious connection between prevalence and welfare state type. For example, Finland and Sweden—two countries associated with relatively generously funded, social democratic-modelled welfare states—have some of the highest prevalence for-profit residential child care provision. Portugal, a country with a less generously funded welfare system, has none. In areas where there is evidence of little, or no, for-profit residential child care provision (the province of Quebec in Canada, Portugal, Northern Ireland, and France), there does not appear to have been explicit legal prohibition of for-profit provision, though in Quebec, stricter regional government control and regulation of the residential child care sector [75] may have played a role. We tentatively suggest that those jurisdictions bucking the trend towards medium- and high-prevalence for-profit provision have done so more by micro-policy-level action to sustain or developing state or voluntary sector residential child care provision than overt policy proscription of for-profit provision. However, further analysis of such divergence is needed.

There has been significant concern about the impact of for-profit residential child care provision in GB [6,19,21,76] as well as Ireland [2], the USA [4] and the Nordic countries (e.g., [45,49]). As with for-profit public welfare provision more generally, assessing impact is beset by difficulties due to, among other things, the absence of agreed measures of cost and quality and, therefore, consistent data collection [37]. Recent analysis from GB does, however, give credence to concern: there is evidence that for-profit residential child care provision in GB has been associated with excessive profit-making [6], on average poorer quality care [28], greater placement instability, and young people's placement further from home networks [25]. Additionally, the lack of transparent accountability processes when contracting out to large, corporate, for-profit providers and the lack of obvious mechanisms for young people to have their voice heard within debates about for-profit residential provision are salient issues.

It should again be acknowledged that concerns about residential child care provision exist regardless of ownership model. There are, for example, significant concerns about the quality of residential child care provision in Portugal, where there is no for-profit provision [44]. There have also been very serious, evidenced concerns about the care provided to young people in state and voluntary sector residential child care provision in the UK in the period since 1945 [77]. These counter-examples serve as a salutary reminder that non-profit residential child care provision can also give rise to marked concerns.

Recent policy recommendations in the UK illustrate some of the different proposals to try to address the negative impacts of the rise in for-profit placement provision. The independent reviews of the Scottish children's care system [76] (p.111) and the Northern Irish children's social care system [19] (p. 209) both emphatically pronounced themselves against the commodification of those respective care systems. Both stopped short of suggesting there should be a legal prohibition on for-profit residential child care provision; however, the Welsh and Scottish Governments have each committed themselves to the goal of moving away from for-profit child welfare provision [6]. Scotland already formally prohibits for-profit fostering agencies. Despite this, the CMA (2022) analysis found that the price of foster placements in Scotland was no lower than in Wales and England where there is no such prohibition. This illustrates a risk that for-profit companies could respond to any prohibition of profit-making from care placements by repurposing themselves as 'social enterprises' which continue to operate in the same fundamental ways as a private enterprise: evidence of this phenomenon occurring has been found in other sectors in England [78].

The CMA analysis (2022) [6] and the review of children's social care in England [21] made different recommendations centred around making 'care markets' function better through improved state commissioning, procurement, and placement supply, including via increasing local authority provision alongside for-profit placements. The English Review further recommended a windfall tax on the 15 largest for-profit residential child care providers and fostering agencies, suggesting this could be 20% of their profits [21] (p. 129): to date, the UK Government has not taken up this recommendation.

Whether or not the policy aim is to move away from for-profit residential child care (e.g., Wales and Scotland) or to try to work better with it (e.g., England), the current prevalence of for-profit provision in GB as well as some other countries of the Global North means that governments will have to continue work with for-profit providers in the short to medium term. Within such a framework, the literature suggests multiple ways for public authorities to better direct for-profit provision, including the therapeutic content, overall models, and particular treatments in residential childcare—from high-level regulation and guidance to local, municipal-level specification of procurement criteria and performance-based contracts [79,80]. State licensing—a key instrument of controlling for-profit care providers—varies greatly between countries—in terms of licensing models, as well as the extent of intervention post-license [81]. The potential of state licensing may often remain underutilized—for example, where it does not focus on major aspects of provision, such as staffing levels, a child's contacts with their biological family, schooling, and health support—and thus may currently be a missed opportunity to ensure the quality of care [82]. Performance-based contracts may also effectively incorporate various quality dimensions including those concerning safety, permanency of care, child and family wellbeing, and the educational attainment and criminal records of children and young people who are being provided with care [79].

5. Conclusions

This article is the first, as far as we are aware, to summarise current knowledge about the rising prevalence of for-profit residential child care across a number of countries in the Global North. This is a topic that has garnered significant media commentary but, to date, limited academic attention. The article also makes a contribution by tracking and contextualizing the rise of for-profit provision in the UK, particularly England, in greater detail, and by exploring available evidence on the impact of increased for-profit provision on the residential child care sector. A limitation is that clear data on the prevalence of for-profit residential provision is not available for a number of Global North countries, and the data on impact of for-profit provision—particularly on costs—while supporting established concerns about the gains of private sector entry into public sector provision, also has some mixed and complex findings that do not currently allow for clarity.

The evidence there is, and which has been reviewed here, illustrates that despite the absence of explicit policy to encourage for-profit residential child care provision, there has been extraordinary growth of it in several post-industrial states in the Global North in the 21st century, though not all. The expansion has occurred without evidence that it brings tangible benefits to the young people who are within it, or to the wider care system. Given that such evidence is required, we have argued, to make a credible moral case in support of for-profit provision, its absence is gaping, particularly in an era when the calls for social work practice to be ‘evidence-based’ are ubiquitous [83]. While assessing the impact of for-profit provision on public welfare service delivery is beset by evidential and methodological challenges, the currently available evidence tends to suggest that, if anything, the increased prevalence of for-profit residential child care providers has had an overall negative, rather than positive, effect. The best case in favour of the continued use of for-profit residential care is currently a non-moral pragmatic one: that in medium- and high-prevalence countries, it would be hard to sustain care systems if for-profit providers were to suddenly withdraw or be withdrawn. Unsatisfactory as this may feel as a basis from which to enact public policy, public authorities can nonetheless avail themselves of regulatory, commissioning, procurement, and contractual arrangements and mechanisms to alleviate the greatest concerns there are about the impact of high-prevalence for-profit residential child care provision.

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Article

Community-Based Alternatives to Secure Care for Seriously At-Risk Children and Young People: Learning from Scotland, The Netherlands, Canada and Hawaii

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Abstract: This article identifies community-based alternatives to secure care being utilised in The Netherlands, Canada, Hawaii and Scotland. These countries offer ways to not only reduce or eliminate the need to deprive children and young people of their liberty in secure care but also reduce rates of child removal and alternative care placements. Secure care is the containment of children and young people, often subject to child protection interventions and residing in residential care, in a locked facility when they pose a significant risk of harm to the community and themselves. An admission to secure care exposes children to restrictive practices, such as seclusion, use of force and restraint. Jurisdictions have an ethical imperative, and often legislative obligation, to ensure there are less intrusive community-based supports available, which could be utilised instead of a secure care admission where possible. However, there is little research on what alternatives effectively divert secure care admissions. Hawaii, Canada, The Netherlands and Scotland demonstrate how countries can reduce the number of vulnerable children deprived of their liberty and exposed to restrictive practices by enhancing research linkages, responding to the voice of lived experience, and positioning secure care and alternatives within system-wide reform.

Keywords: secure care; alternatives to secure care; alternative care; residential care; at risk; deprivation of liberty; child protection; First Nations; trauma; rights

1. Introduction

There is no consistent and comparable definition of secure care neither in Australia nor internationally. Research and evidence relating to secure care efficacy and risk are also limited [1–3]. However, of the evidence available, we know that secure care can be experienced as punitive and retraumatising [4–6], does not alter their long-term trajectories [7], is an ineffective response for young people subject to sexual exploitation [8,9], and that there can be a high rate of fatality post-discharge for young people placed in secure care due to extremely risky use of substances [10]. This research builds on comparable international evidence and attempts to answer the research question: 'is it possible to manage the serious risk of harm children pose to themselves in the community without depriving them of their liberty?' This research aims to provide alternative approaches to seriously vulnerable children who are a risk to themselves, arguing that community-based alternatives can successfully divert and/or eliminate the need for secure care admissions.

2. Secure Care, Community-Based Alternative Models of Care, and Cohort—Definitions, Practice and Research

2.1. Secure Care

This article considers secure care as the deprivation of children's liberty up to the age of 18 years old when they are deemed by a jurisdiction to be at risk of harm from themselves [11], when they are a risk to others (e.g., Western Australia [12]), or as punishment when they are in conflict with the law (as a substitute youth justice or youth justice diversionary response, e.g., England [13]). Sometimes, jurisdictions do not distinguish between children in conflict with the law and those in need of care and protection (e.g., Scotland [14]). Regardless of whether secure care also admits children who are a 'risk to others', admission relating to 'risk to self' accounts for a large proportion of secure care admissions in Australia and internationally, which is a significantly under-researched and overlooked practice [15,16]. The terms children and young people are used interchangeably in the article to acknowledge both the legal status (as children under the age of 18) and social categorisation as teenagers, and identification as youth/young people [17].

Internationally, there is no single model or definition of secure care. Secure care models differ in their key features (e.g., target group, secure care operating model, length of stay, who delivers secure care (public or private), regulatory environments and their restrictive measures) [15]. Secure care can also be referred to as and used interchangeably with secure accommodation, secure homes, secure children's homes, secure service, secure care estates, secure welfare services, secure care services, safe care, secure residential care, special care, closed care, closed youth care, closed accommodation, intensive therapy place or secure residences.

Admission to secure care is generally a short-term (a few days to a number of months) intervention for the purpose of stabilising children when they are in crisis [11–14], and it is intended to be a circuit-breaker to protect children from the risks their behaviours can pose. Jurisdictions can often claim detention is required to provide children with treatment [3,12,14]. Regulatory and operating frameworks underpinning secure care are generally located in child welfare systems and guided by the principle of the child's best interests [18]. However, it can be argued that these welfare-based frameworks and principles undermine children's rights, camouflaging the punitive practices evident in criminal justice systems [19–22].

Secure care research is predominately located in the United Kingdom and Nordic countries. However, the research is limited, sometimes conflicting, and often anecdotal [13,23–25]. This likely relates to the vacuum of cultural silence relating to secure care [16,26,27]. The mandate of most research is based on long-term treatment-based confinement programs, not specifically secure-care-type shorter-term stabilisation-based interventions. Research identifying positive outcomes associated with 'secure youth interventions' is generally associated with mental health service delivery systems, i.e., 'inpatient' facilities [28], or secure care facilities delivering intensive mental health treatment [13,28].

Available research suggests that an admission to secure care can be experienced as punitive and harmful [5,6,17]. Further, Sköld and Swain [29] found that secure care admissions and the use of restrictive practices can be retraumatising and have long-lasting impacts.

The longer-term trajectories of children appear unchanged by a secure care admission [7]. Secure care has been found to make little to no difference for substance misuse or mental health outcomes [7]. Klag [30] (p. 1777) highlighted:

> *Regrettably, three decades of research into the effectiveness of compulsory treatment have yielded a mixed, inconsistent, and inconclusive pattern of results, calling into question the evidence-based claims made by numerous researchers that compulsory treatment is effective in the rehabilitation of substance users.*

For most children and young people, secure care is also ineffective in improving externalised and internalised behavioural problems [31,32]. Secure care appears to be an ineffective and punitive response to sexual exploitation [8,9]. Gutterswijk [33] also found that an increased length of stay in secure care does not correlate with improved outcomes. Studies have also found that after secure care, children and young people are often placed in other secure facilities in the youth justice or mental health sector [10,13].

A small recent Canadian study, specifically relating to secure care in response to extremely risky substance use, suggested it may be ineffective and can have an extremely high rate of death post-discharge: 4 out of 17 (24%) young people died from an overdose and 11 continued to struggle with addiction after being in secure care [34].

2.2. Alternatives to Secure Care

Every model of secure care in Australia and internationally has variations, but what is consistent is that secure care is always intended to be a last resort. However, there is limited guidance on what interventions should be tried prior to a secure care admission. What is the hierarchy of support—the interventions that must be exhausted before a young person's liberty is removed?

This article defines 'alternatives to secure care' as diversions and therapeutic interventions designed to address the specific issues or needs of children identified as at-risk of involuntary containment in a locked facility. This article considers alternatives to secure care as alternatives to the restriction of liberty, while other forms of detention (e.g., involuntary inpatient mental health) or Deprivation of Liberty Orders (the restriction of liberty where a young person resides) are not considered as alternatives to secure care. The effectiveness of an alternative to secure care is determined by its ability to minimise or eliminate secure care admissions.

Types of alternatives to secure care could include intensive community-based wraparound support, intensive alternative care placement options (i.e., intensive residential care or intensive foster care), and outreach/transitional support as part of secure care models of care. This article considers alternatives to secure care as fulfilling either or both diversionary and transitional functions.

This research found that many jurisdictions were conflating the provision of alternatives to secure care as part of secure care reform, with the aim to also reduce residential care placements and rates of child removal. As such, alternatives to secure care are not just utilised when a secure care admission is being considered but at an earlier stage to prevent the need for child removal arising and change the potential trajectory in secure care.

The aim to reduce the use of residential care is in line with the United Nations Global Study on Children Deprived of their Liberty [1] and the Ending Deprivation of Liberty of Children, Institutions: A Review of Promising Practice [2], which consider residential care as an institutionalised response that deprives children of their liberty. The Ending Deprivation of Liberty of Children, Institutions: A Review of Promising Practice [2] (p. 6) report provides guidance for the 'elimination of all forms of care that can in its very nature carry characteristics that are harmful to children and where children are at risk of deprivation of liberty due to the organisational and functioning characteristics of care'. As such, while residential care options are being considered as alternatives to secure care, this article prioritises the investigation of community-based forms of alternatives to secure care.

Research over the last two decades has consistently identified the need for alternatives to secure care to be identified and implemented in order to divert children from secure care [35–39]. Marshall's report on Child Sexual Exploitation in Northern Ireland: Report of the Independent Inquiry in 2014 [35] (p. 88), stated:

> *The challenge for society is to provide the kind of structure, safety and quality of care that these [secure care] facilities provide without depriving young people of their liberty and of the opportunity to develop into individuals who can cope with freedom.*

Research suggests that decisions to admit a child or young person to secure care continue to be made due to a lack of suitable alternatives [40–43]. It is often a jurisdiction's judicial system that highlights a lack of alternatives to restrictive orders and places pressure on a system to reform [7].

The need for a robust suite of alternatives is driven by the ethical imperative to ensure there are effective, less intrusive supports available, which could be utilised instead of a secure care admission when possible [7] (p. 196). Clark [44] outlined criteria that ethically justify a secure care placement. Criterion 2 suggests the provision of 'a continuum of care to ensure access to the least intrusive services'. A continuum of care ensures secure care does not exist in isolation. As Warshawski [38] (p. 198) suggested, 'Secure care is not a panacea and must be nested in a fabric of comprehensive care'; however, diversionary alternatives to secure care are often limited and lacking [40,45].

Youth justice in Australia and international best practice has a suite of diversionary options, court orders and interventions, which form a hierarchy of supports leading up to and diverting a young person from detention. Diversionary practice is considered to be rights-affirming, and obligations are as outlined in youth justice international treaties, such as Rule 11 of the Beijing Rules. This rule emphasises the need for alternatives to institutionalisation and that jurisdictions should develop and promote community-based alternatives to detention. Secure care often lacks clear and/or direct diversionary options. Reasons for this could include secure care's position within welfare structures and child rights frameworks.

Transitional support from secure care is also consistently highlighted as crucial to maintaining and building on any progress and/or stability achieved in secure care [12,40,46]. However, transitional support is frequently highlighted as something that is not well managed [12,40,46], and the needs of young people are not being adequately met after secure care placement [34,46]. Harder's [47] study identified that the problems young people experience during their transition from secure care include those in relation to finances, education and employment, and living arrangements (homelessness and insecure living arrangements).

As is the case with secure care, there is very limited research on the models, outcomes and efficacy of alternatives to secure care. A number of studies suggest that close support, an intensive residential support that often operates as a step down/transitional support from secure care, is a promising alternative [12,40,48]. Walker's [7] study also presented intensive foster care as a viable alternative to secure care, provided the carers are adequately trained, rewarded, supported and recognised. However, the risks associated with the use of alternatives have also not been researched.

Williams' [13] report, Unlocking the Facts: Young people referred to Secure Children's Homes, highlights the risks for young people when they are deemed as needing a secure care admission but secure care is at capacity and they are placed in alternative options. Williams stated, "the lack of knowledge of what alternative accommodation consists of demands further exploration to discover whether it is appropriate and if it can be viewed as a real alternative to a SCH [Secure Children's Home]" (2020, p. 9). Williams' [13] report highlighted significant and legitimate concerns about the quality, outcomes for young people, and research surrounding alternative accommodation; however, it defined alternatives to secure care as 'unregistered placements' in the existing service delivery system and found that nearly half were placed in children's residential care and one-tenth in a Youth Offending Institution. This article suggests that alternatives to secure care are tailored interventions, enhancing and/or navigating the existing service delivery options, to prevent admissions to secure facilities when possible.

2.3. Profile of the Children Admitted to Secure Care

Knowing who the cohort are for alternatives to secure care is vital to the development and implementation of interventions that can effectively respond to their needs. Research on the client group is predominately from the United Kingdom; however, there appears to be an international trend suggesting that secure care and alternatives respond to a child protection population, with a significant over-representation of First Nations (a country's earliest inhabitant, e.g., Indigenous Australia) children, who are an extremely vulnerable, traumatised and marginalised population, particularly susceptible to systematic maltreatment [13].

The secure care and alternatives to secure care client group are often children at the acute end of the child protection system. The children admitted to secure care are generally cared for 'by the State'—children on child protection orders [3,43]. At the time of admission to secure care, most children and young people are residing in residential care [13].

Research suggests that the secure care client group have inflated levels of Adverse Childhood Experiences [49]. It suggests they have experienced serious trauma associated with childhood neglect and abuse [43,48,50,51]. As such, they have multiple and complex needs [52], generally have significant behavioural issues—including violent, inappropriate and/or sexual behaviour [13]—emotional deregulation and are at acute risk of exploitation.

Reasons for admission to secure care can include (and are often a combination of) sexual exploitation, self-harm, substance misuse and/or mental health issues [13,53]. Children admitted to secure care will generally have had multiple placement breakdowns prior to a secure care admission [43] and will experience multiple secure care admissions [15,43]. Internationally, children subject to criminal exploitation are also increasingly either admitted to secure care or recognised as being part of the secure care client group [13].

The over-representation of First Nations children in secure care, while an unchallenged assumption in the sector, is difficult to evidence, as jurisdictions in Australia generally do not make secure care data publicly available. Internationally, data for secure care rarely go into this level of detail. However, considering the evidence of over-representation in youth justice and child protection systems [44], it can be assumed that there is an over-representation that also exists in secure care. This assumption is also supported by data made available by the Australian jurisdiction of Victoria [15].

Secure care is described by Williams [13] as being the consequence of a system, primarily the mental health system, struggling. The secure care client group often do not have access to appropriate mental health or disability support, despite high levels of self-harm and suicide attempts [51], with problematic consequences [54]. The Royal Commission into Victoria's Mental Health System highlighted the problematic distinction between trauma and mental health [55], which is still starkly represented in some models of secure care.

3. Materials and Methods

This article is an extension of the research completed by the author as part of a Churchill Fellowship on effective alternatives to secure care for children and young people at serious risk of harm. The Winston Churchill Memorial Trust offers Australian citizens the opportunity to travel overseas to learn more about a topic they are passionate about and have expertise in, and to bring back best practice that can be applied to Australia. The Churchill Trust funded eight weeks of overseas travel for this researcher to investigate effective alternatives to secure care for children and young people who place themselves at risk of serious harm.

This article aims to identify alternatives to secure care, focusing on the Churchill Fellowship research best-practice case studies. While this research is based on the findings of the Churchill Fellowship and its Australian application, this article departs from that in order to improve the cultural and practice transparency of secure care and instigate investigation and reform of secure care internationally. This research highlights consistent issues that plague secure care internationally.

