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SOS CHILDREN'S
VILLAGES
INTERNATIONAL

Function, quality and outcomes of residential care

Rapid Evidence Review



This report was researched and written by Robert Porter, Miriana Giraldi and Fiona Mitchell, and commissioned by SOS Children's Villages International.

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Executive Summary

Introduction

In seeking to provide an overview of the existing research on residential care, this review addresses the following research questions:

- What is the function of residential care as part of a range of alternative care options?
- What facilitates 'quality' care in residential care? Taking account of it both in the relational interactions between children and their carers, and in how residential care is organised to facilitate high quality care for children.
- What effect does residential care have upon outcomes for children and young people?

Methodology

This review used Rapid Evidence Review Methodology based on the steps detailed in Khangura et al (2012), which aim to streamline the process of synthesising evidence for practical applications. The research questions and the protocol for the search, screening, and reviewing of relevant literature were devised in close consultation with a stakeholder group from SOS Children's Villages.

Observations on the coverage and quality of the research reviewed

Of the 111 papers reviewed, the majority were published in the three years 2017-2019 and reported on primary quantitative studies. Eight systematic reviews were also included. The relevance to the research questions and quality of the papers was assessed by reviewers, only one paper was excluded due to being of insufficient quality. The papers included in the review cover data collected in 68 countries around the world, with the most frequently represented country being Romania, followed by the United States of America and the UK. This reflects the western English language bias present in much academic work, as well as the impact of the Bucharest Early Intervention Project (BEIP), which is the data source for the majority of the papers that include Romania.

Contextual analysis

In reviewing the papers, it is clear that there is little consistency in the terminology and definitions used across studies. Often, terms used were not defined and a description or analysis of the setting was seldom provided. Sometimes terminology and descriptors were used interchangeably within a paper, with no rationales given as to the choices made. 'Residential care', 'residential setting', 'residential centre' or 'residential care home' were the terms used most often. An almost equal number of the papers reviewed refer to 'institutions', 'institutional care', 'child care or child welfare institution', or simply to 'institutionalised children'.

What is the purpose of residential care?

Few studies explicitly addressed questions relating to the purpose or function of residential care. Those that did articulated how residential childcare exists as part of a societal approach to the protection of children, as part of a continuum of support for children and young people separated from their parents. There were many reasons cited for children's separation from their parents, with these clustering in relation to factors that might be understood as situational, primarily related to parental issues or behaviours, or presented as linked to a child's needs. Different uses were cited, including: 'respite' for parents; an interim provision while identifying, securing, or in preparation for a move into, family based care; when alternative family based care is not available or has not sustained, and appears unlikely to be able to offer emotional containment and a stable and continuous support for a child; to provide intensive support or 'treatment' from a group of carers, linked to the severity of the social, emotional and behavioural needs presented; as part of recovery and rehabilitation for children who have been subjected to neglect and abuse, trafficking, or sexual exploitation; as a stage in a move towards independent living following care.

What facilitates quality in residential care?

Few papers set out to explore either what constitutes or enables quality in care as the core topic of study. Those that did, or explored or assessed factors that relate to how well supported children and young people are, how positively they experience residential care in its different forms, and how this contributes to their growth, development and wellbeing, are presented with reference to what appear to be four critical domains of quality: setting, staffing, safety and treatment (Farmer et al., 2017).

The evidence presented shows that the most important aspects in this domain in ensuring high quality care are those related to the environment: quality care is provided in settings that are familial, home-like, affording opportunities for connection, stimulating practices, and activities. Elements such as routines and clear structures also contribute to the re-creation of a family environment, all of which contributes to an experience of daily life that is similar to those of children who are not in alternative care. The opportunity for children to maintain established connections, including contacts with friends, attending the same school, and having continued access to other services and opportunities within the community are seen as essential.

In order to consider meaningfully the ways in which residential care can provide high quality support, it is important to move beyond elements relating to size and structure of the setting, and focus on relationships and interactions. These aspects, analysed primarily in the domains of staffing and safety, help to determine how care can ensure the best quality of support and outcomes for children.

Caregivers play a pivotal role from the moment of placement, providing information, creating opportunities for participation and ensuring children and young people receive emotional support. The relationship they establish with children is essential to children's well-being and development. Appropriate care is ensured through stable relationships based on trust, characterised by continuity and lack of disruptions.

Caregivers need to be physically and emotionally available for children, something that can be successfully achieved when training, support, and supervision are available at the organisational level. A low child to caregiver ratio is another key determinant of success in this respect.

Residential care can provide specialised care for a variety of specific, severe, or complex needs. These aspects were considered in the context of treatment, an essential ingredient at the heart of a quality care programme. Evidence shows that effective, therapeutic care can be ensured by trained, specialised staff working within multidisciplinary teams using evidence informed models of care.

What effect does residential care have on outcomes for children and young people?

A large volume of the papers reviewed had at least a partial focus on the outcomes of residential childcare for children and young people. These papers have a focus on the psychological, social, and emotional outcomes for children and young people, with a reliance on a wide range of standardised measures.

It is clear from papers that focus on institutional care that children and young people in institutional care are at a disadvantage compared to their peers in family environments on a variety of measures. Due to the nature of the research conducted, there is no clarity in relation to issues of causality, i.e. whether this disadvantage is the *result* of care received, or a symptom of experiences prior to admission. However, both the wealth of evidence from the BEIP (using a strong RCT methodology), and more piecemeal evidence from other comparative studies, indicate that children and young people who are either initially placed, or subsequently move to, family based environments are able to match children who were never removed from the home, and make up ground on disadvantages they may have experienced upon placement.

There is also a large volume of less conclusive evidence that children in residential care are disadvantaged compared to their peers. It is not possible to draw clear conclusions on the outcomes of residential care for children and young people from the literature reviewed. This is due to a combination of the use of different methodologies, different measures, with different populations, in different care settings, in different cultural and socio-economic environments.

There remain significant gaps in the research literature around outcomes which was returned from the searches within this study. The clearest of these is the lack of research looking specifically at the experiences of children and young people within, or with experience of, residential facilities. In particular, studies which allow the young people themselves to highlight the outcomes that they feel residential care has provided for them, and the components of care which they felt facilitated, or inhibited, positive outcomes. Another major deficit in the research presented here is in the longer term social and emotional outcomes for children and young people who have experienced residential care, as well as the lack of

high-quality studies which examine which children or young people benefit the most from different types of residential setting.

There is a clear theme of deficit and disadvantage that runs through much of the outcomes literature. As Wright *et al* (2019) describe, this deficit focus risks overlooking the benefits that residential care can have for some children and young people, in some contexts. Combined with a large volume of the literature coming from large-scale institutional settings, it risks overlooking the benefits that may be conferred on children and young people by small-scale, individualised residential care.

Finally, it is worth highlighting that the BEIP has had a significant impact on our understanding of institutional care on children and young people. However, the impact of the BEIP (and other studies) has been such that our expectations of residential care are significantly different from the environment experienced by the children and young people involved in the BEIP. While it is understandably frequently cited in other papers in this review, its findings are limited to the impacts of the environment in which it took place.

Concluding observations

Issues around the use of terminology within the literature on residential care relate to the inconsistency of usage of terms, including institutional and residential, and the lack of detail provided regarding the nature of the settings being described.

Given the variability in terminology used, the context and focus of studies, methodologies used, the lack of integration of considerations of purpose, quality and outcomes together, it is challenging to be conclusive regarding an appraisal of the function, quality and outcomes of residential care across countries.

On the basis of this body of work, it is clear that:

- Large scale residential settings (institutions) are detrimental to the development and wellbeing of children and young people;
- It is challenging to provide quality care in residential settings, where groups of carers are caring for groups of children with divergent needs, and requires close attention to setting, staffing, safety and treatment (i.e. evidence-informed models of holistic care);
- Context and culture are important to understanding the role and impact of residential care, and there is a differential representation of evidence from North America and North and Western Europe;
- Due to the differential regarding the sources of evidence available on residential care, our understanding of the purpose and usage of residential care is influenced by what is occurring within very specific contexts.

1. Introduction

In the 30 years since the adoption of the UN Convention on the Rights of the Child (UN CRC), increasing attention has been devoted to the rights of children who are without, or at risk of losing, parental care. Concerns about the high numbers of children coming into alternative care worldwide, often for avoidable reasons, the conditions under which such care is provided, and the low priority often given to responding adequately to these concerns, led to the drafting and welcoming, by the UN General Assembly, of the UN Guidelines for the Alternative Care of Children (the Guidelines) (United Nations General Assembly, 2009).

The purpose of the Guidelines is to provide ‘desirable orientations for policy and practice’, and to assist Governments and all those concerned with child welfare and social protection to enhance implementation of the UN CRC for children without parental care, through, inter alia, ‘the provision of the most suitable forms of alternative care’. While stating that priority should be given to family- and community-based solutions, the Guidelines recognise the need for a range of alternative care options. This includes residential care, which complements family-based care in meeting the needs of children, and can be used when it is “specifically appropriate, necessary and constructive for the individual concerned and in his/her best interests” (para. 21) (United Nations General Assembly, 2009).

The Guidelines point to the fact that it is important to differentiate quality residential care options from “large residential care facilities (institutions)” (para 23), which should be progressively eliminated through deinstitutionalisation strategies (United Nations General Assembly, 2009). The need for the availability of a range of quality care options, including family- and community-based services meeting the principle of suitability, and to progressively replace institutional care, was further reaffirmed by the UN General Assembly in its 2019 Annual Resolution on the Rights of the Child.

In spite of this international guidance, while there is unequivocal agreement on the need for support of families and to avoid all unnecessary separation, policy debates at national and international levels have continued to focus on what alternative care services should be made available, and specifically, on the role that residential care can play in this context. The purpose of this evidence review is to provide an overview of the existing research on residential care as one of a range of alternative care options, highlighting what specific purpose it serves, what aspects constitute quality, and how it affects outcomes for children.

The specific research questions for the review were:

1. What is the function of residential care as part of a range of alternative care options?
2. What facilitates ‘quality’ care in residential care? Taking account of quality both in the relational interactions between children and their carers, and in how residential care is organised to facilitate high quality care for children.
3. What effect does residential care have upon outcomes for children and young people?

In keeping with SOS Children’s Villages decision to commission the review, following appraisal of evidence relating to the research questions, the report seeks to address the following objectives in its concluding sections:

1. To identify issues around the use of terminology within the literature on residential care
2. To obtain an overview of existing research regarding residential care, and the insights this brings in terms of the care needs that residential care responds to, the effects on the well-being of children/youth, and its role within the range of care options
3. To gain insight into the discourse within the body of research, and the evidence- base for divergent conclusions
4. To provide an account of what the evidence indicates to inform policy debates and policy formulation
5. To provide an account of what the evidence indicates to aid the design, development and improvement of residential care for children and young people across regions of the world
6. To identify gaps in existing research

Understanding and unpicking terminology used in the literature review has proven challenging, due to a lack of consistency and consensus on the use and meaning of 'residential care' and 'institutional care', in particular. Throughout this report, we will use the terminology chosen by the authors in the paper itself in the sections where we report specifically on the findings from the papers.

This means that the term 'institutional care' will be used when mentioning studies that made specific use of this term. In our analysis throughout this report, we will refer to 'residential care' when describing all care provided in non-family-based settings. When information or descriptors about the type of setting discussed within the literature provides sufficient information about the particulars of care provided, allowing an understanding of the model of care in question, the report will refer to 'residential care' or 'institutional care', accordingly.

Finally, in our analysis outlined in the final chapter providing concluding observations (chapter 8), we will use these terms with the meaning given within the UN Guidelines for the Alternative Care of Children, using 'residential care' when referring to care that meets with the criteria outlined in the Guidelines, in recognition of the fact that it can be appropriate, necessary and constructive for children in given circumstances.

2 Methodology

There are many different review methodologies available, and each of them has strengths and limitations. Common review methods include systematic reviews, scoping reviews, and literature reviews. While there are arguments surrounding the true objectivity of systematic reviews (e.g. Boell & Cecez-Kecmanovic, 2010), they are nonetheless regarded as the ‘gold standard’ of literature reviews.

2.1. Rapid evidence review process

As agreed with SOS Children’s Villages, this review used a rapid evidence review methodology, based on the steps detailed in Khangura et al (2012). This method is designed to streamline the process of synthesising evidence for practical applications. In particular, it aims to ensure that the outputs from a review are aligned with the purpose(s) and question(s) which are of interest, as well as functional in the contexts which the commissioning agency wishes to use them. Rapid evidence review methodology also avoids some of the challenges which are present in systematic review methodology, specifically ensuring that it is achievable within a relatively short time- frame. Table 1 outlines a comparison of the approach taken in this rapid review, compared to a standard systematicreview.

Table 1: Comparison between Rapid and systematic evidence review approaches (adapted from Khangura et al (2012))

	Rapid Review	Systematic Review
Timeframe	Fast (3 months)	Slow (6 months – 2 years)
Question	Broad in terms of intervention, outcomes, discipline. Focused on areas of need for knowledge users	Focused clinical questions
Sources and searches	Sources & strategies limited, but made explicit	Comprehensive sources/strategies, made explicit
Selection	Criterion-based; uniformly applied	Criterion-based; uniformly applied
Appraisal	Rigorous critical appraisal	Rigorous critical appraisal
Synthesis	Descriptive summary, categorisation & qualitative summary	Qualitative summary and/or meta-analysis
Inferences	Limited/cautious	Evidence-based
Outputs	Designed to match needs of knowledge users	Formal review report

One of the key elements of the rapid review methodology set out by Khangura et al. is that it involves reference to the knowledge user, particularly at the initiation and set-up of the review process. Therefore, a number of meetings were scheduled with a ‘stakeholder group’, made up of individuals from across SOS Children’s Villages who wished to have questions answered by the review, or planned to make use of the review in their work. This included a focus group with a wider stakeholder group gathering from across regions and functions within SOS Children’s Villages and the formation of a

reference knowledge user group for this review, which consisted of Claudia Arisi (Global Advocacy Advisor), Valerie Jans (Research and Learning Advisor), Rosana Martinelli (Global Advocacy Advisor), and Douglas Reed (Head of Research and Learning).

