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Cameron-Mathiassen, Jacqueline ; Leiper, Julie; Simpson, Jane; McDermott, Elizabeth

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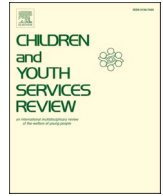
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What was care like for me? A systematic review of the experiences of young people living in residential care

Jacqueline Cameron-Mathiassen^{*}, Julie Leiper, Jane Simpson, Elizabeth McDermott

Faculty of Health and Medicine, Furness College, Lancaster University, Lancaster LA1 4YG, United Kingdom

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ABSTRACT

Residential care can be a relevant option for young people with behavioural problems considered beyond the capacity of the young person's own home or foster care to manage. While some care home residents go on to excel in life, others do not. Understanding how young people's experiences of residential care impact on their well-being might help us improve the outcome possibilities for individual residents. This systematic review of qualitative research aimed to synthesize and identify the experience of living in residential care and suggest how these findings can enhance the well-being of this group in the future. Five relevant databases were searched for qualitative empirical studies published between 1990 and January 2020. Twelve papers met the inclusion criteria. The studies were thematically synthesised to produce findings.

Four high-order analytical themes were constructed: autonomy and control; relationships and support; safety and security; and, child to adult transitions in care. These high-order themes revealed a varied experience of care with some young people experiencing stability and security as well as support towards achieving normative milestones. For others the findings revealed experiences of not being heard and understood by the care institution, creating experiences of poor well-being and a reduction in agentic development. In addition, peer relationships were experienced both positively as friendships and support developed within some care homes and negatively when the peer group accepted bullying and violence as normative behaviour. This review recommends further research into how the care community culture impacts on young people. Finally, this review calls for research on how agency is developed and supported among young people in residential care, and how poorer psychological well-being can be better understood within the realm of residential care.

1. Introduction

This systematic review is focused on the experiences of young people in the age group of 12–25 years who live in residential care and how these experiences impact on their well-being. This age-span is consistent with Heath et al. (2009)'s contention that the age group "youth" has two life stages; the stage between childhood and youth and between youth and adulthood. The term young people will be used throughout this systematic review when referring to the identified age group.

Research within youth and young adult populations contends that this group has, until recently, been overlooked in global health and social policy and therefore has had fewer health gains from the economic development of the post-modern world than other age groups (McGorry et al., 2013; Patton et al., 2016). The concept that youth populations are not thriving as expected has led to an increase in

research within this area (McGorry et al., 2013; Patton et al., 2016). This focus has emphasized the importance of understanding the period of transition from child to adolescent to young adult as a critical phase in life where the emotional, social, cognitive and physical resources that are the foundations for a healthy life become established (Patton et al., 2016).

2. Residential care

Residential care has many definitions and names across countries, within which there are certain modal features that encompass this form of service (Dozier et al., 2012). This systematic review uses Galik's (2013) definition of residential care: a congregate living space with professional staff who are continuously on-site providing an environment which can meet the functional, medical, personal, social, and

^{*} Corresponding author.

E-mail addresses: j.cameron-mathiassen@lancaster.ac.uk (J. Cameron-Mathiassen), aj.leiper@lancaster.ac.uk (J. Leiper), j.simpson2@lancaster.ac.uk (J. Simpson), e.mcdermott@lancaster.ac.uk (E. McDermott).

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housing needs of individuals who have physical, mental, and/or developmental disabilities. Consistent with this definition is the intent of residential care to provide a social service, as opposed to placements within the criminal justice system, which would also entail strict limitations on freedom of movement, choice etc. The approaches the individual residential care facility utilise are embedded not only within the young person's needs but also in the culture in which the home is positioned which, in turn, is influenced by political and historical forces.

Residential care has within the last century evolved from a place where unwanted children could reside, for example in the UK with foundling hospitals, industrial schools, and orphanages etc. These initiatives were often supported by philanthropic voluntary child care organisations intent on improving this group's living and life opportunities (White, 2003). The continuing need to understand and improve residential care has not only led to the continuing presence of charitable organisations but also to an increase in research and knowledge sharing. Courtney et al. (2013) argue that within the last two decades the United States now offers a more family orientated care practice, inspired by efforts made by the Scandinavian countries as well as some other European countries.