Key questions underpinning this research included:

- Background: What is/are a jurisdiction's model/s of secure care? What is the evidence to support its effectiveness? What were the enablers for reform—what is the context, how did the alternative to secure care come about?
- Service: What is the alternatives to secure care model? Who delivers it?
- Efficacy: Is there any evidence of effectiveness of the alternatives to secure care?
- Challenges: What are the primary challenges relating to alternatives to secure care?

This article compared four Organisation for Economic Co-operation and Development (OCED) countries or specific jurisdictions with comparable systems in an attempt to compare experiences, seek answers to common challenges, identify good practices, and develop an evidence base and guide to thinking about social policy alternatives to secure care. Hawaii, Canada, The Netherlands and Scotland were selected because they offered innovative alternatives to secure care and because the countries demographically and systemically reflected elements that were conducive to application in other OECD countries:

- Hawaii has a First Nations population and has a bifurcated youth justice and child protection system. Hawaii offers a unique, culturally grounded, evidence-based

alternative model of care, characterised by self-determination and responding to the needs of traumatised youth. Hawaii also has two non-secure models for responding to sexual exploitation.
- Canada (Alberta) has a First Nations population and a bifurcated youth justice and child protection system. It has secure care that is also a short-term crisis intervention, similar to the Victoria/Western Australian models of secure care. Canada (Alberta) offers a comprehensive spectrum of intensive specialist interventions surrounding and diverting from secure care within a mental health framework.
- The Netherlands has a bifurcated youth justice and child protection system with a very similar timeline as to why and when this occurred. The Netherlands demonstrates how powerful the voice of lived experience of secure care can be in driving reform. The Netherlands have committed to using virtually no secure care by 2030 and demonstrated how providers of secure care can quickly evolve to open models of care focusing on outreach and multidisciplinary alternatives.
- Scotland has introduced the *Children (Care and Justice) (Scotland) Act 2024*, which ended the placement of under 18-year-olds in Young Offenders Institutions and raised the age of referral to the Children's Hearings System to include all 16- and 17-year-olds. The future model of secure care is being considered in light of these reforms. Scotland offers models of intensive community-based support. The alternatives to secure care are the culmination of system-wide reform and reflect strong research partnerships and a rights-based approach.

This research used an investigative analysis of predominately qualitative data, site visits to international jurisdictions, policy and practice contextualising for reform consideration. The research required a high level of researcher reflexivity. The researcher was explicit with stakeholders as to the assumptions and the secure care context (Victoria, Australia) of their research to enhance the self-reflective process and collaboratively critique the research process and findings.

This research is the combination of an initial desktop review and literature review, including the analysis of publicly available information. This was further synthesised with findings from the initial jurisdiction online and email discussions and further supplemented with site visits and in-person meetings with representatives responsible for policy, funding, delivery, research and oversight of the secure care and alternatives sector.

Seventeen case studies were completed as part of this research [15]. The case study included in this article for each jurisdiction was the intervention identified by their key senior subject matter experts as being the most successful alternative to secure care, had the most evidence of effectiveness, and that this researcher determined as having the most potential in terms of 'transferability' to other jurisdictional contexts. Due to the lack of evidence/research relating to secure care and alternatives, the information presented is a synthesis of often multiple oral sources. The challenges relating to each case study are also often the synthesis of those identified by the researchers and/or stakeholders in the sector and/or service.

This research project has the following limitations:

- Findings are primarily based on qualitative data provided by system experts. Due to the highly politically sensitive nature of secure care and reluctance of jurisdictions to share quantitative data, only a limited amount of quantitative data was available.
- No outcomes or comparative data (between secure care and alternatives) were evident and/or made available by any jurisdiction.
- International case study data are limited in scope to the representative meetings and sites visited in the countries of Hawaii, Canada, The Netherlands and Scotland.
- Case studies were, in part, chosen by the researcher, who has experience predominately specific to the state of Victoria, Australia. Further analysis will need to be completed to determine applicability to other jurisdictional contexts.

No ethics approval was sought for this research. It was not required by the Churchill Trust and no children under 18 years of age were engaged with as part of this research.

4. Results

4.1. Alternatives to Secure Care in Scotland

Secure care has been considered as part of the Independent Care Review [56], the promise, Getting it Right for Every Child, and the whole systems approach. As part of these system-wide reforms, there is a drive to enhance the availability and standardisation of alternatives to secure care across Scotland. As part of the whole system approach, pilots were funded, and guidance was developed that highlighted good practice in relation to alternatives to secure care and the need to promote these wherever possible. Alternatives to secure care in Scotland, focused on alternatives for children in need of care and protection, were primarily diversionary community-based intensive support, intensive specialist residential care and transitional/diversionary residential care support.

Case Study 1: Glasgow City Council community-based intensive services demonstrate how system design and the provision of long-term, family-based, community-based intensive services can result in dramatic reductions not only in secure care but also rates of child removal and use of residential care.

These intensive community-based/family services are important to consider as part of this research. Secure care is often a trajectory from residential care. Young people usually enter residential care when other forms of care breakdown, i.e., kinship and foster care. Young people also only come into these alternative care settings when interventions in the home are not successful. Early and stronger intervention in the community and home is critical to stem the trajectory into alternative care, then to residential care and then likelihood of secure care exposure.

Case Study 1. Glasgow City Council community-based intensive services.

Background:
Informed by the Independent Care Review [9] and the promise, Glasgow City Council have developed a suit of intensive services and continued care up until the age of 26, with a corresponding Family Support Strategy. Glasgow City Council's intensive services are enabled by the local authorities' collective leaderships' willingness to hold risk in the community. It is based on the belief that secure care provides system relief rather than being driven by children's outcomes.

Glasgow City Council have a Secure Screening Group with representation from mental health, education, residential care and Alcohol and Other Drugs providers. The Secure Screening Group was initially developed to determine who met the criteria for secure care and make referrals to intensive services when possible as a direct, immediate, bespoke wraparound support, as opposed to a secure care admission. The scope of the group later expanded to also consider young people on the edge of a secure care intervention. As such, the Secure Screening Group divert away from secure care to intensive services when appropriate.

Service

Intensive Services:

The suite of intensive services include the following (with additional information on some interventions in the following, and a spotlight on ISMS):

- Intensive Support and Monitoring Services (ISMS)
- Intensive Monitoring and Support Services Education
- Outdoor Resource Centre
- Functional Family Therapy
- Support and Intervention
- Glasgow Intensive Family Support Services

Intensive Support and Monitoring Service: ISMS was launched as a pilot in 2005, in order to provide a direct community-based alternative to secure care for children aged 12 and over. An intensive, multi-agency service package is coordinated around each young person according to their individual needs and risks. Where necessary, a young person can be subject to a Movement Restriction Condition (MRC) that is monitored by use of an electronic tag, requiring the young person to remain at home or some other specified location for up to 12 h per day. The use of the monitoring component is very low, and there are significant limitations to the use of the monitoring function (e.g., the electronic tag uses RF not GPS technology, meaning it can tell when a child has left a house; however, it cannot track/locate a child). It is sometimes used in cases such as sexual exploitation.

Initial pilot funding of ISMS helped introduce a new mindset in Scotland regarding the use of alternatives to secure care. There is also evidence to suggest it is an effective alternative to secure care (e.g., Glasgow City Council ISMS evaluation, detailed below). However, there has been inconsistent availability and implementation across Scotland.

Intensive Monitoring and Support Service Education: Provide education directly to young people (3 × 1.5 h sessions) in conjunction with school and Interrupted Learners Services. They also bring together the three education providers and coordinate service delivery. There is consideration that this service converts to education facilitation rather than education provision.

Outdoor Resource Centre: A highly flexible, creative method of responding to crisis. Support is provided by 8 trauma-trained staff who can work 1:1 with children up to 25 h a week for a long period of time (e.g., 2–3 years). Staff work alongside other intensive supports. Support varies significantly depending on the children’s interests and can include boat trips or weekends away.

Glasgow Intensive Family Support Service: Support service for families going through tough times with children at risk of being placed elsewhere. About 50% of the Glasgow Intensive Family Support Services provide placement support (e.g., in foster care), with a particular focus on support in kinship arrangements so the child can return to the family.

Effectiveness

Glasgow City Council attribute their intensive services to **dramatic reductions in their rates of child removal and use of residential care**, which they believe has led to a significantly reduced demand on secure care. Based on the cost of secure care (approximately GBP 6500 a week) and intensive services (approximately GBP 2000 a week), it is believed that for approximately every 30 children, Glasgow City Council are saving about 10.4 million pounds. The evaluation of ISMS found that ‘evidence from the case studies and local evaluation and monitoring work indicate that the ISMS and intensive support service programmes have been effective for . . . improved attendance rates on programmes, reducing absconding and reducing substance misuse. There is particularly wide support for the intensive support provision’. Glasgow City Council have also reported:

- A 45% overall reduction in the use of secure care over the last seven years.
- A reduction in expenditure on Secure Care from GBP 3.5 million to 1.7 million in the last five years.
- A reduction in the number of individual children admitted to secure care.
- A 75% reduction in the use of secure care by courts for remand.
- A reduction in the average stay from 21 weeks to 10 weeks.
- 83% of cases meeting the secure care criteria are diverted to ISMS following discussion by the Secure Care Group [57].

Challenges:

- Outcome-based data collection and research comparing secure care and alternative service provisions and relating to how to best respond to young people who require care and protection (as opposed to children and young people who offend).
- Standardisation and consistency of service availability and quality of provision for both secure care and alternatives to secure care across all 32 council areas.

4.2. Alternatives to Secure Care—The Netherlands

The Netherlands refer to secure care as JeugdzorgPlus (youth care plus/closed youth care). In November 2021, The Netherlands Parliament passed a motion to end closed youth care by 2030. The Minister responsible for closed youth care (Ministry of Health, Welfare and Sports, Youth Directorate) responded to the motion by committing to converting closed youth care to open, small-scale residential care by 2025 and to reduce closed youth care to 'close to 0'—with a 'no, unless' principle by 2030. The government of The Netherlands has funded local municipalities EUR 80 million to implement a closed youth care reform agenda, transforming closed youth care to small-scale residential care facilities, setting a strong precedence for other jurisdictions.

The Netherlands Parliament motion to close closed youth care was in large part the result of an influential media campaign led by young people with lived experience of secure care who were supported by The Forgotten Child and Experienced Experts Foundation [58]. The high-profile campaign called for the service sector to stop locking up young people who had not committed an offense and often experienced significant trauma and complex problems. There was public outrage that the practice of closed youth care occurred in The Netherlands and pressure for the closures of closed youth care.

Many closed youth care providers in The Netherlands are in various stages of transition to alternative service provision options. Some providers of closed youth care have completely converted their closed youth care service provision to open community-based alternatives, and some are in the process of transition (e.g., converting 'closed' bedrooms and facilities to 'open' bedrooms and facilities). Providers of alternatives to closed youth care believe alternatives are as expensive as the delivery of closed youth care, coupled with significant reform costs. However, it is believed the long-term costs may be lower as the result of a more effective intervention.

Case Study 2: Thuis voor Noordje outlines how a large, closed care facility can completely convert to outreach and 'open' housing stability. This case study provides an example of how the sector can come together to provide an effective alternative to secure care when there is a coordinated vision and service delivery.

Case Study 2. Een thuis voor noordje—Bovenregionaal Expertisenetwerk Jeugd Noord-Holland (bennh.nl)

Background:

Thuis voor Noordje is a cooperation in the north of Noord Holland (province), which came together with a shared commitment to no longer provide secure care. This cooperation has brought together those responsible for care provision and governance to support children and young people in North Holland who are threatened in their development by complex problems or situations. Parlan is the care provider in this cooperation [59]. Thuis voor Noordje covers a large geographical area with approximately a 2 million population.

Parlan previously delivered a large 80-bed closed care facility with restrictive practices. The average length of stay was six months. Young people admitted to closed youth care had high levels of placement breakdown and/or movement (averaging 8–10 placements) between open residential care and secure residential care. As such, Thuis voor Noordje see housing stability as core to their reform agenda of closed youth care.

As the result of funding changes, including the decentralisation of services to local municipalities, in 2018 it became clear to Parlan that its large-scale closed youth care was no longer financially viable. Parlan believe this financial crisis provided an opportunity for reform. It prompted the establishment of Thuis voor Noordje and what they described as a moral decision to no longer provide closed youth care.

Service:
The following three elements form the crux of Parlan's alternative service delivery response:

- Customisation
- Outpatient care
- Small-scale residential care

When a closed care referral comes through to the organisation, an assessment process is conducted by an individual trained in child development. Intensive outreach and a range of specialist supports are administered (including family group conferencing, individualised treatment/counselling) to support a young person and their caregivers in placement/home and at school. If required as a last resort, an open intensive residential care response is provided. In implementing this new approach, Parlan have also seen a significant decline in demand for residential care, as well as closed youth care.

The residential care offered is intended to provide housing stability and, as such, there is no time period allocated. Parlan currently have two, four- to six-bed (three 'in-house' and three independent living units linked to housing for the older/transitioning cohort) centrally located mixed-gender houses, with 24/7 wraparound support and high staff ratios. Young people are supported to engage with nearby generalist education. There are no restrictive practices or cameras—a harm reduction approach and relational security are utilised.

Effectiveness:
Thuis voor Noordje believe the key to the success of their reform agenda is that their vision/commitment to no longer provide closed youth care is shared by all key stakeholders, across all levels of government (e.g., local municipalities and councils), secondary education partnerships and youth care providers. Ending the use of closed youth care reflected a shared cultural change to the conceptualisation and response to risk—in line with values/principles of all areas/sectors.

Saying 'no' to a closed youth care response has meant a lot of crisis management in the community and supporting stakeholders through this time. Parlan initially converted their closed youth care to a combination of closed and open residential care; however, it quickly became clear once alternatives were in place that they could convert all closed placements to open placements.

The below Figure 1 clearly demonstrates the effectiveness of their alternative service provision in ending the use of closed youth care.

The process of closed youth care reform commenced in 2020, and the area now generally has no closed youth care admissions.

Challenges
Parlan identified the following challenges associated with the implementation of their alternative service provision model:

- It is a struggle to find and gather research to support effectiveness.
- Cultural change has occurred prior to systems change:
  - Funding models—alternatives are not being equivalently funded and can be just as expensive, as there are no benefits of scale and the process of reform is expensive.
  - Education is a challenging component of the model, and at times, very intensive support is required. There is a need for the education models and funding to align with new care service delivery models.
- Outpatient care must be available immediately in order to prevent placements in residential care. They would like to integrate more flexible staffing models and have staff nearby if there is an escalation and additional staff are required quickly.
- It is difficult to provide support to children from their areas when they are placed in other parts of the country.
- Sometimes, other healthcare organisations demand that a child is sent to a closed placement.

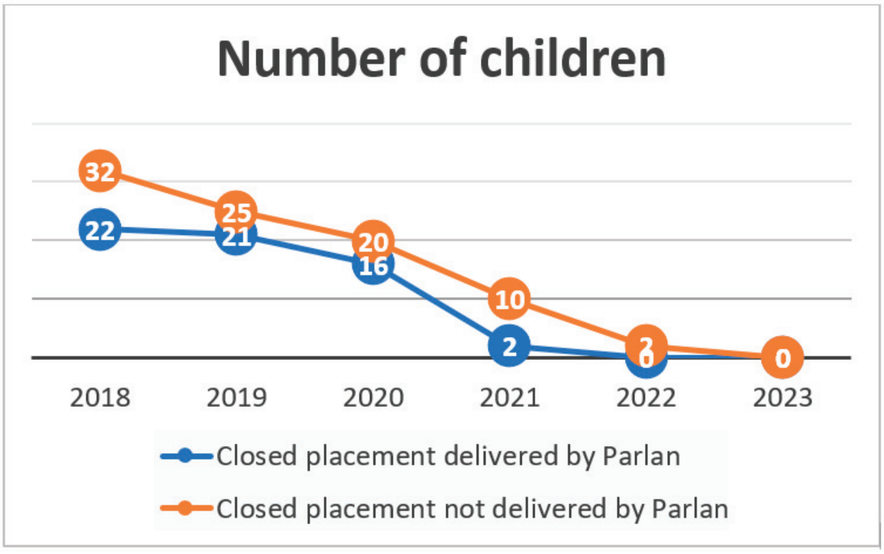

Figure 1. Number of children in closed youth care. Source: Provided by Parlan Jeugdhulp on 20 June 2023.

5. Alternatives to Secure Care—Canada (Alberta)

Hull Services and Wood's Homes are two large campus-based mental health organisations that offered a large suite of alternatives to secure care. Effective alternatives to secure care were considered by the organisations to be intensive community-based specialist supports or residential intensive specialist support targeting issues that face the secure care cohort disproportionately, such as FASDs and harmful sexual behaviour.

Canada has experienced a cultural and practice shift enhancing how interventions respond to the family and community of a young person. There are now specific roles, such as Family and Connections Facilitators (Hull Services) or Family Support Counsellors (Wood's Homes). Both Hull and Wood's Homes have integrated family support services into their models of care and stated that there has been enhanced funding of these interventions, although it is acknowledged that funding systems have not figured out how to fund such services that work across the funding silos.

Wood's Homes, who do not provide or often utilise secure care, offer Therapeutic Campus-Based Care as an alternative to secure care. It provides 24 h intensive, therapeutic support for children and youth who have often experienced multiple placement breakdowns and have complex emotional and behavioural needs. Therapeutic Campus-Based Care is not considered a long-term placement option and has a strong transitional focus. Young people have access to the Whole Family Treatment and the Transitional Services Program, which offer direct clinical engagement and oversight for a 90-day period in the community. Wood's Homes reported that 70% of clients have successfully maintained a stable, less-intensive placement 6 months after exit from Therapeutic Campus-Based Care.

Case Study 3. Acute@Home (Wood's Homes)

Background:
In 2018, Wood's Homes partnered with the Alberta Children's Hospital—Psychiatric Emergency Services—to provide immediate, in-home support, advocacy and system navigation for young people and their families/carers. The aim is to provide a continuum of mental health care through short-term support, which will keep a child at home when there is no imminent risk but the child or young person is:

- at-risk of an involuntary hospital admission, or
- being discharged and waiting for outpatient support, or
- to assist with emergency department overflow.

Service:
The Acute@Home team includes five family support counsellors, a team leader and psychiatric and nursing support from the hospital. The top-five presenting disorders they respond to are:

- Attention Deficit Hyperactivity Disorder
- Generalised Anxiety Disorder
- Adjustment Disorder
- Unspecified Anxiety Disorder
- Major Depressive Disorder

The Acute@Home program provides immediate and intensive outreach to families/carers as they transition from a hospital setting to their family home and community.

Through safety planning, psychoeducation, facilitating referrals and building family connections, Acute@Home supports families in developing the tools to prevent further escalation and establish stability. This program offers one to three sessions that take place with the family over the course of six to eight weeks to help mitigate the need for further hospital presentations.

Clients are referred to the Acute@Home program by Alberta Children's Hospital Emergency Department following a mental health assessment. Once the child is referred, the Acute@Home team will contact the family/carer within 72 h to discuss the child's needs.

The Acute@Home program provides:

- Collaboration with mental health professionals to develop a plan to connect the child and family with immediate and long-term services/resources.
- Short-term flexible care to meet the needs of the child and family/carer (availability seven days a week in your home, school or community).
- Parent and caregiver support and psychoeducation.
- Emotional and mental health support.
- Mental health system navigation.

Efficacy:
The hard-copy factsheet for Acute@Home stated that the outcomes of Acute@Home include:

- 100% of families/carers were satisfied with the care they received.
- 96.8% of clients had a clinically significant improvement in distress.
- 85% of clients had improvement in functioning (Health of the Nation Outcome Scales for Children and Adolescents).
- Increased accessibility, decreased the length of stay in the hospital, shortened the wait time for community clients and eased the presume on emergency rooms.

Challenges:
This intervention primarily supports community (as opposed to children on child protection orders) clients at risk of a mental health inpatient admission; however, it could be adapted to support transitions from secure care facilities.

Alternatives to Secure Care—Hawaii

Hawaii does not have secure care. It offers a range of culturally grounded community-based intensive supports, including wraparound, 'navigation', mental health interventions, and supports specifically targeting sexual exploitation. Supports for children at risk of serious harm in Hawaii are driven by principles of self-determination, access to services and multi-systems approaches. Case Study 4—the Kawailoa Youth and Family Wellness Center—is a stand-out case study, an innovative multi-systems alternative model of care to youth justice involvement. Kawailoa Youth and Family Wellness Center demonstrates to countries with a First Nations population that real system change and self-determination are effective tools to address First Nations young people's over-representation in detention facilities.