Purpose	Decisions/Information
12 February 2020, Online focus group with wider stakeholder group	
<p>To determine an outline for the evidence review:</p> <p>What is of greatest interest to find out?</p> <p>How would findings be used? What is meant by ‘residential care options’ in the specification document?</p> <p>Limits around temporary/permanent loss of parental care.</p>	<p>Key interests are:</p> <p>Role and added value of residential care</p> <p>Outcomes /in comparison to other options What are quality features of residential care</p> <p>‘Dividing line’ between suitable and unsuitable residential care</p> <p>Review is to be used for:</p> <p>Advocacy</p> <p>To support programme development</p> <p>To find available evidence to inform future research needs To understand different types of residential care Residential care includes:</p> <p>All non-family based care outside family home</p> <p>Can be called residential, institutional, foster and many other forms of care</p> <p>Regarding temporary/permanent loss of parental care Where it is seen as long term care</p> <p>Include children living permanently in temporary settings</p> <p>NOT to include shelters or hostels.</p>
19 th February 2020, review and agreement on focus with knowledge user group	
<p>To agree upon and finalise:</p> <p>Research Questions</p> <p>Search Strategy List of search terms</p> <p>Timeline for Evidence review To discuss options for including French and Spanish language searches</p>	<p>Decisions made on:</p> <p>Three research questions</p> <p>Search strategy</p> <p>Inclusion/exclusion criteria List of search terms Timeline for evidence review</p> <p>Approach to French and Spanish language searches</p>
30 th April 2020	
<p>To discuss French and Spanish language searches and alternative options</p>	<p>It was agreed to conduct searches within key French and Spanish journals identified by SOS Children’s Villages staff.</p>
15 th June 2020	
<p>Report draft shared with stakeholder group</p>	<p>Feedback received promoting clarity and overview of the body of literature as a whole. Final report due 1st July 2020.</p>

Figure 1: Stages and timeline of engagement with stakeholder group

Figure 1 shows a timeline of engagement with the stakeholder group and the meeting purpose and decisions reached which influenced the review process. Through this collaborative process, clear research questions and a search strategy were devised. The searches were conducted by the research team in the week beginning the 24th March.

2.2. Conducting the searches

Particular consideration was given to the time period for the search strategy. Initially, a ten-year period was identified (2010-2019 inclusive). The research team conducted searches in English as described here (with a change to the longer time period), which returned approximately 1900 abstracts. Upon completion of abstract review 329 papers were selected for full text review. In email discussions with the SOS Children's Villages' stakeholder group, it was agreed that these numbers returned were unmanageable within the constraints of the project, and a five-year window was used instead. This decision was taken in consideration of the fact that the literature within this five-year period would include: papers based on data collected prior to this window; (systematic) reviews including earlier literature, and; references to prior research within the literature returned. In addition, it was hoped that literature from the later period would ensure a greater emphasis on research conducted within contemporaneous residential care settings. The numbers presented in Figure 2 reflect the results of searches only within the 2015-2019 window.

The search strategy combined the most relevant synonyms used to describe:

- Residential care for children (i.e. Residential care, residential facility, residential setting, children's home, small group home, institution, institutional care, institutional setting, orphanage, boarding)
- Children (i.e. infants, children, young people, youth)
- Quality and outcomes (i.e. effectiveness, impact).

The search is codified into a search string which is applied across all of the databases to be searched. The search string is made up of the specific search terms combined using Boolean operators. Thus, the search string used the **AND** operator to look for published articles which contain the three concepts as follows:

- 'Residential care for Children' AND 'children' AND 'Quality and outcomes'

Each of these concepts was captured using a selection of synonyms, defined in collaboration with the SOS Children's Villages' stakeholder group, linked with **OR** operator. This produced the complete string which was entered into the databases:

- ("residential" OR "children's home" OR "small group home" OR "institution*" OR "orphanage" OR "board*") AND ("infants" OR "child*" OR "young people" OR "youth" OR "teen*") AND ("effect*" OR "impact" OR "quality" OR "outcome" OR "result")

This search string was entered into the databases detailed in Table 2, which also shows the criteria which were applied at the database search stage. Please see Figure 2 for details of the number of abstracts returned, in English, French and Spanish.

Table 2: Search Criteria applied at databasesearchstage

Database: Applied	Social Science Index and Abstracts (ASSIA)	Social Science Database	Social Sciences Citation Index	Cochrane Database of Systematic Reviews
Documents Categories	'Dissertations & Theses' 'Scholarly Journals'	'Dissertations & Theses' 'Scholarly Journals' 'Reports'	N/A	'Cochrane Reviews' 'Special Collections'
Document Types	'Article' 'Government & official document' 'Literature Review' 'Report' 'Review'	'Article' 'Dissertation/thesis' 'Government & official document' 'Literature Review' 'Report' 'Review'	'Article' 'Abstract of published item' 'Data paper' 'Discussion' 'Record review' 'Review'	N/A
Language(s)	English, French, Spanish	English, French, Spanish	English, French, Spanish	N/A
Date Range	2015-2019	2015-2019	2015-2019	2015-2019

2.2.1 French & Spanish additional searches

The searches detailed above produced only one relevant article in French, and one in Spanish. To ensure that the review included relevant French and Spanish literature, the English search string was translated into French and Spanish and re-applied within each of the databases. This produced inconsistent results with only one relevant (French) abstract, which led to the meeting on the 30th April (please see Figure 1), where it was agreed that SOS Children's Villages' staff would identify key journals in French and Spanish, and CELCIS would then conduct a review of all published articles within these journals between 2015- 2019.

The SOS Children's Villages' stakeholder group identified a number of French resources, of which eight were academic journals, and one Spanish journal. The full list of articles between 2015-2019 were reviewed for inclusion from three of the French journals (Enfances, Familles, Générations (three abstracts identified); Les Cahiers de l'Actif (no abstracts identified), and; La Revue Internationale de l'Éducation Famillale (no abstracts identified) and the Spanish journal (Sociedad e Infancias (three abstracts identified). In addition, the most prominent journal in from each of the French and the Spanish database searches ('Revue Française de Sociologie' (no abstracts identified) and 'Revista Latinoamericana de Ciencias Sociales, Niñez y Juventud' (four abstracts identified) respectively) were also reviewed across the same time period. Together these processes produced an additional seven relevant abstracts in Spanish, and three relevant abstracts in French.

2.3. Inclusion and exclusion criteria

In partnership with the SOS Children's Villages' stakeholder group, a set of inclusion and exclusion criteria were agreed upon (please see Figure 1). These criteria (shown in Table 3) were applied at

the abstract and paper review stages - they are critical to the screening of abstracts to identify papers for inclusion in the review. The application of these criteria in the different stages of the work determine the nature of the evidence included within the review. The criteria were chosen to limit the review to higher quality empirical research – that is, research formally published within peer reviewed publications and that reports on primary research studies – and to the literature most relevant to addressing the research questions, and the review objectives.

Table 3: Inclusion & Exclusion Criteria for Abstract and Article Review

Criteria	Inclusion	Exclusion
Target population considered by the study	Children and young people who are under 18	Adult
Intervention considered by the study	Residential care provided to children and young people, separated from parental care (i.e. where children are: cared for by one or more carers who are unrelated to one another; are living within a group of children, and; where the setting is not the pre-existing home of the carers).	Youth offender institutes Immigration centres (i.e. reception, transit or detention) Boarding schools Shelters Hostels Hospitals Kinship care (i.e. where a child's relatives are providing care for them) Traditional foster care (i.e. where only one or two related carers are providing for a child(ren) within their own home)
Type of study	Systematic reviews Primary study	Commentaries Secondary reviews (not using systematic review methodology) Secondary data analysis
Date of publication	2015-2019 (inclusive)	Pre-2015, post-2019
Language of publication	English, French, Spanish	All other languages

2.4. Abstract and full paper review

Our inclusion/criteria attempted to operationalise a definition regarding residential care, denoting an interest in the evidence regarding different forms of residential care, extending from small group homes to large residential care facilities (institutions). In order to ensure that we included as much relevant literature as possible, we did not exclude papers based on the terminology they used but rather by looking at the definition of the terms and setting details that the research described. However, there was a paucity of information provided within papers and it was challenging to differentiate studies of smaller group settings and larger residential care facilities.

At initial abstract review, no methodological or other quality criteria were applied to the papers returned. It is common for abstracts to contain little or no information regarding the methodology or methods, or the size of the population or sample included in the study. Lacking even this basic information makes it impossible to judge the quality of the paper at abstract review.

Accordingly, an assessment of quality was only applied at full text review as detailed below. Table 4 gives an overview of the numbers of papers included and excluded at each step of the review process.

Once a paper was marked for possible inclusion following abstract review, it was subject to full-text review. This was a rigorous process, requiring the researcher to read the entire article, and then complete a detailed pro-forma (please see Appendix A) with relevant information for the review. At this stage, articles could also be excluded due to not meeting the inclusion/exclusion criteria detailed in Table 3, or because they were judged to be ‘not at all’ useful to the review *and* of ‘poor/doubtful’ methodological quality. In total 92 papers were excluded at the full text review stage, due to not meeting the study criteria of being an empirical primary study or systematic review, or because on full review they were found not to meet the inclusion criteria detailed in Table 3. One paper was excluded on the basis that both their methodology and relevance to the review was too poor. Figure 2 shows the numbers of papers sourced, included, and excluded at each step of the review process, in each language.

Table 4: Summary of paper numbers at each review stage

Review Stage	Numbers included	Numbers Excluded/Removed
Articles identified	1759	283
Abstracts reviewed	1476	1273
Full text articles reviewed	203	92
Articles included in study	111	-

2.5. Limitations of the review

As with any study, this rapid evidence review has a number of limitations. It is important that these are borne in mind while considering the conclusions and implications to be drawn from the study.

Firstly, the study is limited in the papers that were returned. As detailed above, significant choices were made at many stages which influenced the number and type of papers returned. As noted, the five-year window for eligible papers means that many studies were excluded from this review. We know from our initial searches (please see Appendix B) that a 10 year window would likely have produced a 50% increase in the number of papers considered in this review.

Secondly, our choices in relation to the search strategy introduce limitations. We conducted searches in four different databases, which were selected to maximise the potential for reaching all relevant research. However, it is inevitable that some papers which would be considered relevant to the review may not have been indexed in these databases. This is likely to be particularly true of non-English language papers. Our search terms were also designed to include all potential papers, but may have resulted in the exclusion of papers which did not use any of these terms in their abstracts.

Thirdly, the nature of the approach to a rapid review, and of using a team of reviewers to cover such a large number of papers, means that it is not possible for any one person to have read all (or even half) of the full texts included in the review. While the review process and pro-forma was designed to minimise the risk of misinterpretation and misrepresentation, there remains the possibility of different interpretations affecting the information entered into the pro-forma by different researchers.

Finally, results presented in this review are necessarily removed from their individual contexts and stripped of many of the subtleties of method, setting, and literature in which they are framed in the papers. While we have strived to include, highlight, and differentiate between relevant factors, it will always be necessary for a reader to go directly to the full texts of any individual paper in order to gain a full understanding of the context and implications of particular studies.

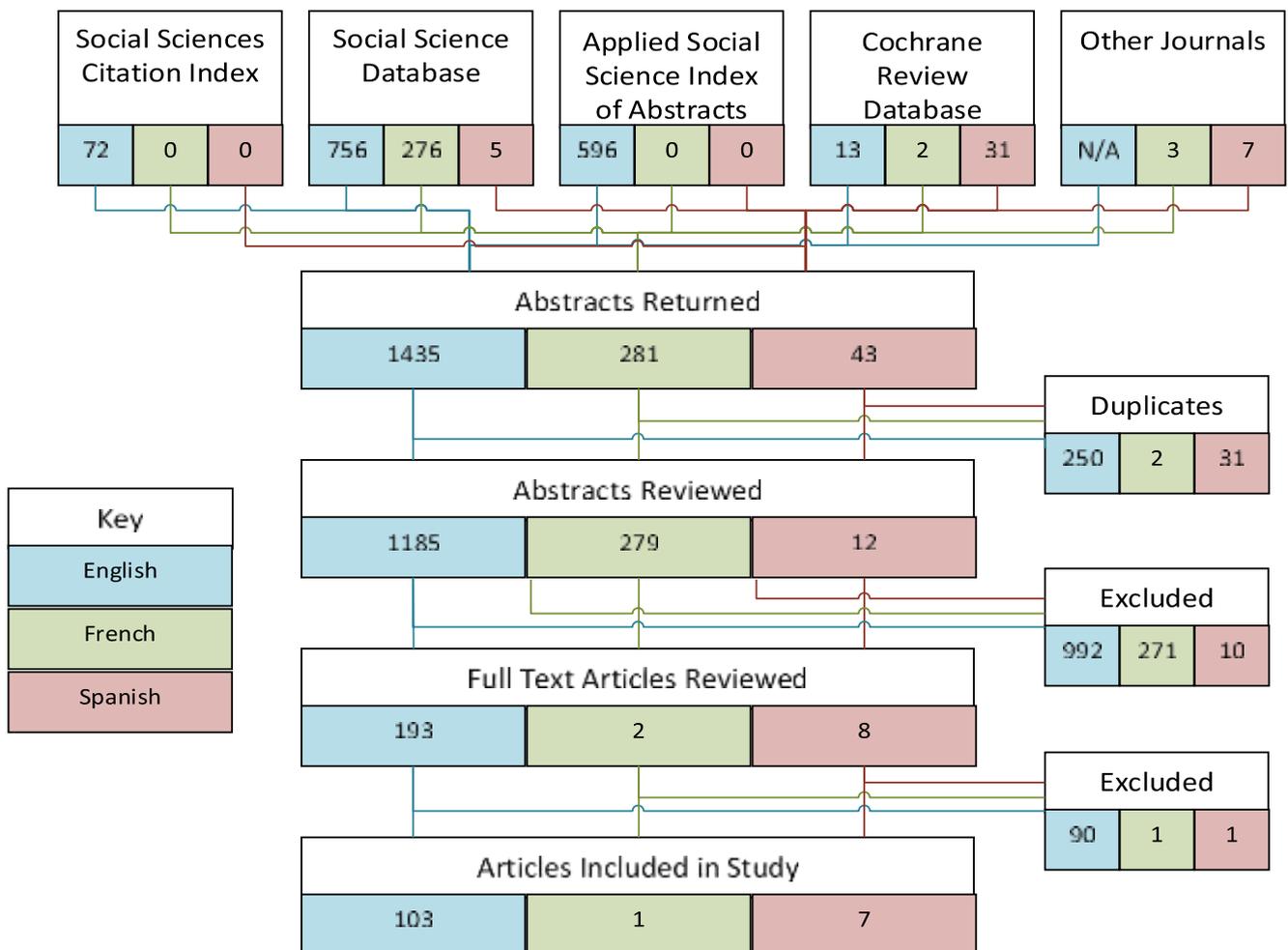


Figure 2: Flowchart of Review Process

3 Observations on the coverage and quality of the research reviewed

As detailed in Chapter Two, the review considered a total of 111 papers from around the world, in English, Spanish, and French. As can be seen in Figure 3, papers included in the review were spread across the five years of the search criteria, with higher numbers present from more recent years. This may indicate an increased interest in residential care for children and young people over the last five years.