Case Study 4. Kawailoa Youth and Family Wellness Center.

Background:

- The Office of Youth Services, Department of Human Services, has led the vision for Kawailoa Youth and Family Wellness Center, advocated for its statutory formation and continues to manage and oversee Kawailoa Youth and Family Wellness Center.
- In 2014, Hawaii legislatively repurposed the land of the Hawaii Youth Correctional Facility to be converted into a Kawailoa Youth and Family Wellness Center.
- A Kawailoa Youth and Family Wellness Center Programmatic Plan was led by the Office of Youth Services and developed by the University of Hawaii and draws on the Native Hawaiian concept of pu'uhonua (place of refuge) to offer young people with deep-rooted and complex challenges a safe place to heal—community-based residential and non-residential alternatives, which respond to the youth, their families and their communities' trauma and cultural needs.
- The process of justice re-investment (moving emphasis and funds to community-based interventions) has been a 20-year partnership approach initially led by the judiciary.

Service:

- The Kawailoa Youth and Family Wellness Center is a First Nations-led response to the needs of young people who have experienced significant family trauma [60].
- Kawailoa translates to 'long waters', describing an ecosystem of youth resources and supports that drive this transformative Indigenous initiative to replace youth incarceration with cultural and therapeutic services that empower youth and strengthen the community [61].
- The aim of the Kawailoa Youth and Family Wellness Center is to provide culturally grounded, strength-based programs in partnership with communities and families [61].
- In 2018, the Office of Youth Services invited community-based non-profits to deliver program services envisioned in the Kawailoa Youth and Family Wellness Center Programmatic Plan.
- In 2020, the Opportunity Youth Action Hawai'i (OYAH) was formally established at the Kawailoa Youth and Family Wellness Center. OYAH is a hui (collaboration/partnership) of state (Office of Youth Services, Department of Human Services) and not-for-profit agencies working to transform punitive modalities of treatment and incarceration with effective therapeutic community-based programs rooted in Indigenous knowledge systems and cultural practices [61].
- Service continuity is viewed as a crucial element of this service delivery. Kawailoa Youth and Family Wellness Center has a shared system framework across education, child welfare and social service sectors, which aligns with the Department of Education's Nā Hopena A'o (HĀ) framework: BREATH outcomes for youth [61] (p. 4).
- The OYAH partners located on-site at the Kawailoa Youth and Family Wellness Center are:
    - ○ Hale Kipa—Hale Lanipōlua Assessment Center (HLAC): HLAC on O'ahu is open to youth ages 12 through 17 who are victims and survivors of commercial sexual exploitation and sex trafficking.
    - ○ Kinai 'Eha: Kinai 'Eha, which means to extinguish pain, provides an alternative education option to 'opio/youth (14–24 years) to support purpose, personal empowerment, education, Hawaiian cultural identity and connection, workforce training in construction and the trades, job placement, community service and leadership.
    - ○ Partners in Development Foundation—Kupa 'Aina Farm: Partners in Development Foundation (PIDF) inspires and equips families and communities for success and service using timeless Native Hawaiian values and traditions. PIDF's Kupa 'Aina farming program uses aloha 'āina (love of the land) to heal youth, families and communities.

  - Residential Youth Services and Empowerment (RYSE): RYSE is a youth access centre and shelter that provides housing, medical and mental health support and vocational resources. The shelter serves youth aged 14–24 years, and its day program provides a safe space for unhoused youth to receive drop-in, basic needs services, 7 days a week.
  - Department of Human Services, State of Hawai'i, Office of Youth Services—Hawai'i Youth Correctional Facility: Hawai'i Youth Correctional Facility provides trauma-informed care to reform juvenile justice practices, as is the goal of the Kawailoa Youth and Family Wellness Center. This pu'uhonua, referring to a sacred sanctuary or refuge, reclaims a culturally storied place for those in need of guidance and connection.
  - Department of Education—Olomana Youth Center: Olomana School is an alternative education school of the Hawai'i Department of Education, offering project-based teaching and learning for students in seventh through twelfth grade, and giving students a fresh start in their learning journey.

Responding to unmet mental health needs:

- In Hawaii, it is believed that some youths were entering the youth justice system partially due to unmet mental health needs (Kawailoa Youth and Family Wellness Center Programmatic Plan, p. 16). There is currently mental health services' provision at Kawailoa Youth and Family Wellness Center; however, there is believed to be a service gap of acute residential services in Hawaii. It is envisioned that HRCY ultimately be repurposed as a mental health delivery residential facility, where young people with mental health issues can receive "individualised, professional treatment under safe and secure conditions" [61]. While there is the desire not to repurpose HRCY with another locked environment, the government are investigating the repurposing of HRCY to a combination of secure and non-secure mental health facilities, which would be run by the Department of Health [62].

Efficacy:

- OYAH were awarded a 2022 W.K. Kellogg Foundation grant of USD 20 million to continue to advance racial equality, continue to gather support and advance its innovative approach [63].
- Hawaii reform to date has resulted in:
  - Reduced incarcerated youth by 82 percent from 2012 to 2022.
  - Periods with no girls incarcerated.
  - Low rates of recidivism [64].

Challenges:

- Institutionalise Indigenous methods of learning and recognition of expertise/knowledge.
- Align contractual requirements and targets with a holistic, whole systems response to young people's needs, regardless of referral pathways or order status (e.g., youth justice or a child welfare client).
- Sharing information.

6. Discussion

The case studies presented above highlight that it is possible to manage the serious risk of harm children pose to themselves in the community without depriving them of their liberty. Alternative community-based approaches to secure care are diverting and/or eliminating the need for secure care. However, a limitation of this research it that there is no evidence available to suggest that one is more effective than the other or that either the use of secure care or alternatives results in improved outcomes for children and young people.

This research found there are significant variations in alternatives to secure care design, provision, funding and availability. However, the jurisdictions believed that the alternatives that were reducing or eliminating the needs for secure care admissions were those that are available immediately for the purposes of safety and stabilisation, are family centred, and provide continuity of care and long-term support. The successful alternatives could be categorised as either, or a combination of:

- Community-based multi-agency intensive support, i.e., holistic, multi-systems and bespoke.
- Intensive specialist services, i.e., alternative care or community-based targeted specialist interventions, such as mental health, sexual exploitation, disability or sexualised behaviours.
- Diversionary and/or transitional support, i.e., alternative non-secure interventions built into a model of secure care service provision, including outreach, support after discharge and transitional housing.

Alternatives were also believed to be effective in reducing secure care admissions when they were offered as a clear and accessible pathway away from a secure care admission. For example, Glasgow City Council has a Secure Screening Group that can make referrals to intensive services as a direct alternative to a secure care admission. The international case studies of alternative interventions and pathways from secure care offer other jurisdictions a range of options through which they can reduce or eliminate the need for secure care admissions.

This research found self-determination to be a key indicator of strong, culturally safe alternatives to the detention of First Nations children and young people. Typically, First Nations children are over-represented in secure care. Hawaii, however, do not have secure care, have minimal inpatient mental health facilities, no secure disability facilities and are in the process of converting their youth correctional facility site into a heavily culturally informed family youth and wellness centre. Self-determination is a key feature of Hawaii's alternative supports for seriously at-risk children. First Nations leaders were at the forefront of decision-making, system design and delivery. Cultural safety and connection to the community were at the forefront of supports. Hawaii has been recognised as a leader in progressing racial equality [63].

The design of secure care and alternatives is highly reflective of a jurisdiction's systemic gaps and political leanings/risk aversions. Due to the lack of evidence, a jurisdiction's decision not to use secure care was a political and/or cultural acceptance of risk. However, this research suggested that improving transparency and considering secure care as part of broader reform processes facilitates the implementation of and access to multi-system intensive community-based responses for this vulnerable cohort. The following elements were key to a jurisdiction's ability to pave the landscape for the provision of alternatives to secure care:

- Secure care was placed within the scope of broader system-wide reform, and there was a systems emphasis on alternative service provision and pathways from secure interventions.
- There was an interrogation of the need for and minimising/eliminating the use of restrictive practices relating to children and ensuring that legislation, oversight and practice relating to restrictive practices are consistent across disciplines (mental health, youth justice, disability and secure care).
- Analysis of children's pathways into secure care to identify and rectify service delivery gaps and/or blockers to service accessibility was completed.
- Insight was gained from children and young people with lived experience of secure care, listening to their views and placing them at the forefront of reform and ongoing policy decisions.
- All available legal protections were in place to adequately protect children's rights.
- Multidisciplinary approaches to secure care and alternatives were enabled.

Further research is urgently needed in order to measure children's outcomes in relation to the efficacy of secure care and alternatives, but also to compare their ability to manage risk [13,56]. The international jurisdictions that were part of this research reported that on some occasions, young people and staff had died while in secure care, in non-secure emergency/contingency placements, and after leaving secure care admissions. A secure care facility in The Netherlands advised they recently had three young people commit suicide within an 18-month period. In Canada, a Wood's Homes staff member was murdered by a young person in Personalised Community Care (contingency/emergency placements). O'Brien and Hudson-Breen [10], in their research, found that 4 of the 16 young people with substance abuse issues had died within 6 months of discharge from a secure care facility.

Further research can be broken down into four key areas:

1. Can risk be better managed in non-secure alternatives than secure care?
2. Can alternatives lead to better outcomes than secure care?
3. How can outcomes be best measured?
4. What elements made alternative interventions effective in response to what cohorts need?

Jurisdictions with secure care and/or alternatives to secure care need to ensure they have rigorous data collection mechanisms to measure the short-, medium- and long-term effectiveness of secure care and alternative interventions for children. Consideration should be given to measuring the effectiveness of different interventions for different age groups and in response to distinct issues that result in secure care admissions (e.g., sexual exploitation or substance misuse).

7. Conclusions

This research identified case studies of community-based alternatives that various jurisdictions have identified as successfully reducing or eliminating the need for secure care. The case studies were in response to the research question: 'is it possible to manage the serious risk of harm children pose to themselves in the community without depriving them of their liberty?' They supported the argument that it is indeed possible to respond to the needs of children who pose a serious risk of harm to themselves in the community without depriving them of their liberty. The research further highlighted opportunities to learn from jurisdictions, such as The Netherlands—with their journey of transitioning from secure care to community-based models of care, and Scotland—in placing secure care within broader system reforms.

Further research, however, is required to determine what are the specific elements of alternatives that are effective and to evidence if alternatives are more effective and rights-affirming than secure care. The precedent studies from Hawaii, Canada, Scotland and The Netherlands suggest a number of ways other jurisdictions can bring secure care in line with international, contemporary practice of secure care, emphasising alternatives. These countries offer ways to not only reduce or eliminate the need to deprive children and young people of their liberty but also reduce rates of child removal and alternative care placements. Listening to children with lived experience, supporting First Nations people to decide what is best for their children and considering alternatives to secure care as part of broader reform reveals a pathway to progressing both self-determination and the de-institutionalisation of seriously at-risk children and young people in care.

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Article

The Care Trajectories and Nature of Care Received by Children Aged 5–11 Who Are in Need of Therapeutic Residential Care

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Abstract: A total of 10% of children looked after in residential care in Scotland are aged 5–11. Although there has been a significant amount of information published about the care trajectories of adolescents in residential care, there is limited information about the experiences of younger children. In this paper, we explore the care trajectories and nature of care received by 5–11-year-olds identified as being in need of residential care. Our results show that younger children who enter residential care have significant trauma histories and experience significant levels of emotional and behavioural dysregulation that foster carers find challenging to manage, resulting in recurrent placement breakdowns. Residential care, particularly small-group-sized care that adopts social pedagogical and psychotherapeutic approaches, was considered beneficial for addressing the psychosocial and emotional needs of younger children. Despite these findings, there were concerns about the long-term use of residential care for younger children. Our results highlight that there is a need to improve access to paediatric mental health services for children in family-based placements. There is also a need to invest in better training and support for foster carers looking after children in severe distress. Community-based outreach services and in-home respite services provided by residential care teams are one way this could be achieved. Finally, in order to promote earlier and more timeous use of residential care, there is a need to shift societal views around residential care being a placement of last resort to rather being a place of recovery and healing that should sometimes be used as a placement of first resort.

Keywords: residential care; foster care; foster care strain; child and adolescent mental health; relationship-based practice; therapeutic practice; looked-after children; care-experienced children; younger children

1. Introduction

Residential care is a form of non-family-based group care, where children and young people are looked after by paid staff who work on a shift basis. There are four broad reasons why residential care is used. First, to provide therapeutic care and education for children with social, emotional and behavioural difficulties, complex long-term disabilities and/or histories of maltreatment, trafficking and sexual exploitation [1–5]. Second, to provide 'respite' care for families and caregivers [1]. Third, as a short-term solution while longer-term family-based placements are identified [2,6,7]. Fourth, as a long-term care placement when suitable family-based care is not available, cannot be sustained or is unable to fully meet the needs of the child [8,9].

There are two types of residential care described within the literature. These are institutional care and therapeutic residential care. Institutional care is characterized by the use of strict routines to provide depersonalized care [10]. It is typically provided within group-living settings such as orphanages, children's institutions, children's homes, infant homes, children's villages and similar residential settings [10]. Therapeutic residential care, on the other hand, has been described as "*the planful use of purposefully constructed, multi-dimensional living environments designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal* *and informal helping resources*" [11]. It is typically delivered in community-based children's homes, community schools or through campus-based care environments that combine living and educational facilities [10].

In Scotland, approximately 1300 children are cared for in residential care placements each year [12]. These placements are most commonly used for the purposes of recovery, rehabilitation and treatment [13]. The general approach taken focusses on using relational practice to support the building of safe, secure and trusting relationships [14]. It also places trauma-informed, attachment-orientated and child-development-centred practices at the heart of this practice [14–17].

Although residential care is a significant part of the Scottish care continuum, it is often viewed as "*a placement of last resort*" [18]. There are two key reasons for this. First, proven episodes of historical child abuse have resulted in concerns about the safety of residential care [19,20]. Second, outcomes-based research indicating that children living in residential care experience poorer outcomes than children living in family-based placements has created concerns about the efficacy of residential care. [21–26]. Within Scotland, concerns about the safety and efficacy of residential care have resulted in practitioners adopting a preference for family-based placements [27]. This preference is most apparent for younger children due to local authorities having previously initiated policies that prevented the placement of children under the age of 12 in these settings [27].

Viewing residential care as a placement of last resort can "*significantly underestimate the contribution that they can make, the stability that they can deliver, and the high-quality care they can extend to children who have had terribly fractured lives*" [28]. This is because existing knowledge on residential care outcomes is likely to have been confounded by the conflation of institutional and residential care. For instance, while previous research has consistently highlighted the poorer mental health outcomes of children in residential care, there is evidence that therapeutic care can result in short-term improvements in the psychosocial, behavioural and educational functioning of children [29–31].

The potential benefits of therapeutic residential care are reflected in current guidance to practitioners. This argues that residential care should be considered earlier in the care trajectories of children with substantial histories of neglect, serious attachment problems, complex physical and mental health needs, and increasingly challenging behaviours that are difficult to manage within family-based placements [32]. In all cases, the decision to use residential care should be based on children's needs, rather than their age [32,33].

Children aged 5–11 account for 10% of the residential care population in Scotland [13]. The limited evidence that exists indicates that these children tend to be boys who require additional levels of care and support due to disability, attachment difficulties and engagement in risky and offence-type behaviours. There is also a tendency for these children to exhibit a range of behaviours that caregivers can find difficult to manage, including age-inappropriate sexualized behaviours; controlling, violent and aggressive behaviours; and dysregulated sleep patterns [29,34]. There is no published information on the nature of interventions used to address the needs of younger children in residential care.

In this paper, we aim to expand our knowledge of how and when residential care is used for younger children. We do this by qualitatively exploring four key issues. These are as follows: (1) the presenting difficulties of younger children requiring residential care; (2) the challenges that parents and caregivers experienced while caring for these children; (3) the range of interventions available to children both before and after entering residential care; and (4) perceptions around the continued use of residential care for younger children.

2. Materials and Methods

In-depth individual and paired interviews were conducted with 22 caregivers (12 residential carers and 10 foster carers) between March and December 2020. The foster carers interviewed included both first time foster carers and those with more experience, including intensive therapeutic foster carers. Intensive therapeutic foster carers are foster carers who have undertaken additional training to support them to use trauma-informed approaches and therapeutic techniques to support the child's emotional well-being and help them develop healthy coping mechanisms and social skills. They usually have a proven record of responding to the attachment and trauma needs of children. The residential carers interviewed included those employed by local authority social work departments and independent providers of residential care.

The majority (n = 20) of the interviews were conducted by telephone or using video-conferencing software due to social distancing restrictions relating to the COVID-19 pandemic. The other 2 interviews were conducted in person prior to restrictions being enacted.

2.1. Inclusion Criteria and Recruitment of Participants

To participate in the study, caregivers had to have experience of caring for a child who: was under the age of 12 and had been looked after in residential care; was under the age of 12 and considered to be in need of residential care by social work; had returned to living in a family-based placement after being in residential care prior to age 12.

The principal method of recruitment involved approaching all Chief Social Work Officers in Scotland and asking for information about the study to be cascaded to their residential and foster care teams. These requests were supplemented with formal approaches to independent providers of residential and foster care in Scotland. Information about the study was also circulated via the social media channels of the Scottish Children's Reporter Administration, the Centre for Excellence for Children's Care and Protection (CELCIS), Children's Hearings Scotland, the Association for Fostering, Kinship and Adoption Scotland (AFKAS), and the Fostering Network. Information about the study was also disseminated via the residential and foster care practice networks operated by CELCIS. Snowballing was used to bolster recruitment by asking participants in the study if they were aware of other carers in their network who met the inclusion criteria.

2.2. Consent Procedures

Information sheets about the study were emailed to all participants at least 24 h prior to being interviewed. The author (CN) reviewed the contents of the information sheet with the participants prior to consent for participation being sought. All participants were asked to give written consent for participation. Individuals who were interviewed in person completed their consent forms directly prior to being interviewed. Individuals who were interviewed remotely were asked to email their completed consent form to CN prior to the interview starting. When this was not possible (i.e., the interview was being undertaken by phone or the participant was experiencing difficulties with their email), oral consent for participation was obtained and the interview was undertaken. These participants were asked to retrospectively complete and submit their consent forms.

2.3. Data Collection and Analysis

All of the interviews were conducted by CN. The interviews focused on caregivers' experiences of providing care to younger children identified as needing residential care. The following topics were discussed: caregivers' understandings of children's backgrounds; the impact that children's backgrounds had upon their behaviour and development; how caregivers worked with children showing challenging behaviour; the support and training caregivers received; how the decision to use residential care for the child had been made; the support available to younger children in residential care; the perceived benefits and risks of using residential care for children's psychosocial and emotional wellbeing; and whether the use of residential care had been the right choice for the child. On average, the interviews lasted 45–60 min.

All interviews were digitally recorded and transcribed verbatim. Transcripts were anonymized prior to analysis by removing the names of any children and places mentioned. The transcripts were then compared with original recordings to ensure that narratives had been accurately captured, with any mistakes or missing segments updated by CN prior to coding being undertaken.

Thematic analysis was used to analyse the data. An initial coding framework was developed by CN. This framework was based on both predetermined research questions and themes identified through close and iterative reading of the interviews. The coding framework was applied to all interviews. Information about whether the coded data reflected a positive or negative representation of residential care was also captured. The initial coding framework was revised abductively. To do this, key messages from the wider literature on residential and foster care practices, as well as the lived experiences of children and caregivers, were used to provide an understanding of the behaviours and practices being described.

All of the transcripts were coded in Microsoft Word using electronic highlighting tools and making annotations within the reviewing pane. An Excel spreadsheet was used for the purpose of collating and consolidating the identified themes.

2.4. Ethical Approvals

Approval for the study and all study materials was provided by the Scottish Children's Reporter Administration's Research Ethics Committee. Consent was not sought to make the raw data publicly available. This decision was made for two reasons: (1) the small number of children cared for in these settings each year increases their risk of being identified; (2) the legal status of the children, many of whom remain subject to legal orders, makes it challenging to obtain fully informed consent for data sharing.