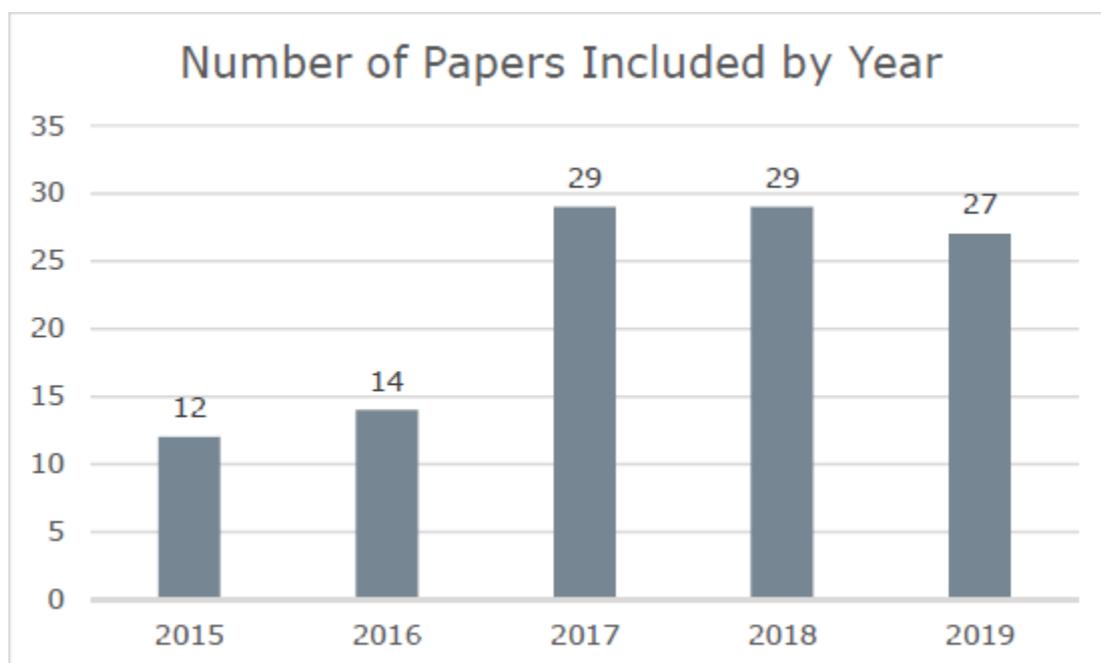


Figure 3: Number of papers included in review by year

3.1. Methodological assessment

As a rapid evidence review, a comprehensive assessment of the methodological quality of each paper was not conducted. Reviewers summarised the research design and attention to validity and reliability, and were asked to rate the methodological quality of the papers on a three point scale, from one being 'poor/doubtful' and three being 'very good'. In order to ensure that relevant studies were included in the review, this rating was combined with a three point 'relevance to the review' rating (one- not at all useful, three – very useful).

A paper was only excluded if it scored one on both methodological quality AND relevance to the review and only one paper was excluded on these grounds. Table 5 below shows the distributions of these classifications across all the papers included in the review.

Table 5: Methodological and relevance ratings for papers reviewed

Methodology	Very Poor /Doubtful	Adequate	Very Good	Total
Relevance				
Not at all useful	0	11	3	14
Useful	8	34	29	71
Very useful	0	11	15	26
Total	8	56	47	111

As can be seen, papers differed in their relevance to the review topics. Many papers only touched upon topics or information that was of relevance to the review, while others were more directly relevant to the review questions. Those which speak to many different aspects of the review questions, are inevitably cited more frequently in the text of this report than those which only speak to one specific aspect. It is important to note that frequency of reference does *not* equate with methodological quality, or the ‘weight’ that should be attributed to a paper’s findings. Table 5 shows that papers of differing relevance to the review also differ in their methodological quality, and that the two are not necessarily related.

3.2. Methodologies used

One hundred and three of the 111 papers included in the review are primary studies and there are eight systematic reviews. Figure 4 shows how frequently different methodologies were employed in the papers.

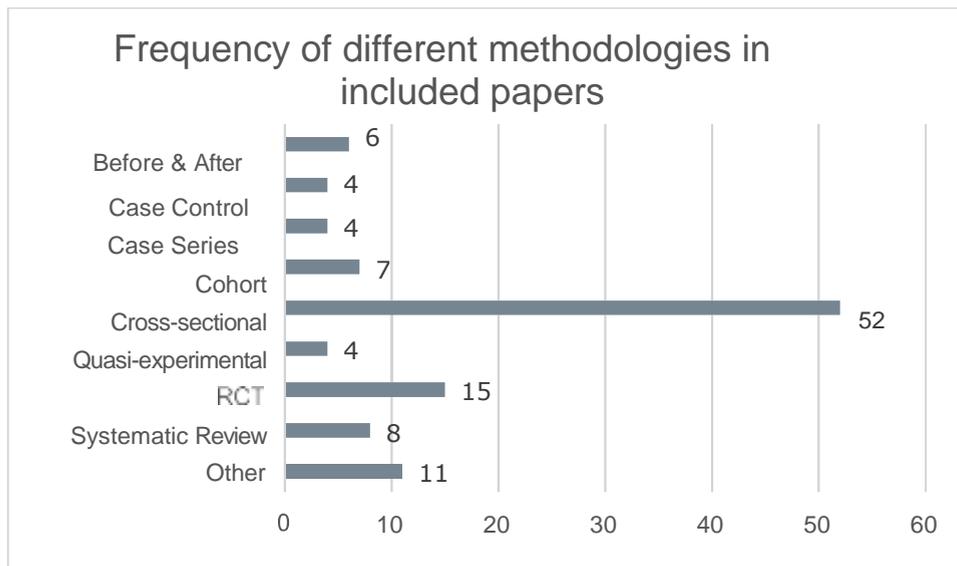


Figure 4: Frequency of different methodologies in included papers

Cross-sectional studies look at the topic of interest at one point in time, often comparing between individuals in different situations. Because they only take a ‘snap-shot’ of the topic of interest, and do not control who was placed in which group, they can only tell us the situation as it is, not how or why

it came to be that way. The prevalence of cross-sectional studies represents a weakness in the evidence base, as these studies are subject to a large number of potential confounding variables. For example, in some country contexts, children and young people placed in residential care may reflect a cohort of the population who have some of the greatest needs and developmental, behavioural, or psycho-social challenges. Cross-sectional studies can only tell us what the differences in the populations are, and can say little about the causality around these differences or, indeed, how residential care interacts with these.

The high number of Randomised Control Trials (RCTs) represented in the sample is encouraging, however as indicated earlier, these are dominated by the BEIP study of effects of institutionalisation in Romania, which accounts for 11 of these 15 RCT studies. The relatively high proportion of systematic reviews represents a strength, as these reviews represent a robust methodology that enables trends in the literature to be identified with confidence.

The different methodologies used may also link to the different disciplines from which the studies approached their research questions. Although the discipline in which a study was rooted was not assessed during paper review, examining the journals in which papers appeared can provide a very rough proxy indicator of the disciplinary approach used.

This should be interpreted with caution, as most journals make explicit efforts to encourage and include papers rooted in alternative disciplines or multi-disciplinary studies. Table 6 shows that most papers came from the social work discipline, followed by psychology, child and youth studies, and health. 'Other' disciplines included criminology and general social science journals.

Table 6: Numbers of papers in journals by primary discipline

Journal Discipline	Number of papers
Social Work	39
Psychology	29
Child & Youth Studies	19
Health	17
Other	7

3.3. Geographical distribution

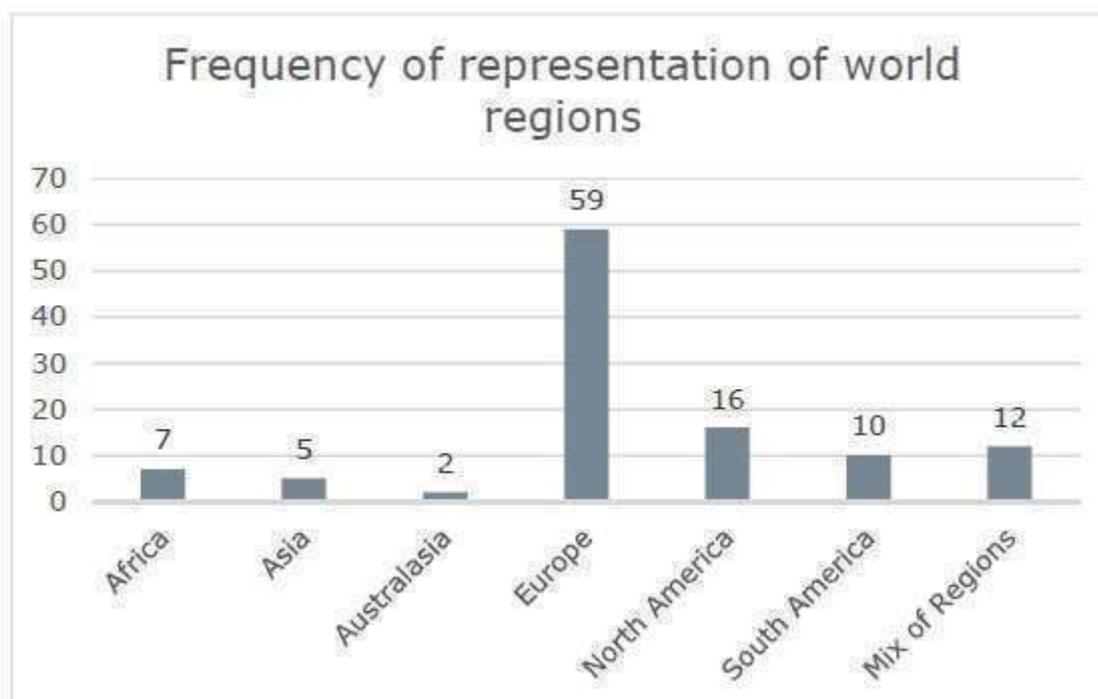
The papers included in the review cover data collected in 68 countries around the world (please see Figure 5 and Table 7). The most frequently represented country is Romania (represented in 15 different papers), followed by the United States of America (14 different papers), and the UK (represented in 10 different papers). This reflects the western bias present in much academic work, as well as the impact of the Bucharest Early Intervention Project (BEIP), which is the data source for the majority of the papers that include Romania.



Figure 5: Map highlighting countries represented in the review

While the overall coverage of different regions of the world is good, the distribution of research throughout the world is not equal. Of the papers included in this study, 59 (53%) reported on research or data that had been collected exclusively within Europe. Exclusively North American research contributed an additional 16 papers (14%), South America 10 (9%) papers, Africa an additional seven papers (6%), Asia an additional five papers (5%), while there were just two papers based on exclusively Australian data (2%). The remaining 12 papers (11%) represented data collected in more than one geographical region.

Table 7: Numbers of papers from different world regions



3.4. Contextual variation

The different terms and descriptors used around residential care was a challenge for this review, as indicated in greater detail in the following section. Different countries and contexts can mean many different things by the terms 'residential care', 'institutional care', 'foster care', and others.

The usage of these terms shows that they are deployed to describe vastly contrasting settings, which in turn makes it challenging to both articulate and assess similarities and differences between settings. An additional challenge to this is that few studies explicitly define their usage of a term or provide clear, specific detail regarding the setting(s) that are the focus of the study being reported upon. Instead, they simply refer to 'institutional care', 'residential care' or any of the other terms referenced during the contextual analysis presented in the next section.

Examining the descriptions of care settings provided in the different papers highlighted that one third of papers failed to present even minimal information about the setting in which their data was collected. There were no clear differences in the distributions between geographic areas. The high proportion of papers which failed to provide even relatively basic information regarding the context in which their data was collected is concerning. The inability to distinguish findings between potentially significantly different care settings represents a challenge to the interpretation and meaning of the existing evidence within this review.

4 Contextual analysis relating to terminology and definitions

The Guidelines provide a description of the environments within which alternative care can be provided, including residential care. Residential care is defined as “care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short and long-term residential care facilities including group homes” (para 29) (United Nations General Assembly, 2009, para 29 C (iv)).

When operationalising our search strategy to identify relevant literature in the framework of this review, ‘residential care’ was defined and described as: residential care provided to children and young people, when their parents cannot care for them (i.e. where children are cared for by one or more carers who are unrelated to each other, are living within a group of children, and where the setting is not the pre-existing home of the carers). The review includes various terms and descriptions that the authors of the studies reviewed framed as residential care in different forms, and that met with the above definition.

Overall, there was little consistency in the terminology and definitions used across the studies reviewed. Oftentimes, the terms employed were not defined, and a description or analysis of the setting was seldom provided, for example, in terms of the size of the setting or number of resident children, the ratio between caregivers and children, or other particulars of the care provided. Terminology and descriptors were sometimes used interchangeably within a paper, with no rationales given as to the choices made.

‘Residential care’, ‘residential setting’, ‘residential centre’ or ‘residential care home’ were the terms used most often, and the descriptor of choice in about a quarter of the articles included in the review. These terms are typically used to denote care settings that accommodate a relatively small number of children, with a low child to caregiver ratio, and that provide care to children with multiple or complex needs, which can mean the availability of trained staff, multidisciplinary teams, and the availability of specialised services. This seems to be one of the most salient characteristics of the options described as residential care in the studies reviewed: these services are of a therapeutic nature, and provide alternative care for children in need of specialised support. A few of the studies provide information about the nature of the setting – for example, small units with three to five residents, a group home in a neighbourhood campus, or a house in a community setting. This is particularly indicative of European and North American literature.

Most often, no negative connotation is associated with ‘residential care’ – though a few papers mention this is seen as a ‘last resort’, particularly when discussing services for children with complex needs, or in particularly challenging circumstances.

An almost equal number of the papers reviewed refer to ‘institutions’, ‘institutional care’, ‘child care or child welfare institution’, or simply to ‘institutionalised children’. A few of the studies that employ this terminology, notably those written in Spanish or French, do so interchangeably with residential care, and do not associate any negative connotation with this concept. In these instances, ‘institutional care’ refers simply to care provided in a residential setting, with the objective of affording children with the opportunity of establishing significant bonds with those providing care.

Only in a small number of the studies written in English ‘institutional care’ is used with a rather neutral connotation (Jozefiak, T., and Kayed, N. S., 2015 and Jozefiak et al., 2017, refer to child welfare or residential youth care institutions in Norway; Nakatomi, T. et al., 2018, discuss children’s homes, framed as institutional care, in Japan in a positive light).

The terms 'institution' or 'institutional care' are mostly associated with implicit or explicit negative connotations in the papers under scrutiny. A handful of the studies make reference to the physical aspects of care provided in these settings, pointing to size, routines or material aspects of the care provided when describing them. In the majority of cases examined, however, the emphasis is on the relationship between children and those providing care. This is depicted, among other things, as: not child centred; lacking sensitive, warm interactions; not emotionally responsive, and as depriving children of positive experiences.

Additionally, factors such as a high child-to-caregiver ratio, lack of consistent caregiving, and a high level of staff turnover are mentioned when discussing care of an institutional nature, leading to increased difficulty for children to form stable attachments and bonds.

Other terms and descriptors in the papers investigated include 'child protection' or 'child welfare' home, 'out of home care', 'residential foster care', 'group home', 'house in a community setting', 'residential group care', 'temporary care centres', 'institutional foster care setting', and 'orphanage', which highlights again the broad range, as well as inconsistency, of terms employed to designate forms of residential child care. Throughout this report, we will use terminology as outlined in the final paragraph of the introductory chapter.

5 What is the purpose of residential childcare?

This rapid evidence review aimed to explore the purpose of residential childcare. To unpick the notion of 'purpose', we might ask - Why does residential childcare, in its many forms, exist? Who is cared for within a residential childcare context? What is it intended to achieve with or for children and young people? In reviewing the following findings, it is important to remember that our search and screening criteria exclude a whole range of other kinds of uses of residential care for child and youth populations, such as prisons or youth offending institutions, immigration centres, boarding schools, hostels and hospitals (please see Appendix A). The review of the papers did not reprise papers' integration of others' findings on the purpose of residential childcare, only how they articulated or framed this in relation to their primary research.

5.1. Residential care as part of a continuum of support for the protection of children

Few studies explicitly addressed questions relating to the purpose or function of residential care. Those that did, articulated how residential childcare exists as part of a societal approach to the protection of children. At this general level, studies denoted that it either does, or should, represent part of a continuum of support for children and young people who cannot be cared for by their parents or families (Bogdanova, 2017; Bunea et al., 2017; Jedwab et al., 2019; Lino et al., 2016; Palsson, 2017; Vaz Garrido et al., 2016). In addition to this, some studies provided some qualifiers around this, including that State legislation, policy, and practice is or needs to be oriented towards a presumption of 'family-like' (foster or kin) care over institution (residential care), or, that its usage is or should be restricted (Bogdanova, 2017). For example, some studies referenced mandated exclusion of usage with babies and infants. Others emphasised its usage as a 'last resort' when other options were not available or appropriate to ensure a child's rights or needs.

5.2. Reasons for separation from parental care

There were many reasons cited for children's separation from their parents, with these clustering in relation to factors that might be understood as situational, primarily related to parental issues or behaviours, or presented as linked to a child's needs.

Situational reasons included the need for alternative care arising through the death or severe illness of parent(s) during war, epidemics (specifically HIV AIDS), natural disaster, displacement/migration, or other reasons (Caserta et al., 2017; Nsabimana et al., 2019; Pandya, 2018). Dire economic situations, poverty, and hardship were drivers for parents to seek alternative care of their children or to abandon them, with residential care then affording access to food, shelter, education, and health care (Baptista et al., 2017; Mota et al., 2017). Societal or cultural views on the birth of children outside marriage also led to abandonment of children. State policies on restricting the number of children per family, as in China, was also identified as a reason for abandonment.

Family breakdown, parental conflict or violence were also reasons for parents being unable to care for their children. Parental alcohol and drug dependency or addiction, incarceration, and mental ill health were issues cited as affecting parental capacity to care for their children (Jaramillo et al., 2016; Jozefiak et al., 2017; Rakhlin et al., 2017). Neglect and different forms of abuse (physical, emotional/psychological, sexual) were also identified as reasons for children's entry to residential care (Cox et al., 2017; Hickie & Roe-Sepowitz, 2018; Garcia-Quiroga et al., 2017; Wendt et al., 2019).

Some studies focused upon the developmental needs of children or their behaviours as reasons for alternative care. When these reasons were cited, it was not always with reference to how these are likely to be secondary effects linked to parental capacity to care and/or experiences of neglect and abuse. Studies noted impairments and disability as reasons for children living in residential care, including specific reference to children with developmental delay, Down Syndrome and Cerebral Palsy (Llosada-Gistau, Casas, et al., 2017). There was reference to needs relating to children's mental health, described variously as 'trauma', 'severe psychological strains' 'serious psychopathology', 'severe psychological or behavioural problems', and 'a range of adversity and behaviour difficulties that have placed them at risk of harm to themselves or others' (Boel-Studt et al., 2018; Eenshuistra et al., 2019; Hurley et al., 2017; Jedwab et al., 2019; Luksik, 2018; Marvin et al., 2017; Mota et al., 2016; Schuurmans et al., 2018; Swerts et al., 2019; Vejmelka & Sabolic, 2015).

While studies rarely discerned how different country contexts interacted with reasons for entry to residential care, it appears that the usage of residential care to promote recovery, rehabilitation or treatment of children is a feature of North America and European (North and West) studies rather than studies from other areas of the world where situational reasons appear to be more clearly associated with entry to residential care.

5.3. The age profile of children who are cared for in residential care

Given the variability of the contexts and objectives of the studies reviewed, it is not possible to discern a description or patterns of the age profile of children who are cared for in residential care. However, it is clear from the studies that residential care has been and continues to be used for very young children as well as for children through middle childhood and into adolescence. There does appear to be some variation in time and place, with some studies focused on taking account of earlier usage of institutional or residential care for babies and infants, and with much of the North American and European (North and West) studies exploring the usage of residential care with youth populations.

5.4. The use of residential care

Across the studies, the following uses were cited regarding the provision of residential care for children:

- In order to support them to live with their parents in the longer term, by providing some level of temporary support framed as 'respite' for parents (Luksik, 2018)
- While identifying or securing family based care (foster, kin, adoption) (Chege, 2018), or, in preparation for moving into family based care (Jedwab et al., 2019; Vacaru et al., 2018)
- When alternative family based care (foster, kin, adoption) is not available (Gayapersad et al., 2019; Wright et al., 2019)
- When alternative family based care (foster, kin, adoption) has not sustained, and it appears unlikely to be able to offer emotional containment and a stable and continuous support for a child (Grey et al., 2018; Wright et al., 2019)

- To provide intensive support or ‘treatment’ from a group of carers, linked to the severity of the social, emotional and behavioural needs presented (Boel-Studt et al., 2018; Eenshuistra et al., 2019; Hurley et al., 2017; Jedwab et al., 2019; Luksik, 2018; Schuurmans et al., 2018; Vejmelka & Sabolic, 2015)
- As part of recovery and rehabilitation for children who have been subjected to neglect and abuse, trafficking, or sexual exploitation (Brown et al., 2018; Hickie & Roe-Sepowitz, 2018; Rafferty, 2018)
- As a stage in a move towards independent living following care (Gander et al., 2019)

It was not possible to differentiate patterns of usage systematically across regional or country contexts, other than cited as above that there is a clearer tendency towards recovery, rehabilitation and treatment of social, emotional and behavioural issues for children and young people within North American and European contexts.

5.5. Summary

Our approach to reviewing the studies connected to the empirical research reported on by the paper and how this framed the aims or purpose of forms of residential care, its identified uses, as well as descriptors and detail provided regarding the reasons and the characteristics of children and young people living in forms of residential care.

Perhaps surprisingly, given debates around different forms of residential care, few papers paid close attention to articulating, assessing or critiquing the form of residential care being studied, and the nature of the use of the form of residential care analysed, including the reasons why children are cared for in residential settings, their circumstances and characteristics.

From our perspective, it appears that much of this detail is assumed rather than specified, which may be less problematic if reviewing research within a specific country where the social and economic context, legislation, policy and cultural norms might be more easily referenced, but it becomes highly problematic when trying to make sense of patterns and differences across regions and countries. Due to the preponderance of research undertaken in North America and Europe, this overview is more likely to capture patterns of use within these contexts rather than other regions of the world, and, notably, its potential in supporting the recovery and rehabilitation of children and young people experiencing social, emotional and behavioural problems arising from their experiences of familial care, neglect, and abuse. It is not possible to determine how this applies globally or with specific reference to any region.

6 What facilitates 'quality' in residential care?

Following on from the exploration of the terminology and definitions used across studies and the analysis of the functions attributed to forms of residential care, this section draws out assessments, observations and recommendations made regarding quality in residential care. As with other sections, we have integrated findings that are drawn from the study of many different forms of residential care, and attempt to use the terminology used within the studies. This creates challenges for generating understanding because the use of terminology is so variable, and given that both 'institutional' and 'residential' are generic descriptors, these are often used without specific reference to the settings being studied.

Few papers set out to explore either what constitutes or enables quality in care as the core topic of study. Some key exceptions include a study that aimed to articulate a framework for assessing quality of care with reference to small group homes (including campus based cottages) in the USA (Farmer et al., 2017) and studies that attempt to draw out an articulation of ways to measure quality of life in the context of comparing forms of alternative care or with reference to 'institutional' care specifically (which appears to be focused on smaller group homes) in Norway (Greger et al., 2016; Jozefiak et al., 2017; Jozefiak & Kayed, 2015).

Many studies did focus upon exploring or assessing factors that relate to how well supported children and young people are, how positively they experience residential care in its different forms, and how this contributes to their growth, development and wellbeing. These findings are presented with reference to what appear to be four critical domains of quality: setting, staffing, safety and treatment (Farmer et al., 2017). Outcomes represents a fifth dimension of quality and is addressed in Section 7.

6.1. Setting

Setting includes attributes of the physical environment that both promote and indicate quality practice. These include basic assessments of cleanliness and conformity to considerations about health and safety (Farmer et al., 2017). In the context of a study on the interactions between affective caregiving and resilience in youth in institutions in Portugal, the nature of the physical and structural space is deemed to have an effect on relationships (Mota et al., 2016).

A Chilean study exploring factors associated with attachment styles in foster care compared with residential care (apparently settings with low child to caregiver ratios) identified environments with appropriate levels of stimulation, including language stimulation, good learning materials, and variety as enabling the development of nurturing relationships and children's engagement in activities in their day-to-day routines (Garcia-Quiroga & Hamilton-Giachritsis, 2017). A systematic review appraising the determinants and outcomes of social climate in therapeutic residential care note the smaller size of a facility, among other structural factors, create more space for a constructive focus on treatment of behavioural issues (Leipoldt et al., 2019). Various studies note the relevance of children and young people experiencing a 'home-like' environment, which is constructed and sustained through attention to both the physical and social aspects of this (Mota et al., 2016; Vejmelka & Sabolic, 2015).

Children's own subjective well-being and satisfaction with their placement in residential care are linked to the size of the setting - the smaller the size, the greater the level of satisfaction, possibly because

they are more similar to a family environment, and therefore offering an experience of daily life comparable to that of the general child population (Llosada-Gistau, Montserrat, et al., 2017).

6.2. Staffing

Staffing is a central domain in literature on deficiencies in residential care, factors associated with positive outcomes, and frameworks for assessing quality. Caregiver affect and behaviour toward children and young people are key dimensions of quality (Farmer et al., 2017). Key indicators seem to be training, supervision, turnover, continuity, and child-caregiver ratios (Farmer et al., 2017; Mota et al., 2016; Garcia-Quiroga & Hamilton-Giachritsis, 2017).

6.2.1 Caregiver affect and behaviour

Children's experience of the relationship with residential carer(s) is fundamental to their growth and development, and is critical to their recovery from prior experiences of attachment, separation and loss, and the detrimental effects of neglectful or abusive parental care (Steels & Simpson, 2017; Wright et al., 2019). Higher quality care is characterised by carer(s) capacity to express warmth, sensitivity, playfulness during routine caregiving activities, such as feeding, bathing, changing, as well as through developmentally appropriate play, handling, positioning and interaction (Chernego et al., 2018). Carer(s) establishment of positive relationships with children depends upon their engagement, sensitivity, affection, and disciplinary style (Garcia-Quiroga & Hamilton-Giachritsis, 2017).

The provision of care within a context driven by risk-aversion can undermine carers' capacity to be physically, psychologically and emotionally available to children (Brown et al., 2018). Specifically, it can disrupt the willingness of carers to use appropriate physical touch essential to children's growth, development and wellbeing, and to work in risk enabling ways that can promote children's learning and access to play and activities.

Assessment of characteristics of the quality of caregiving within 'institutions' suggests that there is a clearer association between attachment disturbances than with emotional/behaviour problems (Oliveira et al., 2015). Yet, there is a suggestion that 'even in the unfavourable environment of an institution' sensitive caregiving may reduce children's attachment-disturbed behaviour; whether less problematic attachment behaviour elicited more sensitive caregiving or sensitive caregivers promoted children's attachment behaviour remains unclear (Oliveira et al., 2015).

Interestingly, there is some indication that in certain cultural contexts children may experience the social support offered by carers within a residential setting more positively than that offered by carers within family settings in the community (Caserta et al., 2017). A Nigerian study also highlights the potential of group care over family based care, to provide for higher quality caregiver-child relationships because residential carers are trained, guided by rules, and are expected to provide care to children (Ushie et al., 2016). This is distinguished from the impact of differential status accorded to birth children within a family home, the use of fostered children as 'domestic workers' within family homes, and a suggestion that societal expectations regarding the success of children can contribute to lower foster carer commitment towards children who may be struggling or exhibiting behaviours deemed unacceptable. A Japanese small scale study was suggestive that in some contexts, residential care may offer increased quality of life due to the constant availability of a group of carers (Nakatomi et al., 2018).

Some note the importance of retaining contact and relationships beyond the time that children live and are cared for within institutions (Vejmelka & Sabolic, 2015).

6.2.2 Selection, training and supervision

The literature illustrates the importance of residential care staff capacity to understand and practice in alignment with a care provider's intended objectives (Mota et al., 2016). Tapping into and testing for carers' underpinning beliefs or world views may help to minimise the use of inappropriate, insensitive approaches to care and discipline (Levy & Reuven, 2017). Seeing change as a continual process may be important (Boel-Studt et al., 2018). There are indications that a strong 'belief in a just world', where 'individuals deserve what they get and get what they deserve', may result in a higher tendency to respond in disciplinary encounters with physical power assertion and love withdrawal and a lower tendency to use induction (Levy & Reuven, 2017).

Studies described the need for training on a range of knowledge and skills, including:

- Contextual understanding of children's rights, the impact of neglect and abuse, child protection legislation and system, the provision of alternative care, and the background to quality, standards and interventions in residential care
- Working with laypersons, carers and professionals to challenge negative social images and perceptions of children and young people living in residential care (Vaz Garrido et al., 2016)
- Exploring and influencing personal values and beliefs that may be in conflict with relational practice with children that is centred on their social, emotional and behavioural needs (Levy & Reuven, 2017)
- Increasing recognition of the elements that make up relationship based practice at the micro level, and challenging the detrimental effect of risk aversion on positive relational practices (Brown et al., 2018)
- Understanding child developmental milestones and the role of carer affect and behaviour in stimulating their achievement (Major, 2018)
- Developing an in depth understanding of attachment, attachment behaviours and the emotional needs of children (Hueche et al., 2019; Vacaru et al., 2018)
- An appreciation of the importance of family origins and ties (Llosada-Gistau, Casas, et al., 2017; Neagu & Sebba, 2019)
- Strengthening understanding and knowledge of trauma and of practices that promote recovery from traumatic experiences (Baker et al., 2018; Rafferty, 2018), and ensuring that organisational supports ensure attention to, and address the effects of, vicarious trauma for staff (Bailey et al., 2019; Baker et al., 2018)
- Assessing and promoting professional self-awareness and self-control is an important aspect to consider for staff training, recruitment, supervision and performance evaluation processes (Major, 2018; Vaz Garrido et al., 2016).
- Using skills in working collaboratively with children and young people, assessment and case planning, crisis management, emotional support and behavioural interventions, engaging children in daily activities and acquisition of life skills (Eenshuistra et al., 2019)
- Introducing mechanisms and strategies that focus on the management and reduction of the use of restraint at an individual and organisational level (Deveau & Leitch, 2015)

Approaches to supervision and wider organisational supports are highlighted as integral to quality of care (Baker et al., 2018; Eenshuistra et al., 2019). This includes the importance of organisational attention to the balance of on-call responsibilities and the provision of adequate vacation or mental health benefits (Baker et al., 2018). Other studies pointed to the importance of understanding and working with the psychological effects of caring for a group of children (Vejmelka & Sabolic, 2015), such as taking account of vicarious trauma (Bailey et al., 2019) and caregiver perceptions of helplessness in the caregiving task, because this can contribute to a reduction in social and cognitive stimuli for children (Barone et al., 2016).