3. Results

3.1. The Presenting Difficulties of Younger Children Requiring Residential Care

Our results indicated that children who are looked after in residential care before the age of 12 have complex trauma histories that are often compounded by the additional health and social care needs of their parents: "*in terms of his experiences, there was drugs, alcohol, lots of domestic violence and lots of people in and out of the house*" (*intensive therapeutic foster carer.* Intergenerational transmission of abuse and violence were also common, as was exposure to poverty: "*their families often have a history of abuse or being in the care sector*" (*residential carer*).

Trauma and adversity were considered to have negatively impacted children's ability to form secure and trusting attachments with adults. These difficulties were often reflected in children's behaviour, with many of the caregivers describing the children they cared for as being overly self-reliant, pushing people away and being unable to seek comfort. For instance, "*when she (age 8) hurts herself, she'll just run off. She'll run to her room. She won't go to an adult*" (*foster carer*). Many of the children were also considered to be overly controlling of both people and their environments: "*He (age 11) cannot let go of the control. He has to keep that control*" (*foster carer*).

It was also common for trauma to manifest itself behaviourally, with many of the caregivers describing the "*challenging*" and "*distressed*" behaviours that the children they cared for had. These behaviours included "*screaming for hours*", "*tearing their hair out*" and "*scratching themselves*". Some of the children, particularly boys, were also engaging in risk- and offence-type behaviours that were alarming their parents and caregivers: "*his (age 11) behaviour in the community was just awful. He was setting fire to the neighbour's house and breaking into the neighbour's car*" (*residential carer*). Others were described as demonstrating age- and developmentally inappropriate sexual behaviours that caregivers had found difficult to manage: "*we have children (aged 5–11) who have quite extreme sexualized behaviours that foster carers struggle to cope with*" (*residential care manager*).

Caregivers reported frequently witnessing destructive and physically aggressive behaviour from the children: "*there was a lot of destruction of property. Televisions. Furniture. Just picking up anything and throwing it at people*" (*residential carer*). This behaviour was considered to stem from the children being hypervigilant and having easily triggered fight, flight or freeze responses: "*this kid (age 10) was constantly on alert and he would fight all the time because that was how he protected himself*" (*residential carer*). Several of the children were described as having used weapons to threaten or harm their caregivers during periods when triggered. For instance: "*we were eating tea and something just set him off. It could have been something on the plate. Asmell. Some kind of trauma trigger. It just set him off. He became really quite dysregulated, kicking and punching, and before I knew it he had grabbed my steak knife and tried to stab me in the neck*" (*foster carer*). The physical aggression displayed by children during these periods was often directed at the primary caregiver who, in the majority of cases, was female.

The behaviours being demonstrated by children often intensified in the evenings. This resulted in children developing disrupted and dysregulated sleep patterns. When this happened, children were described as "*refusing to sleep*" or "*not sleeping through the night at all*". Some caregivers suspected that the children they cared for were actively afraid of going to sleep: "*she (age 5) was screaming and she would actually urinate on the floor. At nighttime her level of violence would increase and it was just an absolute fear of going to sleep*" (*residential carer*). In these cases, the suspicion was that the children had been sexually abused. In some cases, it was believed that the children had trained themselves to stay awake in order to care for and protect their younger siblings: "*he (age 7) said 'I had to stay awake to look after the baby'*" (*foster carer*).

The trauma histories and the behaviours that stemmed from them were considered similar to those demonstrated by adolescents living in residential care. However, what caregivers frequently commented on was both the "*intensity*" and duration of the behaviours being displayed by really young children. For instance: "*It could be two, three hours sometimes of her (age 7) screaming, rolling around in the mud, tearing her hair out and scratching herself*" (*foster carer*). Similarly: "*she (age 5) was putting herself at significant harm [in foster care]. She was trying to headbutt glass and hanging over bannisters, and she was like that for hours and hours just struggling*".

3.2. The Challenges That Parents and Caregivers Experienced While Caring for Younger Children in Need of Residential Care

Breakdown of foster care placements was a common factor in the care histories of younger children in need of residential care: "*she (age 5) had three foster care placements in three months*" (*residential carer*). Placement breakdowns were usually attributed to foster carers being unable to cope with the intensity of the behaviours being demonstrated by the children in their care. Changing placements often created a vicious cycle, in which children's behaviours became increasingly dysregulated, further increasing the risk of placement breakdowns. For instance: "*the foster carers were just unable to manage so she (age 7) got moved on and her behaviours got worse. Every time she moved, her behaviours just got worse*" (*foster carer*).

Placement breakdowns were considered to happen because the allocation of children to foster families was often based upon availability rather than the careful matching of children's needs against the skills, training and experience of foster carers. This sometimes resulted in first time foster carers being asked to care for highly dysregulated children. Many of the caregivers we interviewed believed that placement breakdowns could have been prevented if the children they had cared for had been allocated to intensive therapeutic foster carers as "*singleton placements*". However, both the limited number of these placements and the intensity of the therapeutic parenting caregivers were already providing meant that these places were not always available. For instance, one intensive therapeutic foster carer told us: "*the social workers were asking for a more experienced foster carer to take her (age 7). Had we not had any additional children when that seven year old came [for respite care] it might have been a situation where I could have helped her, but it just wasn't possible when we already had one with us who as on the verge of becoming that challenging*".

Looking specifically at foster carers' experiences, we identified three main reasons why caregivers struggled to manage challenging behaviours. The first reason related to the "*exhausting*" nature of caring for children with dysregulated sleep patterns. Caregivers who were living with children who struggled with sleep specifically emphasised the toll that lack of sleep took on their ability to effectively support and care for children during the day. For instance, one foster carer stated: "*we're not wanting him (age 11) to leave here [to go to a residential care placement], but right now he's an 'unloved child'. We're going through the motions. We're washing him, feeding him, putting him to school and giving him hugs and kisses when required. But it's all just going through the motions as we are just so tired*".

The second reason focused on the lack of practical support and interventions available for children in foster care placements. The foster carers we spoke to described being actively dismissed by social workers when trying to gain access to services for children. They also expressed frustration at being offered support that either did not meet the level of need being demonstrated by the child or was being provided by individuals without specialist training. For instance, one foster carer angrily described declining the offer of play therapy for a child who was demonstrating significantly challenging and aggressive behaviours: "*you can hike off with the council play therapist as she's a support worker who has no formal training in play therapy*" (*foster carer*).

Often, the main support offered to foster carers was respite care: "*if you're struggling we'll give you a bit of respite*" (*foster carer*). Planned respite care was not always taken up by the foster carers. This was because some carers believed that using strangers to provide care would be perceived as another form of rejection by the children and would worsen the behaviours being demonstrated. They also worried about the ability of respite carers to cope with the behaviours being demonstrated: "*I don't get a break if I need to go and get him (age 8) in the middle of the night because they can't cope with his behaviour*" (*foster carer*). The ability of respite carers to cope with behaviours was considered particularly important as some foster carers had experienced respite carers actively refusing to look after children they considered to be "*too difficult to manage*". For instance: "*they didn't want to take him (age 11) because he was too high maintenance. There are no carers who will take him so it ends up that we don't get any respite*" (*foster carer*).

The third reason related to the quality of training received by foster carers. Both residential and foster carers identified that foster carers were not trained to deal with complex behavioural and mental health difficulties. For instance: "*the training that foster carers are given is terrible. It doesn't go into any great detail in the training. It doesn't prepare you for the reality*" (*foster carer*). Some of the foster carers felt that there had been an expectation from social workers that caregivers' professional training would help prepare them for caring for children with complex needs: "*what we [retired police officer and manager of a mental health charity] were told was that we would be fine because of our backgrounds*" (*foster carer*). These backgrounds included being employed as police officers, residential care workers, mental health nurses and social workers.

Several of the foster carers revealed that they had tried to address their lack of knowledge by asking to be sent on specialist training courses and investing hours of their spare time researching potential interventions to support the child(ren) in their care. For instance: "*I must have spent hours and hours and hours researching, just trying to find something, anything, to help her (age 7)*" (*intensive therapeutic foster carer*). Two of the foster carers who had asked to be sent on specialist training expressed frustration that there was a lack of funding for foster carers to receive additional training. These foster carers self-funded their training: "*we asked social work for training, but we couldn't get it, so we paid [£600 each] to go on a course to find out more about attachment and trauma*" (*foster carer*).

3.3. The Range of Interventions Availale to Children before Entering Residential Care

Many of the caregivers identified that there were a number of underlying factors that explained the behaviours that they were witnessing. These included the following: the children having never learned how to emotionally regulate; the impact of learning difficulties and developmental delays upon children's ability to communicate; and the impact of suspected or confirmed mental health difficulties or neurodiversity on their behaviour. For instance: "*he (age 10) has been on medication for ADHD since he was in residential so he obviously had ADHD in foster care and it was unrecognized and unmedicated.*

Knowing what we see here, when he is medicated, I can see how his behaviours would have been really challenging to other foster carers" (*foster carer*).

The awareness that there could be an underlying reason for children's behaviour resulted in some foster carers actively seeking support for assessment and treatment from other services, mainly Child and Adolescent Mental Health Service (CAMHS). There were a number of barriers identified to accessing CAMHS. These included complicated referral pathways and the length of time it took for children to be referred, assessed and treated: "*It was a bloomin' nightmare getting CAMHS involved. It took years. We didn't get her diagnosed until she was 13 and we got her at 10. Three years it took us*" (*foster carer*).

One caregiver expressed frustration that poorly worded referrals to CAMHS could result in children being rejected by the service. They could also result in children receiving the wrong assessments and having to go back on waiting lists to be correctly assessed: "*when we got there the mental health nurse said he (age 10) is here for a mental health assessment and I was like 'no… he needs a wider assessment around attachment'. 10 weeks later they said 'he doesn't have mental health difficulties' and we agreed. So off we go back to the doctor to get re-referred. Three months have passed and he goes back on the waiting list for another 6 months, only for it to be rejected*" (*foster carers*).

Challenges to accessing mental health support were compounded by CAMHS being unable to undertake diagnostic assessments or therapeutic work if the children were considered to be too young or "*not stable enough in their placements*" for assessment. Not being in a permanent placement was considered a particular barrier to accessing support: "*psychological services would normally be for a child in a permanent placement. If they are not in a permanent placement it will all need to end again when they move again*" (*intensive therapeutic foster carer*). There was also a perception among some foster carers that services did not want "*to label*" children in care and that this was acting as barrier to children receiving support. This was a particular source of frustration for foster carers as not having formal diagnoses acted as a barrier to caregivers accessing other support services for children: "*on the one hand I can see that you don't want to give children too many labels, but on the other hand a label can help you to push for services*" (*foster carer*).

Several of the caregivers perceived the children in their care to be "*at the end of the queue*" for community-based mental health support. This resulted in foster carers using informal networks and education services to try to understand and support children's mental wellbeing: "*I know the CAMHS team here quite well so it was good to be able to get some informal advice or a suggestion about alternative things that I hadn't been trying with her (age 7)*" (*intensive therapeutic foster carer*). Some caregivers also offered to pay to purchase therapeutic services themselves: "*I said I'll pay for counselling for him (age 10) myself*".

There was a general belief that moving children into residential care increased their likelihood of receiving the intensive therapeutic support that was needed: "*I think in residential care children get the help they need quicker, whether that be educationally, physically, mentally or psychologically*" (*intensive therapeutic foster carer*). One foster carer, when reflecting on the challenges they had experienced accessing mental health support for a 13-year-old who had been looked after in residential care between the ages of 5 and 10, stated: "*she shouldn't have had to go back into residential care (at age 13) to get the support she needed*".

3.4. The Range of Interventions Available to Children after Entering Residential Care

In the majority of cases, the transition to residential care was unplanned and related to a crisis point being reached within the foster care placement. For instance: "*it tends to be that when it's a placement breakdown something has happened after a gradual demise that requires emergency intervention. For the younger children it tends to be a really traumatic event that has happened*" (*residential carer*). There were a few examples within our data of foster carers finding themselves in the uncomfortable position of having to choose which foster child "*in crisis*" they could continue to support and which child would need to be looked after in residential care: "*we lost our girl (age 13, in residential care from 5–10 years old) at that time as* *she moved on to residential as we couldn't cope. We had to choose. It was going to be her or him (age 10). We couldn't do both*".

The need for emergency placements resulted in some children being moved rapidly and without any of the preparatory or settling-in work that would usually be undertaken as part of a planned move. It also meant that the decision about which residential care facility to use was based largely upon bed availability rather than a careful consideration of children's needs: "*there were no foster care placements available. We didn't even have a bed available so he ended up sleeping on a day bed in the lounge*" (*residential carer*). In several cases, the need for specialist residential care had already been identified prior to the crisis point occurring; however, the purchasing of these placements had not been completed. This resulted in some children quickly experiencing a second planned move into a setting that was considered to better meet their needs.

The majority of the children described in the interviews were placed into independently provided residential schools and children's homes after an initial emergency move into a local authority children's home. These specialist facilities were considered to offer an opportunity to build a team around children who were demonstrating challenging behaviours. They also provided high staff-to-children ratios, i.e., "*we have 5 members of staff to 4 kids*" (*Residential Carer*). They were also considered to avoid the potential for younger children being placed into a local authority home that was structured around adolescents and where they could be exposed to a range of negative and risky behaviours.

The high staffing ratios, along with the shift patterns that caregivers worked, were considered to be beneficial as it allowed for children to be consistently supported. It also allowed caregivers to focus on building relationships with children. For instance: "*with the high staff ratio we are able to provide support and really get in-depth and speak to the kids and have reflective chats with them*" (*residential carer*). High staff-to-children ratios were also viewed as a means of minimizing burn out when working with traumatized children. For instance: "*I remember how intense it was in terms of the residential perspective, but the strength was that you had a team around the child. I can only imagine how difficult it would have been as a foster parent to try and support those behaviours on a day-to-day basis. It would very quickly wear you down*" (*residential carer*).

Being able to build a team around the child was also considered to be beneficial as it removed the pressure on children to form an attachment with one individual and instead allowed them to choose which adult(s) they wanted to develop relationships with. This was considered advantageous for children who really struggled in family settings, or whose trauma responses were triggered within the family setting. For instance, one residential caregiver described how an attempt to move a 5-year-old girl from residential care to foster care had failed as a result of the child really struggling to live in an environment that mirrored the mother–child dyadic: "*She was trying to kick holes in walls, trying to destroy the house, and just unable to settle... but I think it [living with a single female carer] was just too much of a mirror image of what she had had growing up and she just couldn't settle and trust that this person was able to keep her safe*".

The residential carers we spoke with were highly trained individuals who were constantly seeking and receiving support to develop their knowledge of child development and how trauma impacted upon this. This was reflected in caregivers' discussions around the applicability of attachment theory, social learning theory, social pedagogy, the impact of adverse childhood events (ACEs) on childhood development and the early years curriculum to their practice. The training residential carers had received was considered to be beneficial as it helped to contextualize the behaviours they observed from children. For instance, one residential carer reflected that "*we are much more immersed in theory and understanding of theory and why children behave in the way they do. So rather than just dealing with behaviours you are seeing them as symptoms of what's deeper and the trauma that is really there*". The amount of training that the residential carers we spoke to had received contrasted starkly with the training received by foster carers.

Although residential carers emphasised that the use of residential care removed the pressures on children to form secure attachments with their caregivers, they often described the residential care setting as being a "*secure base*" for children. In particular, residential carers spoke about the importance of nurturing the development of secure, trusting and consistent relationships between children and staff. Looking first at the issue of consistency, the majority of the residential carers spoke of the need to provide children with consistency, stability, routine and boundaries. This was considered particularly important given that many of the children were entering residential care with dysregulated sleep patterns and found it difficult to relinquish control to adults: "*we support them in terms of regulating their emotions, regulating their sleep patterns, their eating and all of these things that would have been quite chaotic prior to coming to us*".

Many of the residential caregivers spoke about how their organisations had drawn upon Dyadic Developmental Psychotherapy (DDP) to develop an attachment-promoting service. For caregivers, this meant embedding PACE/PLACE within their practice: "*you have to practice with PACE. That is you have to be playful, accepting, curious and empathic. But recently they've added an L into its. So it's PLACE and it's Love. You bring your whole self to work, and you have to have a glint in your eye, and be curious, and just be alongside the young people*". Playfulness and play-based learning were common themes raised in relation to undertaking emotions work with children. For instance: "*we use lots of visual things that we can use to discuss thoughts and feelings, and we do lots of imaginary conversations through teddies or puppets*" (residential carer). These approaches often reflected the nurture-based play approaches that some of the foster carers had tried to use to help younger children make sense of their worlds: "*At home we were doing the nurturing work. I had a big box of bandages and I would bandage him up like a mummy every night and we'd give him magic creams and magic sprays and magic fingers, and we had all the magic teddies. There was nurse teddy, doctor teddy and mummy teddy. And they all went around his bed on a night time*" (*foster carer*).

Relationships and relational practice were identified as the foundation of residential care: "*a lot of the time it is just the relationships that we use as the intervention. They're the intervention as relationships are the most powerful thing*". In fact, many of the residential caregivers we spoke with described themselves as being social pedagogues, i.e., practitioners who value relationship-centred approaches which aim to holistically support well-being, learning and social inclusion. This holistic approach could be seen in two key ways. First, several residential carers described how the physical environment of the residential care settings they worked in had been carefully designed to try and help children emotionally regulate. This included using space, physical activities, sensory experiences and chillout zones to provide a range of different options that could be tailored to the needs of children and their personalities. For instance: "*we've got bits that go on doors so that kids can hang and stretch and try to regulate their emotions. We've got giant beanbags in place so kids can just jump into them and disappear. We've got kind of hanging baskets that they can just climb into. We've got dark places that they can just go into to cut all of their sensory input. Outdoors we've got lots of big basket swings and trampolines that take account of the idea of regulating emotion through motion*" (*residential carer*).

Second, residential carers talked about the ways in which elements of forest school practices had been incorporated into their relational and nurturing practices with children*:* "*we've got a huge focus on learning through the outdoor environment*". This included allowing children to develop relationships with animals and introducing elements of monitored risk-taking into play. In many cases, there was a recognition that naturalistic learning practices served as an alternative form of education for children who were not able to engage with more formal education. For instance, one residential carer explained how their setting had taken "*a more pedagogical view that is less driven by league tables and more about encouraging the kids to learn by whatever means there is*". These approaches also recognised that maltreatment and trauma often resulted in children operating at a different development stage to their chronological age: "*we're very clear that we respond to our kids at their developmental stage as* *many of them are much younger developmentally and respond a lot of the time as 2 and 3 year olds"* (residential carer).

Placing younger children into specialist residential care was also identified as a means of accessing mental health support that were not available in the community. While local authority care homes tended to rely upon the involvement of looked-after children's nurses to seek advice and support around children's mental health, independently provided residential care placements were often able to purchase psychotherapeutic support for children in the absence of CAMHS services. It was common for children living in these settings to have psychologists and psychotherapists involved in their care: "*we work really closely with the child psychotherapist and the child psychologist and they're very much involved with the therapeutic meetings that we have*" (*residential carer*).

Residential carers described three key ways that clinical staff worked with residential teams to support the care of younger children. First, clinical teams worked with residential caregivers to develop and revise care plans for children. For instance: "*they would support the team in terms of where the child was at just now and the different interventions and strategies that were included within the support plan or the care plan that we had*" (*residential carer*). These plans were described as being regularly reviewed, with the clinical team offering pastoral support and guided reflections with staff members.

Second, they supported residential carers to reflect upon and understand the context of the behaviours that they were observing. This was undertaken through a mix of training, reflective discussion and developing tools that could be used by practitioners to help identify developmentally appropriate behaviour. For instance, one residential carer described how they had asked their in-house clinical psychologist to help develop a tool that could help caregivers to identify whether children were reaching developmental milestones: "*I was thinking how do we help our adults understand where that child might be emotionally and socially? So I had a conversation with the psychologist and she helped develop a template that carers can use to match [the behaviour] against a list of milestones that children should be able to do between the ages of 0–2, 2–5 etc.*".

Finally, in-house or purchased clinical resources were commonly used for the purpose of conducting therapeutic conversations with children or supporting caregivers to have conversations with children around their behaviours and needs. For instance, one caregiver reflected on the role that the clinical team played in supporting conversations with children about their involvement in risky behaviours: "*sometimes they would get involved in that conversation with the young person and the staff member, and other times they would just give advice to the staff member who was going to have that conversation about different ways of approaching it*". One aspect of the support that residential carers particularly valued was the space that psychologists provided for them to reflect on their practice. This was considered particularly useful if there had been an incident within the residential care setting, as it allowed carers an opportunity to reflect on all of the factors that might have contributed to the incident, including their own reactions to children's behaviour and how these could be better managed. For instance: "*we create a lot of space for staff members to reflect and talk. . . and think about what their triggers are and how to understand the kids triggers as well*" (*Residential care manager*).

3.5. Perceptions on the Future Use of Residential Care for Younger Children

Many of the residential carers that we interviewed felt that residential care, particularly therapeutic residential care, was not used early enough within the care trajectories of children who were demonstrating challenging behaviours within family-based placements: "*the research and the evidence is overwhelming that the earlier the intervention is the better the outcomes are. I think there are potential benefits of using residential care earlier*". Some residential carers felt that using residential care earlier in children's trajectories could minimize some of the drift and delay that children experienced as a result of placement breakdowns. For instance, "*it would probably be most successful if local authorities didn't see residential as a last* *resort and actually used it as a first resort in some occasions so that there hadn't been such significant breakdowns in foster care*".

It was identified that one of the main barriers to residential care being used earlier in children's care trajectories was the costs of commissioning these services. This was particularly identified in relation to specialist therapeutic providers of residential care: "*because of the cost of a service like ours local authorities are reluctant to place children unless they feel it has gotten to that last resort*". Another barrier to earlier use of residential care services for younger children was the perception that these settings were "*loveless*" "*institutions*" that could not replicate the emotional security that could be provided by living in a family-based placement. For instance, one foster carer told us: "*when she was in residential nobody touched her. They didn't touch her. She was six and had learning difficulties and she hadn't had a hug in all those years*".

Concerns about institutionalisation were particularly common among foster carers, many of whom described the impact this had on caring for children returned to family-based placements. For instance: "*she (age 10, lived in residential care from age 5–10) was completely institutionalised. It was awful. She would ask which one of us is going to be staying up overnight. 'Who is on duty?' 'Who is going to be awake?' And she would expect to be able to get up and just talk to the staff in the middle of the night*". To minimize the risk of institutionalisation, it was identified that the main use of residential care for younger children should be to provide short-term rehabilitative and therapeutic interventions for younger children: "*it should be an intervention and not a destination. It should be used as a period of calming and settling before matching and moving onto foster care or kinship care, or if the work is being done with the family then you go back to the family*".

Although this was the aspiration, it was not uncommon for caregivers to describe younger children who had been living in residential care for 3–5 years. This was particularly common for children who had both complex trauma histories and complex health needs and who needed significantly more preparation and support to be able to live in a family-based placement. For instance: "*she (age 9) has been here since she was 6 and they are looking for permanency. Social work are in agreement about her remaining here until we can get the autism assessment done. It's not writing off foster care completely. We just have to take it at a slower pace*".

The longer-term nature of placements meant that several of the residential carers spoke of caring for children who were at risk of "*ageing out*" of their residential care placements. This was because their registrations did not permit the establishment to care for older children. Two of the residential care providers we spoke with told us that their organisations had specifically changed their registration status to allow children to remain in their homes beyond 13 or 14 years of age. For instance: "*it didn't feel right for a kid at 14 years old to have to leave behind what had become their family and what had become their support network so about 2 years ago we changed our registration to allow us to keep the kids right up until their 18th birthday*". Addressing the continuity of care for younger children in need of longer-term residential care was considered an issue that needed to be addressed.

When asked how residential care could be improved for younger children, several of the residential carers highlighted how their skills could be used to provide earlier support for families and caregivers with children on the edge of residential care. For instance: "*I think the role of residential care should be to get in and around the family and support that family with their wee person. I'd like to see residential units becoming more like a family support service that services their locality or neighbourhood*". This was an approach that some residential providers were trying in order to promote the sharing of knowledge around children's behaviour: "*that was the beauty of being hand in hand with the fostering team… there was that seamless link where we (residential carers) are able to share our knowledge, insight and understanding of the children with the foster team*".

Some of the residential carers identified that using residential care to provide support in this way could reduce the number of emergency admissions to residential care for younger children. It was also considered to support better transitions between residential and family-based living. For instance, one residential carer recalled how the children's home she had worked in had provided support for parents: "*we had a brother (age 4) and a sister (age 8) with us for about a year and we did extensive parenting work with their parents and they went home. They would come into the unit at bedtime and alongside staff they would learn how to do a bed time routine and things like that. And our staff would go into their home at crucial times and just watch what was going on and give praise and support*". Another recalled a similar offering that had been in place for foster carers: "*we used to do a thing in this area where each of the residential care homes knew the foster carers that were in the locality and they could phone for support from the residential care officers, particularly at night*".

One independent provider of residential care was piloting a service which would provide additional training and support to foster carers looking after 5–11-year-olds who had previously been in residential care. The children involved in the pilot had all had difficulty settling within family-based placements and were living in small group care settings with high staff-to-child ratios. All of the children had received psychotherapeutic support, and the residential carers were working with the children to prepare them for living in a family-based environment.

Prior to entering foster care, children were carefully matched with the foster carers, and a residential care worker was allocated to the family to provide in-home support and respite care. The level of support allocated was based on the assessed needs of the child. For instance, one foster carer who was looking after a 12-year-old boy who had been in residential care since he was 9 described how they had "*had keyworkers coming in from [the residential care centre] to support us twice a week for about four hours and then another day for about six or seven hours*". Another told us that they had been allocated "*37 hours a week of keyworker support*". Regular reviews of the support provided were undertaken to allow it to be both increased and decreased as required.

This type of partnership working was considered particularly beneficial as it allowed for the residential care ethos of building a team around the child to be extended into family-based placements. It also allowed the child's place within the residential care setting to be maintained while it was ascertained whether a family-based placement could be sustained. The importance of this was emphasised in the case of one child, who became "*highly distressed*" as a result of the move and returned to living in residential care. Her residential carer told us: "*we'd managed to get her (age 6) to a point where she was calm and we found an intensive foster care placement for her, and within six weeks that broke down and she returned to us. There was a package of support fit around her needs. She was initially getting 37 hours a week of support, but towards the end it was near enough around the clock. . .. with people having to be sent down to provide additional support. It wasn't feasible for anybody to sustain*".

One of the key benefits of residential carers working with foster carers to provide this additional support was that it provided both children and caregivers with a larger support network: "*we've ended up doing more things with the keyworker rather than them coming in to give us a break. It's like he's the uncle of the family, and it's not about us getting a break from [the child] or us getting a break from him. It's about being together as a family*". Although this continuation of relationships was viewed as important, it was highlighted that this type of collaborative working could not be implemented without additional resources. In order to minimize the time that younger children with complex trauma needs spent in residential care, it was identified that there was a need to invest in the following: the provision of mental health services for children; additional support for foster carers caring for children whose placements were at risk; and both upskilling and supporting foster carers to better recognise and respond to the mental health needs of younger children. The latter of these was considered particularly important as "*there is a lot of focus on getting children into CAMHS and external therapies, but if we could upskill and train the adults that are around the children they would have the confidence to approach and respond to these situations*".

4. Discussion

Our results highlight that 5–11-year-olds who are looked after in residential care often grow up in households characterized by parental mental ill-health and substance misuse, poor parenting skills and exposure to interpersonal violence and abuse. These findings, while providing insight into the lived experiences of younger children entering residential care, are not novel. Instead, they replicate findings from previous studies highlighting the presence of parental mental ill-health, substance dependency, interpersonal violence, poor parenting and maltreatment in the backgrounds of adolescents entering residential care [35,36].

Younger children in need of residential care had complex trauma histories that manifested in a range of dysregulated and developmentally abnormal behaviours that parents and foster carers found difficult to manage. These behaviours included age-inappropriate sexualized behaviour, violent and aggressive behaviours and being overly controlling of their environment and people. Many of the children also experienced dysregulated sleep and had significant difficulties regulating their emotions. The range of behavioural difficulties described builds upon existing knowledge of the characteristics of 5–11-year-olds, particularly boys, in residential care [27,29,34]. It also reflects the finding that adolescents in the care system are more likely than their peers to experience mental health difficulties, display harmful and age-inappropriate sexual behaviours, demonstrate offence-type behaviours, have insecure and disorganized attachment styles, and be overly controlling of situations and people [36–38].

Many of the children discussed within the study had experienced multiple changes in caregivers prior to entering residential care. The range of difficulties experienced by children and the challenges caregivers experienced in managing these were frequently cited as a reason for the breakdown of family-based placements. Our findings suggest that the experiences of caring for children who have trauma-driven emotional and behavioural difficulties extends beyond normative parenting experiences and places significant strain on foster parents. Fostering strain has been shown to reduce the parenting capacity of foster carers, resulting in carers becoming less attuned and responsive to children’s needs [39]. This was something that was discussed in this study, particularly in relation to the effect that sleep deprivation had upon caregivers’ ability to sustain the level of support needed by the children in their care.

Lack of support, conflict with social workers and poor access to services can compound fostering strain [40]. These were all issues that foster carers in this study raised, with many of those we spoke to seeking out informal support networks to try and address these gaps. The reliance on informal networks by foster carers is not a new phenomenon. In fact, previous research has indicated that the use of informal support networks by foster carers is associated with their ability to sustain fostering [41].

Although informal support may offer some benefits to foster carers, there is a danger that these individuals, through lack of understanding and training, could provide advice that exacerbates the difficulties being experienced. The use of informal support also raises questions about the extent to which seeking advice from others, even if they could be viewed as ‘in trust’ due to the role they occupy, would breach children’s right to privacy. To minimize these risks, there is a need to ensure that foster carers are provided with support by individuals who have a detailed understanding of the impact of trauma on child development. Our findings indicate that using trained residential carers to provide in-home support and respite for children with complex support needs could be one way of addressing this.

Ensuring that foster carers, particularly those who are not registered to provide intensive therapeutic foster care, are not placed in the position of caring for multiple children exhibiting the levels of distress reported in this study is also important. No caregiver should be placed in the position of having to actively choose which child they have the capacity to support. This is particularly important given the difficulties that foster carers in this study encountered around accessing mental health assessments and therapeutic support for the children in their care.

Concerns around accessing mental health support for children, particularly those in care, are not new. In the UK, less than 1% of health funding is currently spent on mental health service provision. In the light of the COVID-19 pandemic, calls have been made for significant investment in CAMHS provision. This includes a recognition that there needs to be increased investment in mental health service provision for children under the age of 5 [42,43]. The current lack of investment in mental health provision for children and young people can be seen in the fact that just one in four children identified as requiring mental health treatment go on to receive it. It is likely that this figure is lower for children in care, as a survey conducted in 2010 revealed that one in two children in foster care with identified mental health difficulties were not receiving CAMHS [44].

Limited resources within CAMHS means that access to services is now often prioritized for children who are actively suicidal, anorexic, severely depressed or demonstrating actively dangerous behaviours [43]. Lengthy waiting lists also mean that one in five children who require treatment wait four or more weeks to receive it [42]. While the targeting of limited resources at those children most at risk is understandable, the limits on CAMHS provision does not help caregivers who are struggling to manage challenging and developmentally abnormal behaviours.

In the absence of increased funding for CAMHS, our results highlight the need for foster carers to be adequately supported to better understand the emotional and behavioural problems that children in their care are exhibiting. Providing psychotherapeutic parenting support for foster carers may be one way of doing this. Promising examples of work in this area include the evaluations of the following: (1) the Reflective Fostering Programme, a trauma-informed group-based psycho-educational programme that is designed to help foster carers reflect upon how they experience, respond to and manage challenging behaviour [45,46]; and (2) Dyadic Developmental Psychotherapy provision for foster carers [47,48].

The formation of close and committed relationships between staff and children in residential care has been identified as a form of therapeutic intervention in its own right. This is because it can provide children with a secure base [14–17]. The residential carers interviewed in this study situated relational practice at the heart of their work with children. Descriptions of their practice largely reflected the models of place-based and relationship-focused care that have been identified as exemplars of best practice within residential care [49]. It was also clear that the residential care workers we interviewed were drawing heavily on social pedagogy and were trying to create a holistic and child-development-focused approach to identifying and addressing the needs of children. The extent to which this was delivered accordingly cannot, however, be assessed.

Social pedagogy embeds the idea of working alongside children and young people to foster well-being, learning and social change through both formal and informal learning activities. For children in care, the adoption of social pedagogical approaches by caregivers has been associated with reductions in daily conflict, lower levels of running away from placement, increased engagement in education and caregivers being increasingly perceived as being emotionally warm. It has also been identified as a tool through which to promote greater staff cohesion in residential care by providing a shared language, ethos and culture [50]. In the UK, the evaluation of "head, hearts, hands", in which social pedagogical approaches were adopted into foster care, found early signs of placement stability during the latter stages of delivery [51].

It is this stability that the use of residential care for younger children appears to bring. For instance, a previous study conducted by Nixon and Henderson [29], which explored the case files of 135 children aged 5–11 in residential care, concluded that residential care can act as a stabilizing environment for younger children with challenging behaviours. In particular, the study concluded that within two years of entering residential care, there had been significant reductions in the number of behavioural difficulties displayed by children and an improvement in their mental wellbeing. Much of this improvement was attributed to the fact that three-quarters of the children had experienced either no placement moves or just a single move to a planned specialist therapeutic placement within that period.

While none of the caregivers we spoke to in this study wanted to see younger children living in long-term residential care placements, it was not uncommon for the 5–11-years-olds that the caregivers spoke of to have been living in residential care for 2–5 years. This echoes our previous finding that 82% of 5–11-year-olds who enter residential care remain living in these settings two years later [29]. The likely explanation for the length of these placements is that the severity of distress and emotional dysregulation that the children were experiencing upon their admission into care, along with the stability that was then created, resulted in decisions being made to maintain these placements. This raises the question as to whether earlier entry to residential care for younger children could have resulted in an increased likelihood of the children being rehabilitated into family-based care or indeed whether the use of shared care or the provision of edge of care services by residential care providers could have resulted in younger children's places within foster families being maintained. Future research should explore these issues.

Residential care, particularly when delivered therapeutically, has the potential to improve outcomes for some of the most emotionally vulnerable children in society, which highlights the need to significantly reframe how residential care is viewed. Within this study, we continued to hear residential care being framed as "*a last resort*" for children and young people, rather than being actively considered as a potential "*first resort*" for those children who were clearly struggling to develop the safe, secure base that is needed for healthy development within family-based placements.

Many of the foster carers considered the use of residential care to be potentially harmful for younger children. What we heard instead were multiple examples of child-centred and trauma-informed relational practice being undertaken to support the recovery and rehabilitation of children with significant and complex needs. The most prominent concern among foster carers related to younger children becoming institutionalized. Within this study, the use of this term very much focused on the entrenchment of children in systems, language and routines that seemed foreign within the context of the family home. Most importantly, it did not reflect concerns among foster carers that the children in their care would be placed into large group homes offering depersonalized care. These findings raise questions as to whether residential care is being commonly conflated with institutional care and whether this would act as a barrier to the use of residential care at an earlier point in children's care trajectories.

In order to alleviate any potential concerns about the impacts of therapeutic residential care, there is a need to explore whether the conflation of institutionalized care and residential care has had an impact upon the findings of outcomes-based research. For instance, it is widely known that the use of large-scale institutional care results in particularly poor outcomes for children [52]. However, the same may not be true of residential care that offers psychotherapeutic and pedagogical parenting practices within the context of "*homely*" care with high staff-to-child ratios [53–59]. Combining these types of care could therefore result in any measurable benefits of therapeutic residential care being effectively cancelled out. Future research should therefore aim to fully explore the extent to which the effects of residential care can be disaggregated by the nature of the care that children are receiving.

Our results also highlight that there is a need to better inform individuals about the role that residential care can play to support children with complex trauma and behavioural histories. Moving the discourse away from placement type to placement purpose [60] would be one way of addressing these concerns, as our data suggest that negative attitudes towards residential care can act as a barrier to the use of earlier and more timeous interventions for children in crisis within family-based placements.

One particular barrier that needs to be addressed relates to the potential role that perceived differences in parenting practices between residential and foster care might be playing in perpetuating the view of residential care as a last resort. This observation is based upon our findings that foster carers who rehabilitated children from residential care settings were often frustrated by the parenting practices within these settings, many of which they described in ways that suggested they found the parenting styles used to be too permissive and lacking the structure that would normally be seen within a family home.

This finding is not new. For instance, an evaluation of the use of "head, heart, hands" with foster carers concluded that some foster carers considered the approach to be too permissive, while others felt that the principles did not fit with the existing practices for caring for children in foster care placements. If social-pedagogical approaches are to continue to form the approach to parenting that should be adopted for children in care, then there needs to be further research conducted to understand how differences in existing local practices, culture and attitudes towards different parenting approaches across the care continuum affect the adoption and implementation of social pedagogy [61].

5. Conclusions

The care trajectories of younger children who enter residential care are complex and reflect the effect of trauma, placement instability and lack of community-based support to address the psychosocial and mental health needs of this population. It is clear from our findings that there continues to be a need for increased investment in support for foster carers, with psychotherapeutic support identified as something that could be particularly beneficial. There is also a need to address the crisis that exists in mental health funding for children and young people in both Scotland and the wider United Kingdom, and more consideration needs to be given as to how the mental health of children in care is addressed given the challenges that placement instability place upon accessing assessment and treatment. Finally, there needs to be greater recognition that residential care, in particular small-group-sized, therapeutic and relational care for children, can promote stability and have beneficial effects on their psychosocial well-being. To address this, there is a clear need to continue shifting the view of residential care as a placement of last resort and instead work towards creating an ethos within social services wherein therapeutic residential care is viewed as a resource that can be used earlier in children's care trajectories for the purpose of rehabilitation and recovery.

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Reduction in Restraint and Critical Incidents in a Norwegian Residential Treatment Facility for Children Aged 7–13 Following the Implementation of the Neurosequential Model of Therapeutics

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Abstract: In child and adolescent inpatient, residential and day-treatment facilities, the use of physical restraints and the occurrence of critical incidents are a significant problem. Restraints may sometimes be necessary if a child exhibits dangerous aggressive behavior, but may also be misused or overused, and have been shown to be preventable in many cases. This study aims to investigate if the implementation of the Neurosequential Model of Therapeutics (NMT) has an effect on the annual number of physical restraint incidents in a residential treatment facility for children with complex mental health disorders. Data before and after NMT implementation were collected from the agency's restraint records. The results showed that post-NMT implementation, there was a substantial and sustained reduction in restraint incidents, with a Cohen's d value of 2.03, indicating a very large effect. Limiting restraint use in treating children with complex mental health disorders can foster a safer and more therapeutic environment, with potential improvements in treatment outcomes. This study demonstrated a substantial drop in restraint incidents following the implementation of the Neurosequential Model in a residential facility for children aged 7–13. This reduction is presumably pivotal for children with complex mental health disorders, making treatment less coercive and offering promise for settings in which restraint incidents are a concern.

Keywords: physical restraints; critical incidents; child mental health; NMT; residential treatment

1. Introduction

In child and adolescent inpatient, residential and day-treatment facilities, the use of physical restraints and the occurrence of critical incidents are a significant problem [1]. Children and adolescents referred to such treatment facilities often exhibit impulsive, aggressive, and explosive behavior that can create a sense of unsafety [2]. Restraints are viewed as a security measure to protect both patients and staff in situations of aggression [3]. Restraints may be necessary if a child exhibits aggressive behavior in an unsafe way but are also noted to have been misused and overused according to the U.S. General Accountability Office (1998) [3] and to be largely preventable [4]. When using the term "restraint" in this article, we refer to '…the use of physical contact which is intended to prevent, restrict, or subdue the natural movement of any part of the patient's body' [5]. According to Norwegian law, only restraint and the isolated use of short-acting drugs for sedative or anesthetic purposes are allowed as a coercive method for children under the age of 16. Importantly, sedative drugs are rarely used in such contexts. With adults and youth older than 16, one may also use mechanical restraints, i.e., a track bed, or place them behind a locked door. Notably, the law clearly states that for staff to use restraints, a child must be in danger of seriously harming themselves or others or doing serious damage to property [6].