6.2.3 Child-caregiver ratios, staff turnover, and continuity of care

The ratio of children to caregivers is a structural component that is fundamental to a child's access to appropriate care; that is care where an adult is physically, psychologically, and emotionally present and responsive to a child's developmental needs (Mota et al., 2016; Garcia-Quiroga & Hamilton-Giachritsis, 2017). The number of children each caregiver has under her care seems to be crucial, with larger groups of children experiencing difficulties in establishing a secure attachment, while smaller groups facilitate security (Batki, 2018; Chernego et al., 2018; Garcia-Quiroga et al., 2017; Rafferty, 2018; Sánchez-Reyes et al., 2019). Psychological literature emphasises that the presence of a more selective caregiver-child relationship reduces the risk of inhibited attachment disordered behaviour (Corval et al., 2017).

There is recognition that this is inherently difficult to enable within the context of group care, where, by definition, multiple carers are responsible for multiple children. Research suggests, potentially linked to 'burnout', that carers themselves may avoid forming attachments with the children they are caring for (Garcia-Quiroga et al., 2017), and staff turnover disrupts continuity of relationships for children (Bailey et al., 2019; Mota et al., 2016). On the latter point, studies point to the implementation of organisation wide approaches to trauma informed care as a mechanism to prevent staff 'burnout' and reduce turnover (Bailey et al., 2019). These models incorporate a range of therapeutic techniques, and provide an overarching approach and common language employed across all levels of the organisation. While the evidence base is low, there is preliminary support for the efficacy of organisation wide, trauma informed care models in out of home care (Bailey et al., 2019).

Continuity of care setting is important for children's relationships with their caregivers, their peers within the home, with wider friendships and relationships in school and the local community (Llosada-Gistau, Montserrat, et al., 2017; Mota et al., 2016). Some argue for structural changes within the organisation of the child welfare system and in improving legislation so that disruptions in placements and relationships is minimised (Jozefiak et al., 2017). In promoting stability of caregiving, a study of foster care compared with small group homes in Chile recommends: the reduction of child:caregiver ratios; a shift system that reduces the number of different caregivers in a week period; using a key person system; improving the end of placement process with time for preparing for separation; revisiting the age-based organisation of residential care with a 'graduation' system; and using flexible time frames according to a child's needs (Garcia-Quiroga et al., 2017).

6.3. Safety

Safety is particularly prominent in literature on inadequacies of residential care (Farmer et al., 2017). Across existing sources, there is a sense that assessments of quality must include youth's own assessments of the setting's safety, and that safety relates to rules and structures, discipline, and addressing fears of abuse by staff or other youth.

6.3.1. Child and young person led assessments

A positive social climate must constantly be evaluated and (re)created based on combining the perspectives of residents, staff and external perspectives (Leipoldt et al., 2019). A number of studies drew attention to using approaches and tools to engage children and young people in assessing quality of care, quality of life, or their own wellbeing (Gander et al., 2019; Llosada-Gistau, Casas, et al., 2017; Swerts et al., 2019). Some advocate that this can aid organisations to move beyond a deficit-oriented and socially desirable outcomes, to be grounded in the subjective experience of children (Swerts et al., 2019).

One study explored the engagement of children in offering perspectives in audits and inspections, and there is some indication of the need to promote active listening to children's views and perspectives in this regard (Palsson, 2017). Involving children and young people in collaborative planning can also strengthen approaches to managing or mitigating risks. For example, integrating young people's perspectives on how carers can prevent and contain the use of self-harm strategies could strengthen practice. The strategies that young people proposed include: collaborative planning, discrete and sensitive use of observations, being discerning in the removal and substitution of belongings used to harm, providing and facilitating access to positive emotional support, and the increased availability of care staff to minimise the disruption to other young people with whom they are living (Johnson et al., 2017).

6.3.2. Rules and structures that promote safety

A key task for residential care is to establish rules and structures that can promote and sustain a positive climate within a group context. This requires the capacity to take account of group dynamics between carers, between carers and children, and between children. Tensions were found between the needs of children expressing emotions (i.e., challenging behaviour) and the safety of other children. Negative experiences such as disruptive behaviour in the residential group and inadequate direct support and staff attitudes cause tension and may reduce a sense of personal safety, which in turn can negatively affect well-being. It is, therefore, pivotal that organisations invest in ways to establish positive group climates and to ensure that staff members build positive relationships (Swerts et al., 2019).

Dealing with difficult emotions appeared to improve where children and young people learned new strategies (e.g., talking and thinking about their emotions) (Steels & Simpson, 2017). Factors that contribute to a positive climate include: taking a strengths-based approach; open units; quality and experience of staff; intensive, structured, and less emotionally charged treatment programme with varied activities and a daily routine; active monitoring of programme implementation, improving safety protocols with proper incident investigation, and integrating non-clinical staff members with protocols; having supervision protocols for staff members, continuous staff training, measures to prevent burnout, and clinical leadership; and small group size (Leipoldt et al., 2019).

6.3.3. Discipline that is fair and not excessive

Carers' approaches to boundaries, discipline and punishment is another domain important to quality of care (Steels & Simpson, 2017). Emphasis is placed on positive educational practices (i.e., support, understanding, respect, and boundaries) (Mota et al., 2016). Some draw attention to specific programmatic approaches in this regard, with, for example, the core defining features of Positive Behaviour Support (environmental alterations, skills teaching, community access, and self-sufficiency) identified as aiding practice with children who exhibit challenging behaviours in a residential setting (Grey et al., 2018). Some describe carer behaviours critical to the effectiveness of a behavioural model

– for example, the importance of the carer 'finding the child being good' and the adherence to specified ratios of four-to-one for the use of positive reinforcement through praise to behavioural correction (Hurley et al., 2017). Attention is also drawn to the importance of providers making shifts in structural or policy barriers that can undermine positive behaviour supports to the unique needs of children who display challenging behaviours (Grey et al., 2018).

6.3.4. Fears of abuse by caregivers or peers

One systematic review focusing specifically on the study of large scale institutions points to the relatively high risk of abuse within institutions, however it was defined (including physical and sexual abuse), and suggests that adolescents exposed to large scale institutional care were significantly more at risk of physical abuse than those in foster care or the general population (where comparisons were available). The data suggests that younger children are more at risk of abuse and boys are more at risk of harsh punishments. The review did not identify or report on factors that may contribute to increase abuse, although studies that looked at interventions found that close attention to caregiver training and support could result in a reduction in this violence (Sherr et al., 2017).

6.4. Treatment

There is some consensus that 'treatment' is a complex, essential ingredient of a quality residential program for children and young people with emotional, behavioural, or psychiatric problems (Farmer et al., 2017). Studies highlighted that children are likely to have experienced a range of adversities prior to entry to care, including experiences of neglect and abuse, separation and loss of their parents, uncertainty and instability in continuity of care from others with changes in carers and/or care placements. Emphasis is placed on the critical need for effective therapeutic care, psychological support or treatment to enable children to modify the internalising and externalising behaviours they have developed as a result of their experiences, in order to strengthen their potential to experience positive relationships and opportunities in their childhood and adulthood (Baptista et al., 2017; Wright et al., 2019).

Farmer et al argue that on the basis of "critiques of residential care, analyses of key ingredients, and classic and expanded frameworks for assessing quality, treatment is the centerpiece of what makes a quality program (or raises serious concerns about low- quality ones)" (Farmer et al., 2017, p. 30). Looking across this literature, indicators that may distinguish quality include: using an identifiable treatment approach/programme; sufficient structure, routines, and predictability; a focus on positive growth and development; and well-functioning linkages between the residential setting and external supports/individuals (Farmer et al., 2017). Many of the studies reviewed echo these assertions and each is discussed respectively in the following subsections.

6.4.1 Utilising an identifiable treatment approach/programme

Studies argue for the expansion of evidence-informed or evidence-based treatment options (Gander et al., 2019; Oliveira et al., 2015). For example, some studies explore and propose the use of and adherence to specific models. Use of the Attachment Regulation and Competency framework in residential care was found to be associated with a reduction in post-traumatic stress symptomology, with a reduction in both externalising and internalising behaviours and the use of restraint (Bailey et al., 2019). Integrative Therapy for Attachment and Behaviour also has potential (Vacaru et al., 2018). Incentive based programmes were found to influence youth engagement and attainment of treatment goals while in residential care (Boel-Studt et al., 2018).

Studies also focus on exploring how children can access support through their day- to- day caregiving relationships and experiences. This includes describing and evaluating models for practice, and defining core components of care that can be successfully embedded within the collective day-to-day practice of a staff group (Cameron & Das, 2019; Hurley et al., 2017).

Examples include articulating the underpinning knowledge required by carers and their capacities to orient their practice with reference to underpinning values, principles and philosophies for care, such as being optimistic, strengths-based, trauma-informed and collaborative in case planning with children and young people. Intervention programmes promoting positive caregiver-child relationships in institutions, and sustaining professional caregivers faced with a challenging role daily, would help limit the damage to the attachment and cognitive domains in institutionalised children (Barone et al., 2016). Studies highlight the importance of conceptualisation and measurement of therapeutic alliance to explore what it takes to build relationships that enable therapeutic care and recovery, and how these are experienced by children and young people (Boel-Studt et al., 2018; Hurley et al., 2017; Strijbosch et al., 2018).

Studies also draw attention to the place and contribution of targeted interventions for children (Bunea et al., 2017; Vacaru et al., 2018; Wright et al., 2019), especially those who have been subject to trafficking and sexual exploitation (Rafferty, 2018). They argue for provision to occur as part of developing specialised centres or through staff composition including therapists, psychologists or psychiatrists (Leloux-Opmeer et al., 2017; Oliveira et al., 2015). Some advocate for increased access to psychiatric diagnostic assessment and therapy (Jozefiak & Kayed, 2015; Rafferty, 2018), the regular use of psychological screening tools, particularly on admission into residential care and during the process of psychological assessment (Oliveira et al., 2015), and access to intensive (group and individual) counselling (Leloux-Opmeer et al., 2017).

Some identify the potential for liaison services to be established that combine institutionalised care with evidence based psychotherapeutic interventions, to ensure the removal of barriers to treatment and the reduction of institutional care stigma. Those services require structure, adequate resources, and financial support so children can receive the treatment they need and reduce in-patient treatment stays in child and adolescent psychiatric departments (Gander et al., 2019). Overcoming barriers to cost of individualised therapeutic treatment is fundamental to addressing impediments to appropriate support for immediate and longer term mental health (Oliveira et al., 2015; Rafferty, 2018).

6.4.2 Sufficient structure, routines, and predictability

The implementation of personal daily routines, meals, schedules and rules allows for the creation of internal structure and the recreation of the family environment (Mota et al., 2016). The use of routines, rules and boundaries help children develop trust and lead to a reduction in experiences of uncertainty and challenging behaviours (Steels & Simpson, 2017; Swerts et al., 2019). Positive and successful experiences in daily activities contribute to growth of self-esteem and sense of agency, and this in turn is fundamental to children's emotional wellbeing and capacity to access relationships and other opportunities (Batki, 2018; Jozefiak & Kayed, 2015; Orúzár et al., 2019; Swerts et al., 2019). Children with existing mental health issues benefitted from structure, routine and role models, which were significant in helping reduce self-destructiveness. (Steels & Simpson, 2017).

6.4.3 A focus on positive growth and development

Attention to children's choice, agency and rights for participation is highlighted as being integral to

subjective wellbeing (Hueche et al., 2019; Llosada-Gistau, Casas, et al., 2017). Emphasis is placed on the need for intentional efforts to develop traits that aid a child's development of strength, resilience and autonomy, such as fostering self- efficiency, self-esteem, an internal locus of control, optimism, planning abilities, and determination through access to a diversity of social opportunities (Bunea et al., 2017). Young people's perspectives on what enables them to cope and build resilience suggests that the usage of multiple individual strategies and social support can create opportunities to nurture 'resilience strings'.

That is, where an improvement in one area has a positive knock-on effect in another (e.g. taking up sport resulting in increased self- esteem) (Sanchez-Reyes et al, 2019). Conditions for successful adaptation need to be created because this does not occur automatically. The provision or creation of opportunities and resources for cultural, physical and other kinds of self-realisation can help children and young people implement other strategies such as abreaction, compensation or building up independence (Luksík, 2018). Young people themselves highlight the importance of recognising and enabling their realisation of normative goals in adolescence and young adult life, such as good friendships, education and learning, training and employment (Swerts et al., 2019).

6.4.4. Well-functioning linkages between the residential setting and external supports/individuals

Studies draw attention to the importance of caregivers' emotional support of children and young people to strengthen their interpersonal relationships, their connections to their community, and their life expectations (Orúzar et al., 2019; Swerts et al., 2019). Studies point to the importance of this while being cared for and for children's later transition into independence.

Carer attention to children's capacity and opportunity to form friendships and positive interactions with peers is identified as critical to self-esteem and quality of life, in particular during adolescence when peers represent a significant influence on normative development (Hueche et al., 2019; Jozefiak & Kaye, 2015; Lino et al., 2016; Steels & Simpson, 2017; Swerts et al., 2019).

Similarly, close attention to children's knowledge of, and relationships with, their families of origin is critical to children's identity, wellbeing and mental health (Neagu & Sebba, 2019). The approach taken to enabling direct contact can be significant for children's attachment behaviours, with recommendations for ensuring that relationships function positively and support for more meaningful parent-child interactions (e.g. this occurs within natural family daily routines and activities rather than in artificial, family-unfriendly and frequently over-controlled institutional context for family visits) (Corval et al., 2017).

Access to health care and education, including support for learning, are noted (Llosada- Gistau, Casas, et al., 2017; Steels & Simpson, 2017; Vejmelka & Sabolic, 2015). Being able to access activities and resources that are normative, such as having access and use of a computer, are highlighted as important to children (Llosada-Gistau, Casas, et al., 2017).

There is some indication that individualised attention to cultural beliefs and spirituality may incur benefits for children dealing with bereavement and their transition into residential care - in particular, for children who are living in residential care in South Asian and African countries as compared with their counterparts living in residential care in USA, Canada, European and Russian contexts (Pandya, 2018).

6.5. Summary

The studies incorporated in this review rarely set out to discuss quality of care as a primary objective. Issues related to quality and factors that enable it were nonetheless discussed in about half of the studies analysed. These have been integrated in our review across the four critical domains of setting, staffing, safety, and treatment. While these areas are relevant for all types of alternative care, our analysis focused on how they can determine the provision of high quality care within residential care options. The added value of considering these key areas is that they provide an opportunity to further explore elements that are relevant both to research, as well as to debates on policy and practice. An additional, fundamental aspects that is closely connected to quality of care is that of outcomes, which is addressed separately in the next section of this report.