When it comes to the treatment of children, there will always be a fine line and enmeshment between treatment and care. Children and youth in mental health facilities are both in need of treatment, but also of basic care. This means that there, under optimal circumstances, is a smooth transition between setting boundaries and protecting the children and the treatment process. When working with children, there is sometimes a need for a physical intervention, like a "turn and guide", that is not a physical restraint. A restraint aims to stop a child from harming themselves, others, or property by means of force. When restraint is used, the child loses his/her autonomy, whereas a "turn and guide" is a simple redirection of the child.

The use of restraints in inpatient mental health services for children poses several kinds of potential harm to both the children and the staff involved. In their systematic review, Nielson, Bray, Carter, and Kiernan [7] showed that the use of restraints is not only linked to an increased risk of physical harm to the child, but also to an increased risk of death. The potential psychological harm associated with restraints is less researched. Research by Steckley [8] shows that the use of restraints may provide both physical and psychological containment. However, research by Nyttingnes, Ruud, Norvoll, Rugkasa, and Hanssen-Bauer [9] has showed that youth who have experienced restraints have less confidence and trust in their parents and in the staff. By reducing the use of restraints, patients may benefit more from treatment, as the use of force and restraints is a disruption in the treatment and the therapeutic relationship that milieu therapists try to establish with the children.

The lack of statistics and registration of the use of restraints in children's mental health facilities also poses a problem for developing clear pathways to prevent the prevalence of restraints. In Norway, as in many other countries, there is no official registration of the occurrence of the use of restraints. As such, it is impossible to know how many children in mental health facilities are exposed to this as part of their treatment experience. However, restraints are common in inpatient treatment facilities, and there are risks associated with both physical safety and unfortunate psychological effects [7].

Some 65,000 children are treated in mental health facilities in Norway, most of whom are in outpatient clinics, while about 4% are in residential treatment [10]. Children who are patients in residential treatment facilities present with a complex picture of mental health disorders, and as such, are more prone to aggressive and acting-out behaviors, behaviors that may be perceived as a risk to other patients and staff. As Hambrick et al. [1] points out, the threshold for the use of restraints is lowered when the staff is overwhelmed or frightened by the behavior of the patients. To reduce the number of restraints, significant efforts have been made, and strategies that both focus on strong leadership coupled with staff training and preventive interventions show the most promising outcomes [2,11]. Moreover, research by Hambrick et al. [1] showed a significant reduction in the use of restraints and critical incidents following the implementation of the Neurosequential Model of Therapeutics—NMT [1]—in residential and day-treatment facilities for children and youth. And as Paterson, Bradley, Stark, Sadler, Leadbetter, and Allen [12] highlight, there is a need to look into systematically gathered evidence to enhance safety and quality in health and social care.

The Neurosequential Model of Therapeutics (NMT) is a relatively recent approach to clinical problem solving for treating children and adolescents with complicated developmental challenges and/or mental health disorders, especially those who have experienced trauma and adversity. Contrary to traditional therapeutic models, NMT is not defined by a particular therapeutic approach or intervention, but rather is a neurodevelopmentally informed, biologically respectful framework created to assist the clinician in comprehending the therapeutic, relational, and developmental needs of the patient and planning treatment interventions accordingly, increasing the focus on individualized treatment interventions catered to the patient's needs [13]. The treatment is planned by utilizing a transdiagnostic approach rather than targeting a single clinical problem or a patient's functioning across multiple domains [14,15].

In the context of a residential mental health facility for children in Norway, we wanted to investigate if the implementation of NMT would impact the number of incidents of restraints. The patients at this residential treatment center were children aged 7–13, with an average treatment length of 18–24 months. The staff consisted of trained milieu therapists with a three-year Bachelor's degree in child welfare education. The patients are placed in one of three different units, each consisting of eight patients and ten milieu therapists, and led by an experienced child psychologist responsible for each patient's treatment plan. The center is closed on weekends and holidays, so all patients also have a home base. The children typically spend two nights per week at the center; all other days, they are returned to their home base before nighttime. All patients attend the onsite school, which operated exclusively for the patients at the center. Every day at the center has the same structure. The mornings are spent at the treatment units, after which the patients attend school until lunch, which is served at the units, and return to school for the afternoon sessions. The remainder of the day is spent at the treatment center with milieu staff. As this is a treatment facility, the competence of the staff, the employment of a child psychologist, etc., are not necessarily the same as in child care institutions.

Aim of the Study

The aim of this study is to answer the following research question: Is there a reduction in the annual number of physical restraint incidents after the implementation of the Neurosequential model at the facility as compared to previous years?

2. Materials and Methods

2.1. Theoretical Basis of the Program for Prevention and Management of Critical Behavior

For many years prior to implementation of NMT, the institution has consistently emphasized the prevention, mitigation, and compassionate management of aggressive and acting out behavior while safeguarding the well-being of the children involved. The specialized program for this purpose is referred to as "Managing Challenging Behavior—MCB". This program includes the training of milieu staff in understanding the children's needs and their behavior and strategies for preventing and mitigating aggressive behavior. Ultimately, this program also addresses the delicate task of applying restraint in the gentlest manner possible. The program is deliberately referring to "challenging behavior" and not to violence or aggressive behavior as one wants to encompass a wider array of behaviors that may disrupt treatment interactions with a relational focus, acknowledging that staff might find both types of behavior challenging. This includes acting-out behavior, such as spitting, hitting, kicking, property destruction, and name calling, as well as internalizing behavior, such as withdrawing from contact, the rejection of relationships, dissociation, and daydreaming.

With the implementation of NMT, core concepts from this model were included in the MCB program. This means the MCB program was altered to encompass core concepts from the Neurosequential model. Because of this, the MCB program before and after implementation of NMT differed. This was to enhance the staff's understanding of the emotional, social, and behavioral problems that are common in children with complex mental health problems and to shift the focus from "what is wrong with you" to "what has happened to you" [1]. This is an important shift to avoid co-dysregulation, which increases the risk of escalation and in turn leads to increased risk of restraint incidents. As Hambrick et al. [1] states in their article showing a significant reduction in use of restraints after implementation of NMT, "Training in NMT emphasizes aspects of relational 'contagion' that will dramatically influence interpersonal interactions with dysregulated children and youth in both positive and negative ways. A focus on creating proactive regulating interactions and environments helps staff move away from managing each behavior reactively. Such individual changes in staff practices parallel organizational shifts in policies and program elements related to the NMT. This results in improved conditions for both the children and the staff".

2.2. Procedures

The patients at the residential treatment center were all referred from outpatient mental health clinics in Eastern Norway. All patients are between 7 and 13 years of age. They present a complex array of diagnoses and symptoms, and all have tried and failed outpatient treatment. The treatment center is privately owned by a non-profit organization and funded by the regional public healthcare organization. The implementation of NMT was chosen by the leadership of the treatment facility as a promising approach to improve treatment processes and outcomes. This was not motivated by the issue of reducing restraints per se. The restraints records which are the basis for looking into changes in use of restraints are mandatory in order to document the use of restraints according to Norwegian law for treatment facilities such as this. The study was classified as mandated quality assurance in accordance with the Norwegian Specialist Health Services Act and approved by the Data Protection Officer at Østbytunet on 3 December 2019. All caretakers gave their written informed consent before any program evaluation data were collected about their child. The children were too young to give consent according to Norwegian law, and since the restraint records are mandatory according to the law, no consent was sought from the children.

2.3. Participants

The participants were a total of 80 children aged 7–13 years (mean age of 10.6 years), composed of 5% girls and 95% boys, receiving long-term residential treatment. Data were collected between 2009 and 2023 and apply to all children enrolled in that timespan. All patients that at some point were subjected to physical restraint were noted in a coercion record. During the period between 2015 and 2020, the residential center began implementing the Neurosequential Model of Therapeutics (NMT) across the organization. Implementation of NMT began in 2015, and most of the staff were trained in and implementing NMT (e.g., communicating with other staff about client care using NMT frameworks, treatment setting within the NMT framework, etc.) beginning in 2016. The reason for the unbalanced girl-to-boy ratio in this sample is that the vast majority of patients subjected to restraints are boys. This is both because there are more boys referred to the facility for showing extensively disruptive behavior, which is a core reason for referral to the facility, and because more boys show disruptive behavior assessed to put them or others in danger while undergoing treatment, with restraints being used on them one or more times during the treatment period.

2.4. Therapists and Training

Since 2009, the front-line staff have undergone a course program in the MCB within their first months after starting work. Every two years, there was a "refresher" course. The MCB program before NMT implementation consisted of training in understanding "the curve of activation", i.e., being able to read children for signs of overactivation and take measures to decrease overactivation, as well as factors in their milieu that may increase their level of activation, like sensory signals, broken furniture, etc. The MCB program pre-NMT focused on how to understand the triggering factors and the function of these in activated situations. It did not take a holistic approach to the whole functioning of and treatment process for each child.

When the implementation of the NMT began, most front-line staff were highly experienced therapists who had received training in relationally oriented milieu therapy. All units were supervised by a lead psychologist who was trained in the Neurosequential Model of Therapeutics and who supervised the milieu therapist in the NMT every morning during the week. The progress of each child throughout the treatment and the staff's adherence to the model were evaluated once a week. The content of the MBC was changed so that it focused on the core concepts of NMT. The front-line staff go through mandatory MBC training when they are first hired. The training consists of both a 3 h training session on core concepts and a 2 h training session on how to restrain children in the least invasive manner possible. Every week, the front-line staff also have a 1 h training session on MBC, both on core concepts and the use of physical restraint. After NMT implementation, there was also a cross-unit training session and discussion approximately every two weeks. Whenever a restraint has been used, the incidence is evaluated according to the following question: "is there anything we could have done differently to avoid using restraint?"

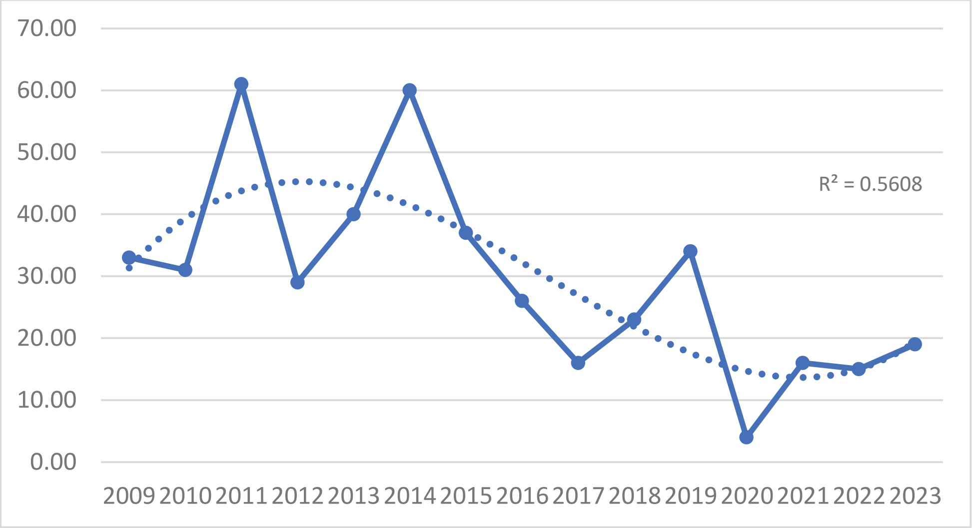
2.5. Statistical Analysis

For analyzing changes in the use of restraint across the study period, we applied ordinary least squares regression analyses to identify both overall growth trajectories and individual trajectories for the different treatment units. We examined the explanatory power and fit of linear, quadratic, and cubic models at both overall and unit levels. To test the significance and magnitude changes in use of restraint before and after implementation of NMT, we then conducted an independent samples t-test comparing overall numbers from the years prior to NMT implementation compared to corresponding numbers in the years after (2009–2015 vs. 2016–2023). For establishing the magnitude of change, the effect size (Cohen's d) was calculated by dividing estimated overall change in the use of restraints pre- and post-NMT by corresponding pooled standard deviations. Cohen's [16] standards for evaluating the magnitude of effects were used, i.e., small effects were classified as $d = 0.2–0.5$, medium effects were classified as $d = 0.5–0.8$, and large effects were classified as $d \geq 0.8$. All statistical analyses were conducted with IBM SPSS, version 28.0.

3. Results

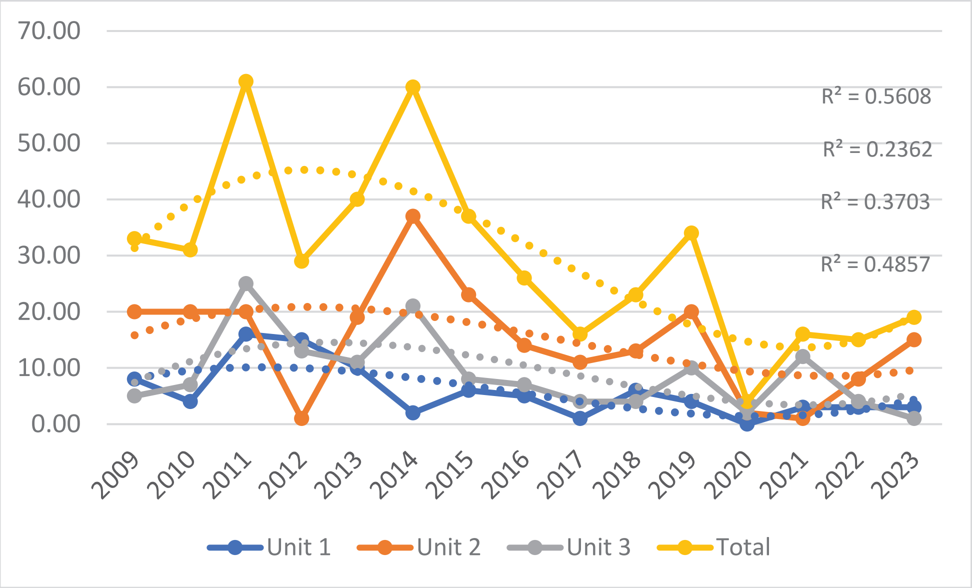
3.1. Changes in the Use of Restraint Throughout the Study Period

The results of the ordinary least squares regression analyses showed that both the overall use of restraint and the use of restraint at each unit were systematically reduced over time. In all cases, a cubic model fitted the data best; thus, the use of restraint appeared to be relatively stable until 2015, before being substantially reduced in the following years and then stabilizing at a new lower level. Figure 1 depicts the observed scores and estimated developmental trajectories overall (Panel A) and at the unit levels (Panel B).



(Panel A)

Figure 1. *Cont.*



(**Panel B**)

Figure 1. Trajectories of use of restraint across time overall and at unit levels. Note: R^2 denotes the amount of explained variance of the best-fitting (in all cases, cubic) ordinary least squares regression models at overall (**Panel A**) and unit (**Panel B**) levels, respectively.

3.2. Testing the Difference in the Use of Restraint Before and After NMT Implementation

Looking more specifically at the change in the mean levels of the use of restraint before and after NMT implementation, the independent samples t-test directly demonstrated substantial reductions in the years after the NMT was implemented. The results of this analysis are presented in Table 1. The analyses demonstrated statistically significant and substantial reductions, with the mean changing from an average of 41.71 restraints per year at the center pre-NMT to an average of 19.12 restraints per year with the NMT, i.e., a reduction of more than 50%. The effects size of this difference was 2.03, indicating a very large effect associated with NMT implementation.

Table 1. Results of independent samples t-test comparing use of restraint pre- and post-NMT.

Treatment	N (years)	Mean	SD	t	df	*p*	d
Pre-NMT	7	41.71	13.31				
NMT	8	19.13	8.85	−3.92	13	0.002	2.03

Note: N (years) = the number of years with data reported pre- and post-NMT implementation, SD = Standard deviation, t = t-value for the difference in scores, df = degrees of freedom, *p* = *p*-value, d = Cohen’s d.

4. Discussion

The aim of this study was to answer the following research question: Is there an effect on the annual number of restraints after the implementation of NMT?

4.1. Summary of Main Findings

Reducing restraint in treatment of children with complex mental health disorders is of vital importance, as restraint can cause trauma. The results indicate that the implementation of the NMT reduced the use of restraints in a residential treatment facility for children in Norway. We note that the children admitted to the treatment facility before and after the implementation of the NMT did not differ in their levels of intake severity, i.e., data from the CBCL demonstrated no significant differences in symptom levels on admittance when comparing patients pre- and post-NMT implementation (with a mean of 72.06 vs. 73.36 on the CBCL in the two groups, respectively). For further details, see also [14]. There were differences regarding the baseline and outcome points at the three different units. This was mainly caused by some children being restrained more than others.

In 2020, there was a big drop in the number of restraints. This coincides with the COVID-19 pandemic, during which the institution due to disease prevention changed its practice to arena flexible treatment and thus reduced some triggers for acting-out behavior, as children were together less frequently and there was more emphasis on helping families cope with the impact of the societal implications of the COVID-19 lock-down, etc.

This study has demonstrated a significant and highly substantial reduction in the number of restraints during and after the period in which the NMT was implemented as compared to before. As noted, the impact of implementing the NMT on the reduction in the use of coercive measures yielded an effect size (Cohen's d) of 2.03, constituting what is commonly operationalized as a very large effect. Even though no causal inference is possible based on our naturalistic data, the results do indicate that the implementation of the NMT may have had a powerful and positive influence on the reduction in the use of restraints, as this was the only substantial change made in the treatment process during this period.

4.2. Clinical Implications

Reducing the use of restraints can contribute to a safer and more therapeutic treatment environment, leading to improved treatment outcomes for children. Children may experience fewer potentially traumatic or triggering events, thus gaining better access to therapeutic interventions. The substantial changes before and after NMT implementation indicate that this approach can be highly beneficial for the institution and the patients it treats. However, it is important to remember that other factors may also influence treatment outcomes.

Clearly, reducing the number of restraint incidents is a goal in and of itself when implementing a new treatment and intervention model. This is because experiencing restraint and physical intervention is likely to be counterproductive to the treatment children receive. By reducing the use of restraint, patients may benefit more from treatment, as the use of force and restraints constitutes a disruption in their treatment and the therapeutic relationship that milieu therapists try to establish with them. The power differential concept within the NMT is important for understanding the reduction in restraint incidents. It emphasizes the de facto power imbalance that exists between children and adult milieu therapists. This awareness is vital in avoiding the use of force based on the adult's physical size or perceived ability to exert power. It also addresses how the power imbalance itself can be intimidating and trigger negative, aggressive behavior from the child.

4.3. Study Strengths and Limitations

The sample size in this study consisted of 80 children aged 7–13 receiving treatment in a Norwegian institution for complex mental disorders. The sample size is an important factor to consider when interpreting the study's findings. A larger sample size typically provides more representative results, but it is also essential to assess whether this size is sufficient to detect the effects of NMT implementation.

The method of data collection involved a review of registered restraint incidents from 2009 to 2023. The data were collected from the institution's own restraint records. This approach is reliable and valid if there are standardized procedures for registration and documentation and if the staff follows them. However, there might be room for reporting errors or the underreporting of incidents.

The data were collected from the restraint records of the institution both before and during the implementation of the NMT. The so-called "Hawthorne effect" [17], a change in the occurrence of the use of restraints, may be an effect of the implementation process, with the increased focus on the professional understanding and handling of the treatment process possibly being one reason for the reduction in the use of restraints. However, the reason for implementing the NMT was not to reduce restraints per se, but to see if an increase in the effect of the treatment process was possible. A reduction in restraint was therefore not the focus during the implementation process for the miliu staff.

One major limitation of the study is the absence of randomization and a controlled design. The absence of a randomized design and a control group makes it challenging to determine whether the observed reduction in restraint incidents can be solely attributed to the implementation of the NMT or if other external factors, e.g., the increased focus on the treatment process, could have contributed to the decrease in critical incidents. Without this kind of design, it is also impossible to establish a causal relationship between the implementation and delivery of the NMT and the documented reduction in restraints in a scientifically convincing way.

4.4. Recommendations for Future Research

Future research should consider the possibility of using a randomized, controlled design and to clarify whether other factors besides the implementation of the NMT are contributing to the reduction in restraint incidents. Future research should also assess the accuracy of restraint incident reporting, ensuring that it complies with legal regulations and current guidelines to minimize potential reporting biases. Future researchers should also look into other age groups, as the participants in this study were in the age range of 7–13 years. Older children or youth may be subjected to more force when restrained due to their body size but may also be prone to a higher level of reflection due to their cognitive maturity and therefore may be less subjected to restraint in the first place. The impact of the Neurosequential Model on restraints in other age groups is therefore in need of investigation. It is also necessary to look into if there are differences between girls and boys, across ages, or in regards to other demographics. Finally, future studies should investigate whether treatment effectiveness improves when the number of restraint incidents decreases.