The nature, structure and size of care settings feature prominently in policy debates on the quality and role of residential care. The evidence presented shows that the most important aspects in this domain in ensuring high quality care are those related to the environment: quality care is provided in settings that are familial, home-like, affording opportunities for connection, stimulating practices, and activities. Elements such as routines and clear structures also contribute to the recreation of a family environment, all of which contributes to an experience of daily life that is similar to that of children who are not in alternative care. The opportunity for children to maintain established connections, including contacts with friends, attending the same school, and having continued access to other services and opportunities within the community are equally essential.

In order to consider meaningfully the ways in which residential care can provide high quality support, and the role it can play in meeting children's needs and promote their rights, however, it is important to move beyond elements relating to size and structure of the setting, and focus on relationships and interactions. These aspects, analysed primarily in the domains of staffing and safety, help to determine how care can ensure the best quality of support and outcomes for children.

Caregivers play a pivotal role from the moment of placement, in providing information to children, creating opportunities for participation, and ensuring they receive emotional support. The relationship they establish with children is essential, as it has a direct impact on children's well-being and development, including emotional development. The quality of these relationship is directly affected by a number of variables that are closely related to training and support available for caregivers, as well as to overall working conditions. Appropriate care is ensured through stable relationships based on trust, characterised by continuity, and lack of disruptions. Caregivers need to be physically and emotionally available for children, something that can be successfully achieved when training, support, and supervision are available at the organisational level. A low child to caregiver ratio, or a key worker system, for example, are other key determinants of success in this respect, as strong and stable relationships are easier to form and maintain when caregivers are directly responsible for a smaller number of children.

Residential care fulfils an important role in the broad child protection system since it can provide specialised care for a variety of specific, severe, or complex needs. These range from children with severe behavioural needs or mental health issues, to support recovery and rehabilitation, and providing stability following placement breakdown. These aspects were considered in the context of treatment, an essential ingredient at the heart of a quality care programme. Evidence shows that this effective, therapeutic care can be provided within organisations offering clear personal daily routines, structures and schedules allowing for the recreation of a family environment, and the development of positive relationships based on trust. It is equally ensured by trained, specialised staff working within multidisciplinary teams on the basis of positive educational practices that focus on growth and

development and use an identifiable and structured evidence- informed treatment approach or programme. As noted previously, children who are looked after in residential care settings have often gone through traumatic experiences, and while outcomes are an important consideration when discussing and assessing quality of care, it is important these are assessed in the context of the impact of the experiences that led them into alternative care in the first place.

7 What effect does residential care have upon outcomes for children and young people?

Of the papers to be included in the study following full text review, three quarters contained information relating to outcomes that was highlighted by reviewers as relevant to the research questions. In this Chapter, the findings from these papers in relation to outcomes for children and young people have been presented in thematic groups.

7.1. Outcomes from the child or young person's perspective

These papers presented information that related to the outcomes perceived by children and young people in residential (or institutional) care. A portion of papers presented evidence from the perspective of children and young people, these were in the form of either Quality of Life questionnaires, other self-rated scales, qualitative responses, and a systematic review.

Where the studies compared quality of life for youth in residential care to youth in other placements, most that youth in residential care reported lower quality of life than those in traditional family settings (Jozefiak et al., 2017; Jozefiak & Kayed, 2015; Nakatomi et al., 2018). However Gander et al. (2019) found that youth themselves rated their quality of life similarly to youth in their own families, while caregivers rated young people's quality of life lower.

Perceived social support and positive relationships were found to have positive impacts on quality of life and wellbeing respectively (Llosada-Gistau, Montserrat, et al., 2017; Yendork & Somhlaba, 2016). Self-esteem and perceptions of physical appearance were also found to be supportive (Johnson et al., 2017), while Greger et al. (2016) found that exposure to additional types of adversity had a dose-response relationship with negative quality of life.

Other papers found higher perceived conflict and self-blame among youth in residential care (López-Larrosa et al., 2019), while low self-esteem was found to be both prevalent, and a negative impact on quality of life among youth in residential care (Jozefiak et al., 2017; Jozefiak & Kayed, 2015). Orúzar et al. (2019) looked at subjective wellbeing, and highlighted the strong connection between self-reported wellbeing and day to day activities.

7.2. Observed behavioural outcomes

Several studies looked at observed behaviour as an outcome measure. Two of these came from the Bucharest Early Intervention Project and are discussed later in this chapter, while half of the remaining studies looked at the impact of residential care (often framed as institutional care) on the behaviour of children and young people either within, or having left, residential settings. Most of these studies report negative behavioural outcomes, including less activity and lower pleasure responses in institutionally reared infants (MacKenzie et al., 2017), greater distress or anxiety (MacKenzie et al., 2017), greater externalizing behaviour problems (Nsabimana et al., 2019), and poorer social interactions (Mota et al., 2016). However, one study found contradictory evidence that 'institutionally reared' children have less reported behavioural and socio-emotional problems than fostered children (Perry et al., 2019), and

another found no evidence of impact of care setting on behavioural outcomes (Finet et al., 2018). All of these papers were rated strong methodologically.

Other studies looked at interventions aimed at improving behavioural outcomes. Schuurmans (2018) highlighted a meta-analysis that found implementing evidence informed or based models of treatment significantly reduced behaviour problems compared to 'standard' care (De Swart, 2012, in Schuurmans et al., 2018), a finding supported in the literature in this review (Farmer et al., 2017). The interventions generally included elements of structural changes, and changes to staff behaviour to improve engagement with children and youth in residential settings. One study compared a non-residential intervention for youth with residential settings, and found that while there were few differences in initial outcomes, non-residential settings retained benefits in substance abuse and behaviour for longer (Liddle et al., 2018). Van den Tillaart (2018) found that there was a relationship between group climate and aggressive incidents, but could not indicate any causality between the two.

Kopetz et al (2019) found that 'institutionalisation' early in life leads to lower risk-taking behaviours at age 12, and Nsabimana et al (2019) found that youth in residential care with one or more living parents exhibited greater externalising behaviour than those with no living parents. Farmer (2017) found that children's residential homes that prohibited restraint, showed better long-term (post-discharge) outcomes as assessed by the Strengths and Difficulties Questionnaire (Bourdon et al., 2005) than those that did not. In support of this, Boel Stude et al. (2018) found positive responses to incentive programmes in engaging with therapeutic activities.

7.3. Outcomes persisting into adulthood

A number of papers highlighted the ongoing impact of residential or institutional care into adulthood. The contexts in which these studies were conducted varied significantly. Two papers in particular examined the long-term impact of residential schools in Canada set up to promote the 'cultural assimilation' of indigenous populations (Gray & Cote, 2019; Ross et al., 2015), while others looked at various outcome measures in individuals who had experienced residential care.

Kennedy et al (2016) found that high rates of Attention Deficit Hyperactive Disorder (ADHD) found in children and youth in residential settings persist into young adulthood. While another study highlighted the impact on relationships in adulthood, noting that entering care older (five or above), or with siblings, was associated with a stronger sense of agency (Neagu & Sebba, 2019). Lueger-Schuster et al (2018) found that maltreatment in group foster care settings varied in its impact into adulthood not only in a dose- response type relationship, but also qualitatively, with sexual abuse within such institutions predicting adult psychopathology with greater predictive power than other events.

Grant & Rushton (2018) found no relationship between the duration of residential care, or age at exit from residential care, and adversity in later life, among a group of children adopted to the UK from Chinese orphanages.

The two papers looking at the impact of residential schools in Canada highlighted the negative impact on these individuals in adulthood (with greater risk of alcohol problems, Ross et al., 2015), and also the impact on a second generation who experience higher rates of depression, substance abuse and suicide attempts (Gray & Cote, 2019). These results, however, are rooted in an environment which is recognised as being deliberately damaging to children and young people, in an attempt to force them into conformity with western norms and away from their indigenous culture.

Melkman and Benbenishty (2018), while not relating their results to young people's experiences in residential settings, found that the majority of youth 'aging out of care' have satisfactory levels of support. Similarly, Nho et al. (2017) identified that both social support factors and individual factors were important to 'success' stories of transitions from out of home care.

7.4. Socio-emotional outcomes

A large number of papers looked at the socio-emotional outcomes of residential care. Several of these studies had a specific focus on attachment styles and theory (Bowlby et al., 1989). Many of these evidenced a negative impact of residential environments on attachment styles compared to family environments (Barone et al., 2016; Garcia-Quiroga & Hamilton-Giachritsis, 2017; Vacaru et al., 2018), evidencing more insecure, disorganised attachments, and higher rates of indiscriminate friendliness. One study found no significant differences between populations (Garcia-Quiroga et al., 2017, although those in residential care did score lower on security and higher on disorganisation and indiscriminate friendliness than the parental care comparator group), and another demonstrated that among an institutionalised group, those who have experienced maltreatment are more likely to have poor attachment styles (Suzuki & Tomoda, 2015).

The remaining papers evidenced positive or neutral benefits of residential settings. In Wendt et al (2019), it was found that youth in residential settings had higher negative affect and stressful events frequency, but also higher life satisfaction concerning friendship and non-violence compared to those living with their families. They conclude that '...although it might not be the most desirable solution, it [institutionalisation] can be successful in removing the children from negative influences of the family environment.' (Wendt et al., 2019, p. 38). Other studies found that the negative impacts attributed to residential care may be due to difficulties and experiences prior to admission (Baptista et al., 2018; Suzuki & Tomoda, 2015). Perry et al (2019) found lower rates of socio-emotional and behavioural problems among institutionally reared children compared to fostered children, although the former group displayed greater fear and less positive affect.

The remaining papers evidenced negative impacts of residential care on the socio-emotional wellbeing of children and young people.

The findings varied from less developed emotional regulation (Batki, 2018), experiencing greater stress in close relationships (Perego et al., 2016), and negative impacts on personality and identity (Jaramillo et al., 2016). When children who have been victims of violence and maltreatment are matched between residential and non-residential settings, those in residential settings have lower outcomes on a variety of cognitive, intellectual and emotional outcomes (Deambrosio et al., 2017).

However, Leloux-Opmeer et al (2017) found that the percentage of foster children that experience physical or emotional neglect was almost double that of children in 'family style group' or residential care settings.

Sherr et al. (2017) conducted a systematic review of 43 studies reporting on social and behavioural development of children in institutional care, provided in "large institutions dedicated to care for children with employed staff" (and so looking at 'institutions' as defined within the UN Guidelines). They found that of these 43 studies, 41 evidenced detrimental effects.

7.5. Psychological and psycho-social outcomes

The psychological or psycho-social outcomes of residential care for children and young people were often studied. Approximately half of these studies were a result of the Bucharest Early Intervention Project (BEIP), and the findings of this study are presented separately (see section 7.10).

Of the remaining studies, all but one evidenced negative psychological or psycho-social outcomes for children and youth in residential care, while one (Bunea et al., 2017) evidenced that some personality traits (self-sufficiency, autonomy, planning, internal locus of control and determination, optimism and sociability) can be 'protective' for children in institutional care. The negative psychological or psycho-social outcomes highlighted by the remaining studies include higher ADHD rates for 'high deprivation' groups (Kennedy et al., 2016), lower verbal reasoning and attention compared to family reared children (Barone et al., 2016), lower phonological awareness, nonverbal reasoning, picture vocabulary, kindergarten readiness and pseudo-word decoding (Rakhlin et al., 2017), higher frequency of mental health problems (Rodrigues et al., 2019), and lower cognitive, intellectual, and emotional functions than non- institutionalised children (Deambrosio et al., 2017).

While these individual studies are challenging to generalise from, due to differing methods, contexts, and outcome measures, the systematic review conducted by Sherr et al. (2017) highlighted that of the 45 studies they found looking at cognitive outcomes for children and youth in institutional care, 42 found a cognitive deficit, leading to their statement that "[t]he existing and this updated systematic review clearly demonstrate cognitive delay in children reared in institutionalised settings." (Sherr et al., 2017, p. 49).

Counter to common perception, a Portuguese study (Rodrigues et al., 2019) found that children in smaller residential settings showed more clinical/abnormal, or borderline scores. They report that this is due to the most challenging cases being referred to the smaller centres due to the high quality of care.

7.6 Biomedical outcomes

A small number of primary studies looked at biomedical outcomes from residential or institutional care (Chernego et al., 2018; Perego et al., 2016; Perry et al., 2019; Slopen et al., 2019). Slopen et al.'s (2019) study came from the BEIP and is considered elsewhere, while Chernego and Perry both considered cortisol production, and produced contradictory evidence.

Chernego et al. (2019) found that institutional children had a less pronounced downward slope pattern of cortisol production, with higher evening cortisol levels compared to a family group, while Perry et al. (2019) found that children raised in an institutional environment had a steeper, more typical, downward cortisol slope through the day from wake-up to sleep than a family raised group matched for maltreatment. Perry et al. were able to match their cortisol slope findings to behavioural outcomes (see section 7.2).

Perego et al. (2016) meanwhile, found that adverse early experience (which included institutionalisation from birth) can cause 'aberrant' brain development and functioning, which they liken to post-traumatic stress disorder, which has a range of negative socio- emotional outcomes (see section 7.4).

7.7 Placement duration / change impacts on outcomes

Several studies addressed the impact of residential placement duration or changes in placement on outcomes for children and young people. Of these half were from the BEIP, and the results are presented elsewhere. Of the remaining studies, Finet et al (2018, 2019) looked at changes in placement, and found that institutional care prior to adoption did not place girls at an increased risk for less optimal behavioural adjustment in early and middle childhood (Finet et al., 2018), and that differences in intellectual functioning pre-adoption between institutionalised and foster children were eliminated nine years post-adoption, at age 10.

Lino et al (Lino et al., 2016) and Rakhlin et al (Rakhlin et al., 2017) both looked at the impact of length of stay in residential care on outcomes. Lino et al found that there was variation between individuals, with boys with higher cognitive dysregulation benefited from longer stays in residential care in the form of greater communication, trust, and perception of attachment to peers. In contrast, Rakhlin et al (2017) found that there were no outcome psychosocial measures significantly correlated with length of stay in residential care. Baptista et al. (2017) also found no evidence of associations between ADHD symptoms and age at placement or length of time in institutional care. However, Rakhlin et al (2017) did find significant impacts of age at entry to institutional care and that once this was taken into account, length of time in institutional care had a moderate (negative) effect. Conversely, when looking at self-described residential placements, Talaslampi et al (2019) found that neither the length of residential placement nor the age at first out of home placement predicted educational outcomes.

7.8 Specific intervention evaluation

The remainder of the studies highlighted the efficacy or otherwise of specific programmes of care or service provision within residential care services (Cameron & Das, 2019; Cox et al., 2018; Green et al., 2017; Grey et al., 2018; Liddle et al., 2018; Marvin et al., 2017; Sinclair et al., 2016). These generally had outcome measures attached, such as attendance at therapy sessions, or changes in behaviour or knowledge. In each case, positive outcomes were found of the intervention in question. However, no two studies examined the same intervention, and the systematic review of institution-wide trauma informed care models by Bailey et al. (2019) noted that although the outcomes overall were positive, many studies were methodologically weak and were at risk of bias.

7.9 Care and outcomes

Little work has been done which links the quality of care provided to children and young people, and the outcomes that it produces. A meta-analysis conducted prior to the timeframe of this review highlighted that evidence based outcomes have positive impacts on behaviours (De Swart, 2012, in Schuurmans et al., 2018). In the literature included in the review, Corval et al (2017) report that the existence of a selective relationship with a caregiver is linked to a reduction in Inhibitive Attachment Disordered Behaviours.