5. Conclusions

This study demonstrates a statistically significant and very large reduction in the use of restraints following the implementation of the NMT in a residential treatment facility for children aged 7–13. Reducing the use of restraints is crucial in the treatment of children with complex mental disorders, as this group of patients is particularly vulnerable. In conclusion, the NMT appears to hold significant promise in terms of making the experience of treatment less coercive for children in treatment settings in which the use of restraints is a factor.

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Article

Encounters with Care in a Scottish Residential School in the 1980s

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Abstract: The meaning of care in residential child care is under-developed. It can often be represented through its absence, seen as offering at best basic physical tending but lacking emotional connection or warmth. At worst, residential care settings said to be institutionally abusive can be characterised as being antithetical to what we might imagine care should be. Residential schools and especially those run by religious orders attract particular opprobrium in this regard. In this article, I adopt a broadly autoethnographic approach to reflect on how boys (now men in their late 40s and early 50s) brought up in the 1980s in a Scottish residential school recall being cared for. The article uses Axel Honneth's theory of recognition and its three pillars of love, rights and solidarity to group themes from how former pupils speak about their experiences of care. These accounts challenge the received narrative of such settings failing to offer care. The discussion reflects some ideas around care and about how we understand public care historically.

Keywords: residential school; history; care; recognition; Honneth

1. Introduction

In this article, I reflect on the nature of care in what, in Scotland, were called List D schools but which would more widely be recognised under the term approved schools. Essentially, these were schools for those who had offended and/or were deemed to be in need of care and protection. Initially, I had intended to take a broadly empirical direction, presenting and discussing interviews from former residents of one such school, St Roch's, run by a Catholic religious order, the De La Salle Brothers, with whom I worked over the course of the 1980s. The interviews were gathered for a recent book I authored [1]. This remains an aspect of what I do in the sense that I introduce and engage with the boys' stories around their experiences of being cared for. However, the article has developed into something more reflexive. There is a valedictory dimension to it in which I indulge myself in reflecting on a lifetime's work in direct care practice and subsequently in academia where I have maintained a focus on ideas of care and caring. But the reason for the slight shift in direction is that what I write about does not lend itself to traditional research conventions of presenting and analysing data; that would be inadequate for its nature and purpose and the position from which I write. I cannot be that Archimedean voice from nowhere. Rather, the stories of those I interviewed interleave with my own memories of the school. These stories might be thought of as data, but this implies something abstracted and objectivised. The reality is that I cared for the subjects of my data gathering, not just because it was my statutory duty to do so but because I had and still have an emotional connection to them, and they to me. There is therefore an inevitable existential dimension to my engagement with the subject, which compromises any attempt to pass this off as research in a more traditional sense. This should not necessarily come as a surprise—although care is often presented in policy discourse as though it were a service or a commodity, it is, by its nature, a reciprocal encounter [2]. It is rarely spoken about in public care as such, especially in a context in which any emotional dimensions of care have been pushed aside by responses to scandals, which have led in recent decades to an unremitting focus on institutional abuse [3] and fearful institutional responses [4]. It is only recently that ideas of care and even love have dared (re)encroach on the residential care lexicon

In this article, I try to bring to the surface some of the features of care as experienced by a group of boys who lived in St Roch's. To group these experiences, I draw on Axel Honneth's [5] concept of recognition, which I come on to develop. But these aspects of care are refracted through the lens of my reflections about giving it. To capture this dimension of the article his requires a suitable methodological frame, and for that, I turn to autoethnography, a narrative or storytelling genre.

2. Autoethnography

Dipping my toes into autoethnography in some ways takes me back to my social work training, when one of the first books recommended was C. Wright Mills' *The Sociological Imagination* [6]. Mills claims that 'you must learn to use your life experiences in your intellectual work: continually to examine it and interpret it. In this sense craftsmanship is the center of yourself and you are personally involved in every intellectual product upon which you work' [6] (p. 196). Mills argues that 'the sociological imagination enables us to grasp history and biography and the relations between the two in society. The challenge is to develop a methodology that allows us to examine how the private troubles of individuals are connected to public issues and to public responses to these troubles' [6] (p. 5–6). Denzin [7] takes Mills' work as a starting point in making the case for interpretive autoethnography as a methodology that allows for the examination of this interface between private troubles and public issues.

Autoethnography is 'an approach to research and writing that seeks to describe and systematically analyse personal experience in order to understand cultural experience' [8]. In autoethnography, writing becomes a way of knowing and a method of inquiry through which to challenge canonical stories [8]. This might require comparing and contrasting personal experience against existing research through what Gadamer [9] might call thoughtful reflections on experience. The theme of a recent autoethnography conference, '*Right to Roam*' [10], recognises 'a moral obligation to trouble and expand knowledge and ways of generating knowledge... perhaps protesting against constrained ideas...'.

This is vitally important in a context in which much of sociology has lost its imagination, going further down the road of what Mills [6] identified as abstracted empiricism, within which the realities of everyday life are subordinated to grand theories. This tendency is particularly salient to residential child care, a field dominated epistemologically by other disciplinary perspectives, such as law and psychology. These impose clinical and sanitised versions of what policy makers might want residential child care to be. There are few accounts nowadays that evoke the kind of immediacy, messiness and emotional connection of everyday practice like, for instance, Henry Maier's [11] work or earlier accounts of residential child care (e.g., [12,13]). Yet Ricks [14] makes the case that knowledge about care emerges less from the normative assumptions of what it ought to be like and more through the 'hands-on' experience of everyday caring.

I try and reflect on some of that experience of everyday care here, engaging in an ongoing fusing of horizons between past practical experience and my knowledge developed as an academic to reach a deeper understanding of the field. In painting a positive picture of St Roch's, the findings of this research, unquestionably, challenge the canonical story of residential schools. While I write as an insider on account of my practice experience, I also find myself as an epistemic outsider. I offer a counter narrative, described by Bamberg and Andrews as 'the stories which people tell and live which offer resistance, either implicitly or explicitly, to dominant cultural narratives' [15] (p. 1). Even attempting such a task is difficult when the grand narrative of residential schooling as failing to offer care is so powerfully embedded [16].

The canonical story of residential schools that I challenge is well established across the Western world. Ferguson [17] claims that those cared for in Irish industrial and reformatory schools run by religious orders were 'routinely starved, beaten, humiliated, sexually abused, deprived of education and basic knowledge about life, and their emotional needs were often totally neglected'. He asserts that 'it is beyond question that the entire industrial and reformatory regime was an abusive and cruel one' [17] (p. 124). In a Scottish context, Kendrick [18], in evidence to the Scottish Child Abuse Inquiry, extrapolates from gang member Jimmy Boyle's book, *Sense of Freedom* [19], in which he describes his experience in a school run by the De La Salle Brothers, to claim that approved schools operated rigid regimes in which corporal punishment and violence involving young people or staff was routine. DeWilde et al. [20] discuss how an abuse narrative has become a 'normative truth' with regard to how residential care is thought of. The accounts I introduce here interrupt that grand narrative. They are based around one school at a particular point in time but might serve to ask questions more generally of the singular story about residential schools that has taken hold [1], locating a concept of care at the heart of what they offered.

Styles of autoethnographic writing vary, some becoming very introspective. Stahlke Wall [21] stresses the need to balance the value of personal experience while maintaining scholarly rigour. This, I guess, is consistent with my own approach; I recognise the importance of personal experience but baulk at that itself becoming the story. The approach I take here is consistent with Atkinson's [22] discussion of autoethnography in interspersing personal reflection with more conventional academic writing.

According to Denzin, [7] (p. 4) autoethnographic accounts should have the following features:

- People depicted as characters;
- A scene, place or context where the story occurs;
- An epiphany or crisis that provides a dramatic tenson, around which the emplotted events depicted in the story revolve (and towards which a resolution is pointed);
- A temporal order of events;
- A point or moral to the story that gives meaning to the experiences depicted.

I use this as a loose framework to ground and to structure this article.

3. The Characters in the Story

This book on which this article is based is essentially a case study based around St Roch's. It tells the stories of seven men who, at the time of writing, are around 50 years old, but who, in the mid to late 1980s, were teenagers residing at St Roch's. I also interviewed two former staff members there with connections to the De La Salle Order. The former pupils are Brian, Stu, Dom, Ciaran, Darren, Billy and Ricki. The two De La Salle Brothers are Lawrence and Felix.

As intimated in the introduction, what follows cannot be just my interpretation of others' stories as it is just as much my story. Denzin [7] speaks of interpretive autoethnography as a critical, performative practice that begins with the biography of the writer and moves outward. In that sense, it behoves me to position myself, however superficially, in relation to the research, to outline what Finlay [23] might identify as my reflexive journey. The book gives a fuller account of my positionality.

Reinharz [24] identifies three different categories of 'self' that researchers bring to the research process and how this might impact it: the brought self, which brings in one's personal history, the researcher self, within which research orientations come into play, and the situationally created self, which recognises the possibility that the research process might itself shape or reshape the researcher's identity. Briefly, I started working in St Roch's in 1981, straight out of university, with no idea what a List D school was. But my family background was working class and Catholic, and I was starting to become informed by Catholic social teaching. My background had also instilled in me the importance of education for individual and social progress, and I had thought of going into teaching. So, a school setting with a Catholic ethos offered something of an existential fit for me.

But there is another family ghost that lingers in the background. Doucet [25] suggests that a researcher's engagement with their subject matter can be 'haunted' by 'ghosts' from their own experiences. After I started at St Roch's, I discovered that both my paternal grandfather and one of my aunts had been brought up in care. I recall taking my grandfather down to St Roch's for an open day. He recollected having been there before. He did not attend St Roch's but had visited it from a working boys' hostel in a nearby town and spoke of the school having a pipe band. He himself was a drummer and I wondered if he had learned that through being part of the band. After my grandfather's death, my dad sought to find out more about where he had been placed but did not manage to do so. I know nothing about his experience in care—he did not really speak of it either positively or negatively. My aunt recalls a very positive experience of being looked after by nuns. I am not quite sure what this adds to what and how I write but feeling some sort of personal connection to care refracts one's experience through what Doucet [25] calls a gossamer wall and adds a further layer of complexity to any engagement with its subject matter.

4. Scene Place or Context

Reform schools dealing with youngsters who had offended and industrial schools dealing with non-offenders have existed since the Victorian period These came together in the 1930s under the general heading of approved schools (2009). Following the Social Work (Scotland) Act (1968), such schools, in Scotland, were, administratively, renamed List D schools. A majority of such schools were run by religious bodies, such as St Roch's, which was run by the De La Salle Brothers, a worldwide teaching order with a historical mission to educate the children of the poor. Its existence as a teaching order says something about the nature of the establishment. I remember my interview for the job at St Roch's back in 1981, and, not knowing much about List D schools, I made the mistake of likening them to borstals (which were institutions for young offenders) to be put right by the then headmaster, Brother Oswald, that they were schools—their purpose was broadly educational. The Brothers brought a long tradition of care and education to the work of the schools and a particular philosophy within which they aimed to achieve the following:

> [. . .] to foster a kindly spirit in their intercourse with the student and to maintain that discipline which is, of course, essential in every school, not so much by the enforcement of rigid rules and regulations, as by advice and guidance, given in a brotherly spirit, the object being to make the school not only a place for education, and for the moulding of character, but likewise a happy home [. . .] [26] (p. 79)

For staff, there was an element of care as a commitment to community living. The task was seen, in some respects, as a vocation or 'calling' [27,28]. This was reflected in the expectation that staff stay on-site, with working hours that were long and that, at times, needed to be flexible. Paralleling the emergence of the family group homes in community settings, St Roch's moved away from what had been a 'block' school where boys were housed in large dormitories towards a 'cottage' model where they were looked after, albeit in groups of 20, in discrete units with a combination of smaller bedrooms housing three or four boys, with some single-room accommodation. One of my memories of the school was of space. The buildings and rooms within them were large and there were expansive playing fields. Space, as Maier [29] observed, is a rarely acknowledged determinant of the nature of care that can be offered. In St Roch's, boys, in many ways, had room to grow.

5. The Epiphany or Point of Tension

Depictions of residential schools asserted in the public story of them jar with what I saw and experienced. Moreover, what I experienced was also captured in contemporary literature, which was not afraid to talk about qualities of affection and love. Battersby [26] (p. 92), for instance, spoke of the De La Salle ethos being based around 'the cultivation of an outlook', within which all staff were to contribute to a wholesome atmosphere, characterised by 'kindness, affection and love'. More broadly, a report for the Home Office produced by the Dartington Research Centre [30] (p. 9) spoke of discipline in approved schools being maintained through internal controlling processes such as modelling and identification, but which, importantly, also spoke of caring, warmth and love.

The ethos of St Roch’s was, as far as I am concerned, a similarly healthy one. A few years after I started there, we produced a booklet, an early attempt at marketing the school, I guess. It sought to lay down a philosophy, recognising that ‘a child’s place is with his or her family but that some children, for a variety of reasons, need ‘time away’ to provide breathing space for themselves, their families and their local communities’. The stated aim of the school was to give boys a sense of their own worth and dignity; an appreciation of the feelings and needs of others; an understanding of what life has and will offer them; and an environment in which they can be accepted, treated as individuals, managed with warmth and humour and dealt with fairly and consistently.

The schools, more broadly, were not institutionally punitive (in fact, corporal punishment was banned in them before it was in mainstream education). Through the work of the List D schools’ psychological service, they spawned some of the progressive ideas that informed the Social Work (Scotland) Act [31]. There is little point of connection between what have become received accounts and other sources of knowledge, including the accounts of staff who worked in the schools and the residents who recall positive experiences there.

The cognitive dissonance between my own experience and the abuse narrative that has emerged became an itch that needed to be scratched. In an era when discourse around residential schools is about bringing a legal sense of justice to those who claim their lives were damaged by their time there, I am driven by an equally strong sense of social and natural justice to show another side to this story.

6. A Temporal Order of Events

A prompt for me to take on this task came a number of years ago now. One evening, I was walking along a street near my home. I noticed three young adults walking towards me. As they walked past, one shouted out my name. ‘It’s me, Brendan’, he said. Brendan had been at St Roch’s towards the end of the 1980s. As we stood talking, I was struck (although not surprised) that he described his time in St Roch’s as the best days of his life and how he wished he could turn the clock back for just a moment. Brendan and I said our goodbyes that evening, promising that we would catch up again. But we never did; a few months later, he ended up back in prison and died there. . . But that encounter confronted me with the narrative chasm of how what is so readily assumed to have been an abusive experience could be recalled as the best years of one’s life.

Not long after hearing of Brendan’s death, I was on the touchline for one of my sons’ football games. The coach of the other team, Stu, was another former St Roch’s boy and again had nothing but good memories of the school. He took it upon himself to set up a Facebook page, which built up to around 28 former pupils and staff. Several of those became the interviewees for my book (COVID prevented me from interviewing others as I did not want to do so online).

Methods and Ethics

Consistent with an overall narrative approach [2], I conducted life history interviews with the former pupils. These gave the boys scope to talk about their lives before, during and after their time in St Roch’s. Beyond that basic structure, they were able to take the interview in whatever direction they liked. The interviews were audio-recorded and professionally transcribed. The utility of Honneth’s [5] framework to analyse boys’ stories and to group themes was one I came to after my book was published and in light of my growing interest in Honneth’s work.

Stories of personal experience are said to offer a counterpoint to overly positivist and abstracted accounts of the social world [32]. They can be claimed to ‘give voice’ to individuals and groups who can find themselves silenced beneath dominant versions of how the world is presented, which is of relevance to the context of this study.

Autoethnography also brings some other challenging ethical considerations. Mollenhauer [33] notes that when a child grows up, the asymmetry of a previous care relationship dissolves and any continuing relationship is characterised by a greater mutuality. So, the research relationships (re)established for the book project incorporated elements of friendship and emotional connection within which there could be argued to be a degree of ethical symmetry. On the other hand, the stories I was told were constructed within the context of a previous caring relationship. In this sense, there was a lingering sense in which the research interviews were an extension of these previous relationships, fulfilling some of Denzin and Giardina's [34] purposes for research as involving ongoing pedagogical, political, moral and ethical purposes. Again, this would be consistent with autoethnographic principles, according to which a researcher's primary obligation is to those who are the subjects of their research and their endeavour is underpinned by qualities of kindness and care [7]. In this case, kindness and care went both ways.

At a practical level, while all of the boys I interviewed for the book were happy for me to use their names, I made the decision to give them pseudonyms to offer some level of plausible deniability were they to be identified. I went through standard university ethics processes. However, for a project of this sort, procedural consent is inadequate. Pirrie et al. [35] claim that the personalised nature of some educational research foregrounds the exercise of personal virtue and ethical imagination over adherence to procedure. This requires a reflexive and relational approach to ethics [7]. One thing to point out is my use of the term 'boys' to describe people who are very definitely men but that reflects how they wanted to be thought of and identified.

7. A Point or Moral to the Story That Gives Meaning to the Experiences Depicted—Encounters with Care

For the purposes of this article, I focus on boys' accounts of their experiences of care in St Roch's. For a long while, over the course of the 1980s and 90s, and reflecting the emergence of legal perspectives on care, children's rights became a prominent focus. It is only in recent years that people have begun to talk about love as a possibility in out of home care. Neither rights nor love on their own are sufficient. One of the things that is missing is the broader social dimension. Paul Natorp [36] (cited in [37], often thought of as the father of social pedagogy, identifies the essence of the discipline as being the upbringing of an individual and their integration into society. Children, thus, need to be brought up as social beings. While I have always been wary of trying to apply any single theory to residential child care (Burns' and Emond's [38] article in this volume highlights some of the complexities in seeking to do so), I do think a broad heuristic can be helpful in orienting how we might think about care. In this sense, Gharabaghi [39], in this volume, offers four defining signifiers of quality that one might look for in residential care settings. In a similar spirit, in this article, I draw on Axel Honneth's [5] theory of recognition, as it offers a tripartite schema of love, rights and social solidarity, under which I proceed to group boys' experiences of care in St Roch's.

8. Honneth's Theory of Recognition

Honneth is a German critical theorist associated with the Frankfurt Institute for Social Research. He emphasises the importance of the inter-personal sphere and the basis this provides for one's interactions within the wider world. He makes the case that human flourishing is built upon three pillars of love, rights and solidarity, each of which emerges through a struggle for recognition in the domains of family, civil society and the state, respectively. His theoretical model identifies three types of relation to self, which map onto his three pillars: self-confidence, self-respect and self-esteem.

The broadly ecological nature of Honneth's theory makes it a suggestive framework for social work, and a growing body of literature draws upon it [40–42]. It has also been used in child care [43–46]. Before I go on to say a bit about Honneth's three pillars of recognition, it might be helpful to orient his idea of a struggle for recognition within some of its roots in the work of the German philosopher Georg Wilhelm Friedrich Hegel (1770–1831). Broadly, and very superficially, the wider Hegelian dialectic poses ideas of thesis, antithesis and synthesis. An idea is proffered, it is opposed and some middle way is found. Hegel identifies such a dialectic as a method of historical/philosophical progress towards individual and societal consciousness (or perhaps in a social work context, identity) (see [47] for an application of Hegel's ideas to social work).

8.1. Love

The 'love' pillar of Honneth's theory may be seen to have particular resonance in residential child care, in which there has been an upsurge of interest in recent years [48]. One of the difficulties with this, though, is that ideas of love can become shallow and sentimentalised if not rooted in any wider theoretical understanding of what it might be, how it might come about or how it might intersect with other facets of a child's life and experience. Honneth's work allows for such necessary grounding.

Drawing upon Donald Winnicott's [49] ideas about 'good enough' parenting, love, for Honneth, refers to multiple sources of emotional connections among a small number of people. It takes us beyond the dyadic relationship of attachment theory [45] to incorporate a variety of reciprocal interactions between children and their caregivers, through which each acquires the capacity for affective approval and mutual encouragement. This resultant quality of emotional recognition allows a child to learn that they exist and matter, connected to but also separate from others [50]. One's sense of self emerges through mutual recognition; it is a social, iterative and negotiated process. We cannot demand love as some advocacy groups have sought to do; it needs to emerge through relationships and through everyday activities.

I now turn to consider how St Roch's boys described love, which was undoubtedly part of their memories. They conveyed a clear sense of feeling cared for in St Roch's in a way that went beyond physical care to what Maier [11] calls a state of caring care, encapsulated in what Ciaran called 'a nice kind of warm feeling'. Former residents consistently described their feeling of being cared for in relation to an idea of family. Several made explicit reference to St Roch's feeling more like what they imagined an ideal family to be, which had not necessarily been their experience in their own families. As Stu said, 'St Roch's . . . it was more of a family orientated place than I think it was being back home'. Ricki also made an explicit reference to the sense of family encountered in everyday routines:

> Aye, I loved it. It was like a family. I felt it was a bit more like a home. Get your slippers and your jammies (pyjamas) on. (The housemother) all the time being like your mum. I loved it, I really did. . . I don't know, maybe because I was used to being with parents who weren't there for me.

The boys' sense of care was also equated with a feeling of safety. For Ciaran, St Roch's 'was home. It was where I felt safe, and where I was happy. I wasn't happy at home. I wasn't safe at home. So, it was where I was happy'.

Stu took the view that, having been placed in St Roch's, "This is my family. What happened with my mum and dad. . . Never wanted to go home. I would rather stay here. . . Because this is where I felt safe'. Some of this family analogy was played out in relationships described with particular members of staff. Ciaran recalls his experience with one of the Brothers as follows:

> . . . I felt safe like. . . Brother Barnabas made me feel safe. . . Like I'd play a game with Brother Barnabas, we'd just have a laugh. . . I was small and I just, I just, first time there. So, Brother Barnabas was a big strong man. So, I stood beside him. And he made me feel safe. . . Yeah, just generally I felt safe. I felt safe with him, and we grew a bond. A bond that only like a father, a son, a father would sort of be like.

Ricki continued this family theme, claiming that he 'loved them (the staff) to bits'. He spoke about one in particular 'He was like your uncle, man. Used to go about with him all the time'.

While the nature of the housemother role might be thought of as stereotyping the caring role of women, housemothers validated an element of domesticity in the experience of care, making boys feel cared for, something that was perhaps lost as care became more 'professionalised' over the course of the 1980s. The housemother role was one that the boys appreciated: 'I think to be truthful as well, I think a lot of the kids had really a lot of respect for the housemothers' (Stu). Darren concurred noting that: 'I never ever misbehaved because I respected her. She's just like my mum, you know. My mum, I didn't respect so much, but I didn't do anything bad in front of my mum'. One of the key roles performed by housemothers was around food practices [51]. Stu provided an example of this:

> If you're lying ill in your bed, your housemother would bring you soup and tea to see if you're all right and check. She would let you sleep. She would come in and you were up, she would come in and make sure you were all right and that. . .

A sense of being recognised in caring relationships is demonstrated in the small things of everyday living [52]. One of the things that struck me from the boys' stories was just how significant small things that I or any other staff member had perhaps no memory of could be. Ciaran, for instance, remembers me being instrumental in the decision to take him on our annual football trip:

> Like, you gave me, even though I wasn't in the football team, because I'd help out or whatever, but you gave me the chance to go to Liverpool. I'd watch us play football. So you're good enough to let me come down there. Things like that. You don't forget. It sticks with you. It sticks with you.

Conversely, the good feelings of getting positive, caring messages also brought home to me how other interventions I and others had been involved in might not have been heard or felt as respectful and how these might colour how they look back on their time in St Roch's. Honneth [53] addresses the implication of such disrespect in his later work.

8.2. Rights

While Honneth's theory is a normative one, I take a few liberties here in considering how the second pillar of his theory of recognition, that of rights, might play out in a residential care setting. Honneth links love and rights, arguing that the experience of being loved is a prerequisite to becoming a bearer of rights [5]. While children's rights have been a prominent motif of residential care over the past three decades or so, they have been framed in legalistic and contractual ways that do not convey the realities of life. A more realistic and helpful framing of rights might revolve around how we are with one another. Like love, this cannot be a demand but, according to Honneth, 'is governed by the imperative of mutual recognition, because one can develop a practical relation-to-self only when one has learned to view oneself, from the normative perspective of one's partners in interaction. . .' [5] (p. 92). The experience of love or care developed in the living setting enables an individual to view himself or herself as a subject with dignity and moral worth. From this basis of self-confidence, rights become realisable in the process of an individual striving for self-respect within a community of other rights-bearers.

The St Roch's boys did not speak of rights in any legalistic sense but about a sense of fairness and what might be termed 'right relationships' [54], negotiated through peer relationships and against a backdrop of adult authority. This process emerged through and was apparent in daily living and in inter-personal relationships.

In group care contexts, peer relationships, as Emond [55] argues, are often couched in problematic terms, being associated with bullying and issues of group control. However, in her own research, Emond found that young people placed significant value on the peer group for offering information, security and care, and this is borne out in how the St Roch's boys recalled their peer relationships. Stu reflected: 'And to be truthful, there was never any trouble in there. I just think the kids became like brother and sister. . . but you made loads of friends as well'. He only remembered one fight when one of the lads 'battered' another 'for picking on somebody wee'er [smaller]. Trying to take their money or their tuck or something off them'. However one might think of this example, it evidences a sense of fairness and sets down norms of inter-personal behaviour.

Billy picked up on the sibling idea that Stu introduced:

> You just got on. Like your brothers. Your best mates or your brothers, would do, you'd hang about with your pals at that age. You all spoke to each other. You'd all have a cigarette, you'd give them a cigarette. They would give you one. Everybody made sure they had something.

Dom took a pragmatic approach to how he approached peer relationships:

> Well, the way you had to look at it is, I could fight him five days a week, but I've got to live with him seven days a week... Ken (know) what I mean? So, what's the point? Ken (you know), I'll beat him four times, but that one time there's the chance that he's going to beat me the once, ken what I mean? So it was pointless. See when people that you sometimes disagreed with, you still had to get on with them in life, ken what I mean?

As I suggest above, peer relationships were mediated against a backdrop of adult authority. As Stu said: 'A lot of the laddies never had fear. But they had respect for the staff'. This notion of respect rather than fear perhaps evokes Baumrind's [56] notion of staff reflecting an authoritative parenting style, which is associated with the best outcomes in terms of children's upbringing. Their relationships with the staff were identified as good. As Ciaran said: 'They helped me. In many kinds of situations'. Billy said, 'Everybody was quite friendly. There wasn't any bad staff or anything like that'.

Part of the negotiation of what was considered acceptable within a relationship was negotiated in everyday interactions and in the requirement to fit in with different staff members' expectations. Dom, for instance, described Brother Barnabas as follows:

> [...] a character himself. He used to... you used to hear him marching up that hall for to get you out of your bed in the mornings. So here he comes... And he was just sort of regimental. He had everything, six o' clock on the button, you would hear him coming up those stairs, seven o' clock, and that was it. "Oh, it's Brother Barnabas that's on duty, let's go [laughs]. Let's get moving".

In some ways, Dom's example of Brother Barnabas being a stickler for routine highlights some of the process through which children build up a sense of care. Maier [11] outlines how the kind of rhythmic interactions between adults and children that emerge over everyday events can lead to an experience of predictability and subsequent dependability and that, paradoxically, each side of this relationship achieves greater freedom as a result of it [1]. There were expectations, however, as to what was considered acceptable behaviour and these were generally adhered to. Expectations were reasonable and there was an element of consent. A Home Office publication [30] on discipline in approved schools recognises that control cannot come through coercion and that coercion is more likely to be a symptom of control having been lost in an establishment. Control could only emerge from what the authors identify as follows:

> [...] a unified acceptance by staff and inmates (sic) of the authority which each adult has within the institution. From this acceptance comes a strong normative influence on institutional members through internal controlling processes such as modelling [...]

So, while the care we offered at St Roch's happened without any reference to rights frameworks, it embodied an innate understanding of rights existing within the nature of the relationships that were formed. Latter-day claims to bring children's rights into care settings often floundered because the mutually respectful relationships that are required to realise these were compromised by a lack of adult confidence or, ironically, authority [1].

8.3. Solidarity

The third pillar of Honneth's schema posits that when children can negotiate and feel confident in their rights, they can take these into the social sphere. Rights exist in different forms and the cultural climate which, in Scotland, gave rise to the progressive reforms of the Children's Hearings system in the 1960s was informed by a recognition of broad social and cultural, rather than just individual, rights [57]. Honneth posits that individuals have the opportunity to earn esteem if their particular traits and abilities are in tune with the values of their society. There is a predominant communitarian rather than an individual dimension to this. However, in an era that has become increasingly individual and 'therapeutic' [58], we can lose sight of Natorp's identification of the essence of bringing up children as involving their integration into society [36].

The St Roch's boys did not speak directly about their relationships with or in the wider world and I guess I did not really ask them. But, while the articulation of it might be retrospective, my own thinking was to encourage the boys to adopt a place facing the world [33]. The culture of the school was outward facing—we took part in a lot of charitable events. One of the social workers would teach boys guitar and take them to entertain the residents in local old people's homes. Felix spoke of one of the teachers setting up a scheme for boys to befriend older people in in the community, which had to be curtailed when one was caught stealing. But setbacks like this did not stop us taking risks.

Again, I might understand this next example retrospectively in light of Mollenhauer's identification of the role of upbringing relationships being to pass on a valued cultural heritage from one generation to the next, but one of the things I did was to take out membership with the local theatre company, which gave us group rates of 50p a seat. With a colleague and his wife, I would drive the school bus with around 20 boys to the theatre to see shows like *The Ragged Trousered Philanthropists* and a Moliere season performed in Scots. We would finish off the evening with a fish supper on the way home. We also organised regular cycle trips around youth hostels. Latterly, other staff took trips across Europe or to North Africa. In many respects, we offered what might thought of as a 'rich childhood' [59].

9. A Point or Moral to the Story That Gives Meaning to the Experiences Depicted—Reflections on Care

My focus in this article is on the nature of care in a residential school prompted by claims that such settings did not and perhaps could not provide care. The stories of the boys I interviewed might suggest that care was indeed possible and was felt at an existential level in St Roch's (and I have no doubt in most similar schools). Inevitably, I bring my own preconceptions, Reinharz's [24] 'researcher self', to what I think about what care might be. Like many residential workers, I went through a period while still in practice of thinking that I was missing something and that there was some body of, probably psychological, theory that if only we could bottle, we could solve all the problems of residential care. Others have tried and still try to do this; for a number of years, we witnessed a focus on attachment theory and as I write, trauma-informed care seems to be the only show in town [60]. I am now confident in a view that no such theory maps directly onto residential child care and that the kind of programmes that proliferated from the 1990s onwards are a dead end [61]. Those programmes (in a broad sense) that do seem to work are those that are based in the principles of good, everyday caring relationships [62].

Reflecting back on the basis of the relationships that were formed at St Roch's, they were never overtly 'therapeutic', but they were real. As Howard [63] observes, 'residential care is messy, ambivalent, tempestuous, volatile and sometimes dangerous for children and staff'. So care could be messy but it was, in Winicott's terms, 'good enough'. Care was built, primarily around fun and healthy, authoritative relationships between children and adults. As Felix observed of the residential school ethos: a 'notion of giving kids a good experience of working and living with adults is central. Central to it'. This is a humanistic rather than a clinical endeavour and looking for or operating from the assumption of any external clinical expertise can let workers off the hook of the kind of relationship building that is based on genuine respect and of liking and mattering to one another [64].

Nevertheless, Burns and Emond [38] recognise the merit in staff teams having some theoretical direction of travel, to an extent, regardless of what this is, and I agree. So, while reluctant to pin my colours to any particular mast, I think that Honneth's idea of recognition gives a sufficiently broad conceptual grounding within which to locate the practices of residential care. But whatever theoretical framing we choose to inform our thinking about residential child care, it needs to move beyond inter-personal psychological models of human interaction and legalistic and contractual versions of rights. In this sense, an attraction of Honneth's work is that it is essentially relational and because it is also messy and involves struggle, as different consciousnesses, child on child and child on adult, vie for position and mutual accommodation and ultimately lead to human growth and flourishing, often through a process of rupture and repair.

In group care settings, this process of relationship building happens in what Maier [65] (pp. 408–409) described as the "critical strategic moments when child and worker are engaged with each other in everyday tasks"—the daily events of wake-up and bedtime routines, shared meals, chores and recreation. The inevitable crises and fallings out that these often involve, provide rich opportunities for bonding, strengthening relationships and developing a sense of competence and worth.

But what do we mean by relational? Steckley [66] identifies different orientations towards relational practice, in each of which relationships between adults and youth are seen to be central but also fraught with tensions. We have spoken about relationship-based practice for the past decade or so, but we often pull back from the implications of being truly relational, which involves levels of closeness and risk-taking that political and practice cultures baulk at [4]. Gray and Webb [67] draw on Noddings' [68] ethics of care to suggest that care is ontological in the sense that it is intrinsic to who we are as human beings and it is reciprocal. It is based on the view that humans are relational beings, and a context must be created in which the one caring and the one cared for both derive benefit from the caring relationship. Relationship-based practice is not one approach among many to providing care as some iterations of the term might imply—it is the essence of care. It might in certain circumstances cross over into relationships that could be called love although as bell hooks [69] (p. 127) observes: 'To speak of love in relation to teaching is already to engage a dialogue that is taboo. . . When we talk about loving our students, these same voices usually talk about exercising caution. . .'. So, we row back and talk again of about boundaries [70] that are often more barriers to the kind of relationships that are required to make a difference in children's lives [71]. Monteux and Monteux [2] suggest that everyday care is best understood as a series of human encounters that require courage to embrace the complexity and uncertainty of encountering the essential humanity of those we care for. In order to do so, practitioners need to develop moral integrity, enabling them to navigate situations of care without fixed recipes. This moves us away from ideas of care rooted in clinical traditions to consider philosophical ideas deriving from phenomenology and ethics.

In many respects, this is the kind of care, however rough and ready it might have been at times, that was offered at St Roch's and other schools and which has been pilloried in the grand narrative that has come to define such establishments. It was replaced by a raft of bureaucratic measures designed to eradicate what were identified as the excesses and the procedural deficiencies in the sector. The result of this is that one tyranny, that of abuse, was substituted for another, that of blandness and what [28] terms 'insidious leniencies'. Staff members lost the sense of optimism which I had when I started in residential care and the spontaneity to respond to situations as they arose. Fundamentally, surrounding daily acts of care with ever more rules and regulations dissipated the moral impulse to care [72].

I now turn to the backdrop behind this shift in residential care cultures, which has not been sufficiently considered. While I have become a bit leary of blaming all of the world's troubles on neoliberalism, without saying what neoliberalism is or how this is the case, much of this bureaucracy and lack of care might be traced back to the influence of neoliberalism on relationships. Neoliberalism saw large institutions as antithetical to its core tenets of 'personal autonomy, individual rights and opportunities for self rather than collective advancement' [62] (p. viii). This was when any notion of care became lost to residential care. Neoliberalism commodified relationships reducing them to their fiduciary and contractual bottom lines. This was even reflected in changing terminology, from care with its associations with warmth and affection to 'looking after', which carries connotations of short-term tending. Rights became contractual and subject to someone making a claim against that right. Essentially, this opened the field up to lawyers, which led to foreclosing and risk-averse institutional responses. As one of the respondents in my book, a residential care worker, observed, their risk assessment protocol:

> [. . .] ran to about three yards in length, there was a rule for everything. Why do we need a risk assessment to allow the kid to go to the theatre? How many children have been hurt going to the theatre in the last year? It is just nonsense. [1]

Matt, one of the teachers at St Roch's, recalled taking boys home to help with bits of work around the house, with the boys being given some extra cash for their help. Over time though, having boys help out at home or doing tasks like washing a car became frowned upon. Somehow or other, it was deemed to be exploitative, in which labour was only seen for its contractual value, rather than as a gift relationship within which there might be reciprocal and generative element.

Another aspect of the political culture that emerged over the course of the 1990s harkened back to the Poor Law doctrine of less eligibility, whereby children in care were denied experiences that might be considered as rewarding their bad behaviour. I remember when I was still in practice, newspaper articles railing against 'holidays for hooligans' and Scottish Office guidance that reacted to this by putting an end to such holidays, the result of which was that many of the experiences the St Roch's boys had were no longer possible. When politicians and advocacy organisations talk of the stigma of being in care, this is where much of it came from. I was never aware of the boys feeling stigmatised on our hostel trips or on the various outings and holidays they were taken on. Ironically, we have gone full circle and the latest Scottish Government initiative, *The Promise* (2020), identifies the need for children's care to move beyond a bureaucratic, unfeeling 'care system', with no insight or institutional memory of how we might have got to this state.

10. Drawing to a Close

As I indicate at the beginning, this article has taken me on something of a reflexive journey. I am aware that in reflecting on what I consider to have been a positive and formative professional (and indeed personal) experience at St Roch's, I am inclined to remember the good parts. I wondered if the accounts of the former pupils I interviewed might take the gloss off this rosy picture, but if anything, they were even more positive than I was in their memories. Others will say that what I present is so at odds with the received view of residential schools that it is at best naive and even disrespectful of those who claim different experiences of the schools. This takes us into the realms of how stories and memories are constructed. What I would say is that I did not cherry pick those I interviewed. I became a bit anxious when Ricki came forward as I never felt he was particularly happy at St Roch's—yet he gave a very positive and insightful interview. All of those who attended St Roch's had broadly similar experiences, but for a variety of reasons, some have come to interpret these differently. As Atkinson [73] points out, one needs to be mindful that the relationship from a life to a life history is rarely straightforward: 'lived experience' can be understood and interpreted in very different and ever-changing ways, in light of changing circumstances in indeed individual dispositions. These different perspectives and the contradictions within and between them need to be surfaced in order to bring some nuance and complexity to the story of the schools.

The last note I would like to end on is that recognising that good experiences did not necessarily translate into good outcomes for some of the boys I interviewed. That fact might offer some support to Fraser's [74] argument in her debate with Honneth, in which she criticises him for failing to give sufficient weight to the structural causes of disadvantage and for the need for measures of economic redistribution to tackle this. The reality is that the boys I interviewed left school at a particularly difficult time economically and culturally, at the height of Thatcherite de-industrialization, and many fell into drug use. Against the backdrop of a powerful cultural script that demonises residential schools, it would be easy for them to blame their time there for subsequent adversities. But they did not do so. Several described their time in St Roch's as the best years of their lives. Subsequent poor outcomes perhaps confuse causation in assuming that these can be laid at the door of residential schools, with the perhaps inevitable correlation between being placed in a residential school and subsequent poor outcomes. The reasons for this are complex and to reduce the primarily structural causes of poor outcomes to a couple of years spent in residential school is both lazy and complacent. It is complacent because it proceeds from an assumption that state care has become better as a result of managerial reforms. I am reminded of article by Webb in which he reflects on the work of a great aunt who had been matron of a Church of England children's home in the 1950s. He contrasts the moral purpose and the obligations carers felt towards children with the confusion, ambiguity and doubt that characterises much of present-day child care. In contrasting a religiously-inspired version of care with what might be claimed to be progressive developments since, he cautions that 'the drawing of any invidious comparisons with what takes place today in 'corporate care' might invite a brief reflection on the parable of the mote and the beam' [28] (p. 1400).

11. Conclusions

This article has questioned what has become a normative truth: that residential schools institutionally failed to offer care. That this question should be asked is a matter not just of historical accuracy but of social justice for those who worked in the schools but also those residents whose stories are swept aside by the grand narrative of a lack of care and of abuse. This spoiled identity is not one that the boys I interviewed would recognize or subscribe to. In the context of this article, autoethnography proved to be an appropriate methodology through which to challenge this grand narrative, offering a counter narrative which, drawing on Honneth's [5] theory of recognition, speaks of residential schools as being capable of offering care and even love, of boys' cultural social and interpersonal rights being respected and of them being provided with opportunities to participate in the public sphere. Such a positive depiction poses a fundamental challenge to the received story of residential schools, transcending the image of abusive institutions and replacing it with that of a happy home. As with most stories, such a binary representation is unlikely to capture the complexity of school life, but it does suggest that we need to be open to plural and conflicting accounts. It highlights a need to look past received narratives to gather more finely grained histories of schools and other care settings.

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