Chernego et al (Chernego et al., 2018) found that implementing training and structural changes to the care environment improved outcomes for children in the first two years of life. While Hermenau et al. (2017) found a similar link between such changes and children's emotional, social, and cognitive development. Orúzar et al. (2019) also explicated the link between care and self-reported wellbeing of young people, highlighting the importance of attending to the environment and activities available to young people.

7.10 The Bucharest Early Intervention Project

Of the papers to consider outcomes for children and young people of residential care, many came from the Bucharest Early Intervention Project (BEIP) (Almas et al., 2015, 2016; Bick et al., 2017; Humphreys et al., 2015, 2018; Mota et al., 2017; Slopen et al., 2019; Troller-Renfree et al., 2015, 2016, 2018; Wade et al., 2018). Due to the large scale of this project, the particular context in which it took place, and its prevalence within the literature relating to outcomes, the findings to come from this study are discussed here, separated from the more generalised findings.

The BEIP is a large scale, Randomised Control Trial (RCT) of children and young people who were resident in Romanian orphanages in 2001. RCTs are the 'gold standard' of research methodologies due to their lack of potential bias'. Children in the BEIP were randomised into either the 'Care As Usual Group' (CAUG) (the group who remained in institutional care), or 'High Quality Foster Care Group' (FCG), and a comparison group of non-institutionally raised children were matched by age and gender. Measures were taken at the point of allocation, and the children were followed up at ages eight (2009), twelve (2013), and 16 (2017).

The papers that talked to outcomes from the BEIP looked at a range of different measures, including IQ (Almas et al., 2016), callous-unemotional traits (Humphreys et al., 2015), adaptive functioning (Humphreys et al., 2018), biological measures such as BMI (Slopen et al., 2019), emotional face recognition (Bick et al., 2017; Troller-Renfree et al., 2015), general psychopathology (Mota et al., 2017; Troller-Renfree et al., 2018; Wade et al., 2018), social interactions with peers (Almas et al., 2015), as well as cognitive processing speed and behaviour (Troller-Renfree et al., 2016).

The findings from the BEIP in relation to outcomes for children and young people who are cared for in institutional settings include:

- No biological differences between children who were raised in institutional environments and those in the comparison group who had never been cared for in an institutional environment, nor with those who had been randomised to high quality fostercare.
- Lower IQ scores for both FCG and CAUG as compared to the comparison group.
- Higher levels of callous-unemotional traits among children who experienced any institutional

care as opposed to the comparison group. Those randomised to the FCG had significantly lower levels of these traits compared to the CAUG. These differences were mediated by caregiver responsiveness to distress in boys.

- Children in the FCG were more likely to display adaptive functioning than those in the CAUG, with those placed into the FCG prior to age 20 months more likely to display adaptive functioning than those placed aged 20+ months.
- Slight developmental delay in processing of fearful faces in the CAUG compared to the comparison and FCG.
- Higher psychopathology among those in CAUG and the FCG compared to the comparison group at ages 8, 12, and 16. The FCG had significantly lower psychopathology than the CAUG at age 16. Particularly high rates of attention problems, poor self-regulation, attachment disorders and anxiety are noted among those who experienced institutional care.
- Children who experienced institutional care had reduced cognitive processing speed compared to the comparison group.

Together, the studies demonstrate that while institutional care can result in significant detriment in a wide range of domains, moving to high quality foster care placements can go a long way to mitigating or entirely reversing these detriments. Throughout the studies, it is demonstrated that being removed from institutional care and placed in a foster care environment reduced the prevalence of psychiatric disorders, and promoted healthy brain and socio-emotional development.

While the results of the BEIP are generally clear, it is important to note the context in which the study was conducted, with Romanian orphanages being characterised as offering extremely basic care, with high child to caregiver ratios, minimal personalisation of experience, and ‘severe psychosocial deprivation’ (Almas et al., 2016, p. 1859). In contrast, the foster care is described as ‘high-quality’ and “grounded in the findings from developmental research on enhancing caregiving quality. Importantly, a child-centred approach was emphasised, encouraging foster parents to meet the child’s physical and psychological needs” (Humphreys et al., 2015, p. 4).

7.11 Summary

A large volume of research that returned through the structured database searches had at least a partial focus on the outcomes of residential childcare for children and young people. These papers have a focus on the psychological, social, and emotional outcomes for children and young people, with a reliance on a wide range of standardised measures. There is a particular, and understandable, focus on attachment, with many papers focusing or touching upon this critical element of development for children and young people. These papers highlight that children and young people in institutional care, and to some extent residential care, differ from the general population in their attachment styles (having in general more disorganised, or insecure attachments), and highlight that family based care is effective in reducing some of these differences.

It is, however, clear from papers that focus on large residential care facilities (institutions) that children and young people in institutional care are at a disadvantage compared to their peers in family environments on a variety of measures. Due to the nature of the research conducted, there is no clarity in relation to issues of causality, i.e. whether this disadvantage is the *result* of institutional care, or a symptom of experiences prior to admission. However, both the wealth of evidence from the BEIP

(using a strong RCT methodology), and more piecemeal evidence from other comparative studies, indicate that children and young people who are either initially placed, or subsequently move to, family based environments are able to match children who were never removed from the home, and make up ground on disadvantages they may have experienced upon placement.

There is also a large volume of less conclusive evidence that children in residential care are disadvantaged compared to their peers. It is not possible to draw clear conclusions on the outcomes of residential care for children and young people from the literature reviewed. This is due to a combination of the use of different methodologies, different measures, with different populations, in different care settings, in different cultural and socio-economic environments.

Despite the volume of evidence presented here, there remain significant gaps in the research literature around outcomes which was returned from the searches within this study. The clearest of these is the lack of research looking specifically at the experiences of children and young people within, or with experience of, residential facilities. In particular, studies which allow the young people themselves to highlight the outcomes that they feel residential care has provided for them, and the components of care which they felt facilitated, or inhibited, positive outcomes. Another major deficit in the research presented here is in the longer term social and emotional outcomes for children and young people who have experienced residential care, as well as the lack of high-quality studies which examine which children or young people benefit the most from different types of residential settings.

The focus on the psychological and biomedical elements of development highlight a theme that runs throughout much of the outcomes literature: deficit and disadvantage. As Wright et al (2019) describe, this deficit focus risks overlooking the benefits that residential care can have for some children and young people, in some contexts (see also Steels & Simpson, 2017). Combined with a large volume of the literature coming from large-scale institutional settings, it risks overlooking the benefits that may be conferred on children and young people by small-scale, individualised residential care.

Finally, it is worth highlighting that the BEIP has had a significant impact on understanding of institutional care on children and young people. However, the impact of the BEIP (and other studies) has been such that expectations of residential care are significantly different from the environment experienced by the children and young people involved in the BEIP. While it is understandably frequently cited in other papers in this review, its findings are limited to the impacts of the environment in which it took place, just as the majority of studies presented here are. Presenting, understanding, and highlighting these differences is a critical element of generating a rounded understanding of the impacts of institutional and residential care on children and young people.

8 Concluding observations

This review has been carried out to access and analyse the evidence available on residential care for children and young people from across the world, to understand the purpose that this care model offers within child protection and alternative care delivery systems, and what needs it responds to. The review also aims to shed light on the quality features of residential care in the form of smaller residential settings, as opposed to large residential care facilities (institutions), which is unsuitable for children and must be phased out through comprehensive deinstitutionalisation strategies (Cantwell et al., 2012; United Nations General Assembly, 2009, 2019).

In the following Chapter, we reflect on the themes emerging from the rapid evidence review with reference to the specific objectives identified by SOS Children's Villages:

1. To identify issues around the use of terminology within the literature on residential care
2. To obtain an overview of existing research regarding residential care, and the insights this brings in terms of the care needs that residential care responds to, the effects on the well-being of children/youth, and its role within the range of care options
3. To gain insight into the discourse within the body of research, and the evidence- base for divergent conclusions
4. To provide an account of what the evidence indicates to inform policy debates and policy formulation
5. To provide an account of what the evidence indicates to aid the design, development and improvement of residential care for children and young people across regions of the world
6. To identify gaps in existing research

Throughout these sections, we link the findings and issues raised to the global policy context, in particular the UN Guidelines for the Alternative Care of Children.

8.1 Terminology within the literature

This rapid evidence review focused on gathering literature which examined aspects of residential care. In order to ensure that we gathered as many relevant papers as possible, we used a working definition to identify and incorporate studies for review (please see Chapter 2) which meant that we captured studies that used a whole range of terminology to describe residential settings. We attempted to discern what terms were used and how these were used to describe different forms of residential care. We are unable to draw any firm conclusions reflecting the relative use of terms such as 'residential' or 'institutional' care within the wider literature, or changes in the frequency of use over time due to the significant variation on terminology used throughout the body of literature.

As detailed in Chapter 4, a wide range of terminology was used in conjunction with settings studied in the literature. These included the interchangeable use of 'institutional' and 'residential' care, variations on both of these terms, and specific terms derived from these (such as 'therapeutic residential care').

However, these terms were combined with a lack of clarity on the characteristics of the setting or care provided. This makes it (in a large number of cases) impossible to determine whether the care setting studied would meet the Guidelines definition of residential care, or would rather fall into the categorisation of institutional care.

This is a fundamental flaw in the literature reviewed, which has significant impacts on the ability to draw firm conclusions in relation to many of the other research questions.

The source of this mixed or unclear use of terminology likely stems from a number of sources, but an important source is the lack of an exclusive definition of residential care (in differentiation from any other non-family based care), and the wide range of settings that are encompassed as a result. Discussing 'residential care' is to discuss settings which vary in their purpose (for example: to accommodate children whose parents have died; to provide treatment/therapy; to accommodate children or young people who are not cared for in other settings; to act as a transition from a care setting to independent living), and the context in which they operate (e.g. as one option in a wide range of alternative care provision for children and young people; in the context of parental economic hardship; as the sole option for care). As all combinations of these variations are (at least on some occasions) characterised as residential care, identifying findings which apply to residential care as a whole is nearly impossible.

The following sections highlight the links and conclusions that can be made within the literature, however they are all weakened and diminished by the limitations of this terminological ambiguity.

8.2 Obtaining an overview of existing research

Within each of the findings chapters on purpose, quality, and outcomes literature, a summary has been given which speaks to the research that is presented therein. In this section, we focus on a view of the literature as a whole, highlighting the links, contradictions, and omissions that exist within it.

The literature included in this review is best characterised (for the most part) as a 'mosaic' of research, with each piece looking at a specific question, within a particular setting. This provides us with many specific pieces of information within specific settings, but makes it difficult to identify overarching themes or findings that can be drawn. This is particularly true of the outcomes literature, where there is a lack of research looking at outcomes holistically, but also applies to the literature reporting on purpose and quality.

This mosaic is due in some part to the range of different residential settings provided, however there are also attempts to link the disparate pieces into a more coherent whole, in relation to particular areas of interest. The most reliable form of these attempts are systematic reviews, and this report included eight such reviews, each of which focused on a particular area:

- Effect of structural interventions and training on care quality within institutional care (referring to different forms of care) (Hermenau et al., 2017)
- Perceptions of children in residential care (referring to small group homes) (Steels & Simpson, 2017)
- Trauma-informed care models in out of home care (referring to a range of alternative care settings, including small group homes) (Bailey et al., 2019)

- Effect of training on residential youth care professionals' skills (referring to group homes) (Eenshuistra et al., 2019)
- Experiences of violence in institutional care (with attention to large scale institutions) (Sherr et al., 2017)
- Neural and cognitive factors influencing psychopathology in institutional care (with attention to large scale institutions) (Perego et al., 2016)
- Social climate in therapeutic residential care (focused on small group homes) (Leipoldt et al., 2019)
- Predictors of better functioning among institutionalised youth (including a range of residential care settings) (Wright et al., 2019)

Although the literature allows us to say very little with confidence, there are some things that are either clear, or clearly indicated by the literature.

1. Institutional care is detrimental to the development and wellbeing of children and young people.

A strong body of literature which related directly to the outcomes of explicitly institutional care highlighted the emotional and developmental challenges experienced by children and young people within institutional care. This literature includes the Bucharest Early Intervention Project (please see Chapter 7), which used a strong Random Controlled Trial methodology to demonstrate the differences in outcome for young children placed either in institutional or high-quality foster care. Studies demonstrated institutional care

causing more disorganised and insecure attachments, developmental delays, and less adaptive behaviours. These findings support the implementation of the Guidelines, highlighting the damaging effect of institutional care, and the positive impact of family based care on those who have already experienced institutional care.

2. It is challenging to provide quality care in residential settings

Across both the quality and the outcomes Chapters, the challenges inherent in providing residential care are clear. The psychological, physical, and social development of children and young people is universal, and requires care which can be challenging to provide.

This is particularly clear in relation to attachment and emotional development. Children require continuity of caregiver(s) with whom they can form a bond. This requires both the continuity of care and attention, and also an environment, that allows and encourages both the child and the caregiver to develop a stable attachment relationship. In residential care this is inherently challenging, due to the fact that by definition children will have many caregivers. However, there are indications of domains in which quality residential care can be developed: setting, staffing, safety, and treatment.

The Guidelines make particular reference to the setting domain, emphasising family-like environments with low caregiver to child ratios. However the research in this review also highlight the importance of many factors including well trained, knowledgeable staff who are supported by the organisational structure to be physically and emotionally available to the children or young people they care for. The quality domains of safety and treatment reflect factors critical to the purpose of residential care.

3. Context and culture are important to understanding the role and impact of residential care

As touched upon above, the majority of research included in this review comes from Europe or North America. Accordingly, it is rooted in a wide set of cultural and contextual factors, including economics, individualism vs collectivism, family dynamics, perspectives on children and childhood, and role of the state. Many of these factors are different in different geographic areas, and there are limited indications in the literature presented that this impacts on the experience of different forms of care (e.g. the experiences of Nigerian orphans in foster care settings, Ushie et al., 2016). This highlights that we must be cautious in generalising from experiences in particular contexts, and that when discussing the benefits or challenges associated with residential care we must be mindful of the setting and culture within which those findings were generated.

4. The purpose of researched residential care has a geographic imbalance

As discussed above, residential care is used in a variety of settings for a variety of purposes. However, there is a notable imbalance in the purposes of residential care in the research included in this review. There is a higher propensity of research from North America and North and Western Europe, published in English language, which means that the predominant purpose or usage of residential care within these contexts is more clearly articulated and understood. That is to say, it is used to promote recovery, rehabilitation or treatment to address particular issues that a child or young person may be experiencing. This is often in preparation for a move to a more family-based care setting, or to move on towards independence. Linked to this is the fact that residential care is predominantly used in this geographic region to care for young people, rather than children.

However, residential settings in other geographic areas (which are less represented in the research, indicating we must be cautious in attributing too much weight to this finding) may reflect different usages, such as being one option in a limited range of options available to care for children and young people whose families have been impacted by situational factors as well as family breakdown and issues relating to children's social, emotional and behavioural issues.

8.3 Examining the evidence base

When discussing the evidence surrounding residential care, it is important to understand in greater detail the limitations of the evidence base as presented here. Many of these limitations have been touched upon above, including the challenges encompassed through the lack of consistent or clearly defined application of terminology. However there are also characteristics of the body of evidence as a whole that are important to consider in thinking further about the purpose, quality and outcomes of residential care.

1. Methodological limitations

As discussed in Chapter 3, the methodologies employed in the majority of studies limits the conclusions that can be drawn. The prevalence of cross-sectional designs does not allow for any indications of causality. When examining differences and similarities between pre-classified groups (e.g. children placed in residential care vs. children placed in foster care), cross sectional designs do not take into account the likelihood/possibility of pre-existing differences between the groups.

In examining the literature around residential care, it is important to be aware that children's experiences prior to entry to residential care will also have a bearing on outcomes and that studies seldom take account of this. Accordingly, differences in outcomes may also be a result of these pre-existing influences, rather than due to the success or shortcomings of particular settings.

2. Geographical imbalance

We have touched on the geographic imbalance of the research included in this review above, but it is particularly important when we consider the implications of the literature as a whole. The predominance of inclusion of research conducted in North America and parts of Europe has implications as discussed above, and, therefore, has implications for how this evidence can be used to inform understanding and improvements as regards alternative care options and residential care specifically.

3. Linkage between care quality/interventions and outcomes

The literature included in this review highlights a lack of research which links care quality, or specific interventions, to outcomes for children and young people. While there are links made between the two (e.g. the examination of specific care quality aspects such as punishment on outcomes) there is a lack of research assessing or measuring quality of care and how this then interacts with outcomes.

8.4 Evidence and Policy Debates

Due to the limited ability to draw firm conclusions from the literature included in this review, it is also challenging to provide clear input into policy debates. However, it is clear that the 'mosaic' of research presented here reflects a number of subtleties and nuances which it is important are incorporated into policy debates on residential care.

The clearest of these is that the evidence on residential care is not sufficiently conclusive. On the evidence presented here, it is not possible to say definitively that residential care (were it to be clearly defined) is better or worse than (for example) foster care. Equally, it is not possible to say that residential care provides care that well-resourced and supported family-based care could not. A significant reason for this ambiguity is that there is little research conducted in relation to who residential care works for, and in what circumstances. This is research which would also speak directly to the necessity and suitability principles in the Guidelines, topics that the studies reviewed say little about.

However, the research evidence does support the Guidelines' emphasis on elimination of large scale residential settings through strategies of deinstitutionalisation. It is also suggestive that there are inherent challenges for continuity of caring relationships for children who are cared for by a group of carers within a group of children with divergent and potentially significant needs, which can be addressed through careful attention to quality of environment, relationships, and evidence-informed models of care promoting recovery, rehabilitation or treatment.

8.5 The design, development and improvement of residential care

The evidence presented in this review highlight clear aspects of quality which are discussed in detail in Chapter 6. In short, these highlight the importance of four domains of quality: Setting, Staff, Safety and Treatment. These form the basis on which the design, development, and improvement of residential care should be based.

At present, however, these domains are 'sketched out' from the mosaic of evidence available. Much work is still to be done to develop a clear picture of what each of these aspects precisely looks like, how they are best operationalised and sustained within daily care, and which elements are particularly important for different children and young people in different contexts.

8.6 Gaps in the literature

Throughout this report, there have been clear indications of gaps in the evidence base, which limit our ability to draw conclusions or make strong statements about residential care.

1. Linking Quality Care and Outcomes

As indicated above, there is a lack of research which links the quality of care provided, and the outcomes achieved. This is to the detriment of both assessments of quality of care (where it is unclear the extent to which care categorised as 'high quality' contributes to improved outcomes for children and young people) and outcomes (where there remains a challenge in determining if outcomes are due to the care provided, or other potentially pre-existing factors). Linking quality of care and outcomes likely requires longitudinal studies of residential settings which provide clearly articulated standards of care, which are assessed for fidelity and effectiveness. There are no such studies in the literature included in this review.

2. Engaging and Involving Children and Young People

There is a scarcity of literature on residential care that incorporates the views, experiences, and wishes of children and young people. In particular, there are few studies examining what quality care looks like from the perspective of children and young people, or what outcomes they feel residential care is providing for them. Where these studies do exist, they often rely on subjective wellbeing measures or quality of life assessments, as opposed to allowing children and young people to define what they consider to be important in their care, and lives.

3. Considerations of brothers and sisters

The lack of consideration of the provision and impact of residential care on brother and sister groups is a major gap in the literature. The Guidelines are clear that wherever possible brother and sister groups should be kept together, but there appears to be little consideration or assessment of this in the context of residential care. This clearly has implications for the emotional development, sense of identity, and relationships for children and young people, and as such is an important area to be studied in the future.

4. Widening representation from around the world

The geographic imbalance has been addressed above, but it is important to highlight that the only way to address this issue is to promote, conduct, and publish a greater number and proportion of studies from regions outside of North America and Northern and Western Europe. Direct comparative research between contexts would also develop our understanding of the impact of context and culture on residential care.

5. Understanding what elements of residential care are beneficial for who, in what circumstances

In order to provide alternative care that is both necessary and suitable to the children or young person, we need a greater understanding of who particular models of residential care are effective for, and in what circumstances.

6. Embedding the literature on care quality within a wider literature.

There is a significant body of literature outside the scope of this review, which would support the development of clear quality criteria, as well as facilitating an understanding of for whom residential care might be appropriate. Literature which is currently not applied in relation to residential care, such as literature on operationalising human developmental theories, behavioural descriptions of nurturing and caregiving practices, definitions of and evaluations of specific residential care models, and what works in implementing these is likely to be of additional merit in this regard. Additionally, the decision to focus on peer-reviewed empirical papers to ensure an appropriate level of rigour in the literature reviewed excludes sources of information which do not meet this criteria. This excluded information includes practitioner experiences and reflections as well as 'grey' literature such as commissioned reports and evaluations from government and non- governmental sources.

8.7 Closing reflections

The UN Guidelines for the Alternative Care of Children focus on promoting the best interests, wellbeing, and welfare of children and young people who cannot be cared for within their own families. In general, the evidence echoes the need for a presumption towards family based care, as inherently this increases the potential for a child's developmental and recovery oriented needs to be met, though, of course, notions of suitability relating to needs and quality are as important in that regard as they are for residential care. It does also echo the importance of a range of care options being available for children, and the consideration that residential settings may be appropriate, necessary and constructive for children and young people in specific circumstances.

The UN Guidelines refer to 'institutions' explicitly only once (United Nations General Assembly, 2009 para. 23), and purposefully use only a very brief description - large residential care facilities - that mainly points at physical aspects of the settings as a meaningful qualifier. While the size of setting is important, it is important to move beyond elements relating to size and structure of the setting, and focus on relationships and interactions to determine how care can ensure the best quality of support and outcomes for children. Evidence points to the need to consider different domains relating to quality, and, in particular, what individually and organisationally enables caregivers to be available physically, psychologically and emotionally to children irrespective of needs, age and stage, or of the dynamics of competing or conflicting needs within a group of children.

Many of the policy debates taking place nationally and internationally conflate the concepts of 'institutional' and 'residential' care, and this confusion is reflected in the evidence base. The review highlighted that there is no consensus on terminology, and on how it is used to describe different residential care settings. It also highlighted that there is an absence of close attention to the relationship between carer behaviour, setting, and implementation outcomes in the context of residential care. With particular relevance to better understanding how these elements effect children's experiences and wellbeing, there is also a need to strengthen closer attention to the effect of children's experiences prior to entry to residential care and if and how residential care practice mediates the effect of these on children's wellbeing in the immediate, medium and longer term. Without more systematic evidence in this regard, it is not possible to determine for whom residential care is an appropriate necessary and constructive option for alternative care.

Appendix A: Protocol for evidence review

Summary of needs assessment, question development and refinement

Taking the main research question included in the original SOS Children's Villages Terms of Reference, the CELCIS team facilitated a discussion with a stakeholder group drawn from across a range of functions and country contexts within SOS Children's Villages.

The original main research question was stated as follows "What does the research say regarding the role of residential care options in the alternative care of children, and how it (does or does not) complement family based alternative care options in meeting the needs of children who have temporarily or permanently lost parental care?".

Participants in the discussion were asked to respond to five questions:

1. How will you use the findings of this review?
2. When you read the main research question, what is the thing that you are most interested to find out in relation to residential care?
3. When you read the main research question, what do you think is intended by the phrase 'residential care options'?
4. What is that is that you want to know about the relationship of residential care to family based care?
5. When you read the main research question, what do you think is intended by naming both the 'temporary' and 'permanent' lost parental care?

We took away from the stakeholder discussion the following key points and emerging themes:

- The primary purpose, or use, of the review is to guide and inform policy debates around the role of residential care in the alternative care of children. The secondary purpose, or use, is to help guide and inform practice developments within SOS Children's Villages in their delivery of alternative care to children.
- There is an identified need for access to empirical evidence regarding residential care, which is drawn from across the world and that can help deepen or nuance debates and discussions around 'family based', 'family like', 'residential' and 'institutional' care.
- There is a strong interest in understanding what the empirical evidence indicates is
 - the function (value) of residential care – what needs does it serve for whom and how does it serve them?; what is its suitability for children and young people; what differentiates it from foster care; what is its added value?
 - quality care within a residential context – what is the nature of quality care and affords that to be the case within a residential setting;
 - the effect that residential care has on children's development and wellbeing (outcomes).
- The challenges of navigating the range of terms/labels used, the lack of consistency in their usage/application, and how terms are often used interchangeably to denote different types, models/practices, and settings of care. The importance of appreciating that boundaries between are blurry or grey, and that some terms may carry connotations despite the variability in how they are used/applied across contexts.

- Some clarity around excluding attention to boarding schools, hospitals, hostels, shelters within the range of studies to be reviewed.

The CELCIS team would like to make explicit the need to make choices about how to focus the review that take account of ideas around purpose and scope as well as the need to balance the resource available (i.e. the funding and time allocated to this) and what was agreed as part of the commissioning and contractual process.

The CELCIS team used the points made and emerging themes to inform the following draft protocol of the study, with the themes being integrated into:

1. Key research questions that can be fully applied in the conduct of the study.
2. A search strategy that would allow us to find recent literature that will address the research questions.
3. An approach to sifting and sorting all literature abstracts returned to identify the most relevant, empirically based literature (i.e. what gets excluded and included for review)
4. An approach to appraising and extracting an assessment of the quality of the study and its relevant findings
5. Outline approach to distilling the learning from across the studies while addressing the research questions and the ultimate purpose of the review.

Finalised research question(s)

With a focus on children and young people:

1. What is the function of residential care as part of range of alternative care options?
2. What facilitates 'quality' care in residential care? (I.e. both in the relational interactions between children and their carers, and in how residential care is organised to facilitate high quality care for children).
3. What effect does residential care have upon outcomes for children and young people?

Search strategy

The search will focus on the identification of literature published in:

- The years 2014 to 2019 inclusive
- The languages of English, French or Spanish.

[Research team to apply search using five year span, and to incorporate systematic reviews to ensure that the review can also draw on insights from older literature/evidence]

The search strategy will combine the most relevant synonyms used to describe

- Residential care for children (i.e. Residential care, residential facility, residential setting, children's home, small group home, institution, institutional care, institutional setting, orphanage, boarding)
- Children (i.e. infants, children, young people, youth)

- Quality and outcomes (i.e. effectiveness, impact).

The searches will focus on the interrogation of the largest and most relevant databases:

- Applied Social Science Index of Abstracts (ASSIA)
- Social Science Database (ProQuest)
- Social Sciences Citation Index (Web of Science)
- Cochrane collaboration

Searches will be applied, collated and consolidated by one researcher, with total counts for searches, duplicates, and consolidated list accounted for, as part of the write-up of the study. The raw search files and outputs will be shared with commissioning body wherever possible (i.e. in keeping with license and copyright obligations).

Sift and sort of consolidated list of abstracts

The group of researchers will divide the review of abstracts and apply the following inclusion/exclusion criteria to identify the most relevant empirical studies for review. The researchers will compile a record of the total numbers of abstracts reviewed, excluded and included.

Inclusion/exclusion criteria to be applied at the abstract screening stage

Criteria	Inclusion	Exclusion
<i>Target population considered by the study</i>	Children and young people who are under 18	Adult
<i>Intervention considered by the study</i>	Residential care provided to children and young people, when their parents cannot care for them (i.e. where children are cared for by one or more carers who are unrelated to each other, are living within a group of children, and where the setting is not the pre-existing home of the carers). We will include anything framed as 'alternative care' by the authors, which meets the above discussion and which may be labelled as a whole range of terms (e.g. small group home, institutional care, foster etc)	Youth offender institutes Immigration centres (i.e. reception, transit or detention) Boardingschools Shelters Hostels Hospitals Kinship care (i.e. where a child's relatives are providing care for them) Traditional foster care (i.e. where only one or two related carers are providing for a child(ren) within their own home)
<i>Type of study</i>	Systematic reviews Primary study	Commentaries Secondary reviews (not using systematic review methodology) Secondary data analysis

Case series (description of a number of cases of an intervention and an outcome (without comparison with a control group) Other: _____		
Summary		
1. Estimate methodological quality (1 <i>poor/doubtful</i> , 3 <i>very good</i>)	1	2 3
2. How useful was this paper to the review question? (1 <i>very</i> , 3 <i>not at all</i>)		1
2 3		
If 3 for both, then discard		
Findings/key conclusions – summary of evidence on definition and/or descriptors used for residential care and any connotations expressed in relation to terminology		
Findings/key conclusions – summary of evidence on identified purpose/function of residential care		
Findings/key conclusions – summary of evidence on aspects of quality in care		
Findings/key conclusions - summary of evidence on effect of residential care on outcomes for children (i.e. in immediate, intermediate and long term)		
Further thoughts and comments		

Appendix B: Test Database Search Results

Database	Search limitations	Results Returned			
		2015-2019		2010-2019	
		Anywhere /'ALL'	Abstract	Anywhere /'ALL'	Abstract
ASSIA	'Dissertations & Theses' or 'Scholarly Journals' 'Article', 'Government & official Document', 'literature review', 'report' or 'review' English, French, or Spanish	16188	690	22362	1098
Social Science Database	'Reports', 'Dissertations & Theses' or 'Scholarly Journals' 'Article', 'dissertation/thesis', 'Government & official Document', 'literature review', 'report', or 'review' English, French, or Spanish	61157	841	88678	1134
Social Sciences Citation Index	'article', 'abstract of published item', 'data paper', 'discussion' 'record review', 'review' English, French, or Spanish	9118	(Title, no abstract option) 83	12509	(Title, no abstract option) 108
Cochrane Database of Systematic Reviews	'Cochrane Reviews' or 'Special collections'	649	12	1051	17
TOTALS:		87112	1626	124600	2357
	Duplicates		287		445
	TOTAL		1339		1912
	English		1241		93%
	French		1		<1%
	Spanish		14		1%
	Other/not listed		83		6%

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