Current work on improving the quality of and outcomes from residential care has led to the concept of therapeutic residential care, and the establishment of an international work group, the International Work Group for Therapeutic Residential Care. This initiative held a summit in 2016 after which Whittaker et al. (2016) highlighted that, within developed countries, child advocacy agencies have the aim of achieving better outcomes for young people in care through focus on closer collaboration with the young people's families, community and culture. In addition, focus on care leavers suggests they are a disadvantaged group (Mendes & Rogers, 2020), and therefore in need of additional help as they transit out of care and into the community (Mendes & Rogers, 2020).

In most countries, governmental health and social services make the decision to place a young person in residential care. Major markers for developing the need for residential care are cited by, for example, the appropriate body in England and Wales, the National Institute for Health and Care Excellence (NICE, 2013) as abuse, neglect or family dysfunction that is causal of acute stress among family members. For some of the young residents residential care can contribute to the development of good mental health as adulthood approaches (Holmes et al., 2018). For others, however, extreme behavioral patterns within the residential care environment, including adverse risk taking, self-harm, isolation and anti-social behavior, indicate lower levels of well-being and result in more mental health diagnoses when compared to other youth groups (Cordell & Snowden, 2015).

Macdonald et al. (2012) suggest the young person's mental health burden, if not adequately addressed, can be not only one of the determinants for placement in residential care, but also become one of the determinants for an unsatisfactory placement in residential care. Vinnerljung and Sallnäs (2008) point to almost 33 % of residential care residents being hospitalized for mental health concerns at 20–24 years of age compared with 1.2 % in the general population. In an English study on living in residential care (Berridge et al., 2012) young people in care were assessed with a level of mental health difficulties at nearly six times the rate of the wider child and youth population and 75 % had, in the previous six months, exhibited violent or aggressive behaviors.

3. Aims, objectives and research question

This systematic review has the objective of (1) identifying qualitative research articles which explored experiences of residential care by young people residing in residential care from a first-person perspective; (2) implementing a high-level approach to synthesis aimed at extracting interpretations beyond those offered in the original papers; (3) discussing how the findings illuminated insight on the impact of residential care on the young people's well-being.

With these aims and objectives this systematic review had the following research question:

What is known about the experiences of youths and young adults who live in residential care, and how do these experiences impact on their well-being?

No evidence was found of an existing systematic review investigating this area. Consequently, the protocol for this systematic review was registered at PROSPERO (York, 2019), with the registration number: CRD42019159342.

4. Methodology

This systematic review followed the Preferred Reporting Items of Systematic Reviews and Meta-Analyses (PRISMA) (Moher et al., 2009) guidelines which provide an auditable approach of clearly defined and transparent methods for each stage of the review (Jesson et al., 2011).

5. Methods

5.1. Provisional search

A provisional search (Jesson et al., 2011) was conducted to get a general sense of the literature in the area and to enable a working assessment of the volume of available qualitative data, the type of data and the disparity of the data. The provisional search contributed towards the development of the final systematic search strategy (Booth et al., 2016). The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) search strategy tool was engaged (Cooke et al., 2012) to ensure both the sensitivity and the specificity of the search.

5.2. Search strategy

The search strategy was originally developed in the SocINDEX electronic database and adapted to ensure a comprehensive search (Booth et al., 2016) of five databases: PsycINFO, SCIE, SocINDEX, Child Development & Adolescent Studies, and MEDLINE Complete. In addition to the database searches, citation searching (Booth et al., 2016) uncovered one additional paper. The sourced studies were imported into Endnote. Titles and abstracts were screened to remove duplicates and papers that did not fulfil the inclusion criteria (Boland et al., 2017). The search was conducted during January 2020. The following search terms were used: (youths or adolescents or "young people" or teens* or "young adults" or juvenile*) AND (experiences or perceptions or attitude or views or effects or impact or coping) AND ("residential care" or "care homes" or institutions or "looked after" or "out of home care" or "congregate care") AND ("qualitative research" or "mixed methods research") AND (behavi* or problems or "mental illness" or "mental health" or "mental disorder").

5.3. The inclusion and exclusion criteria

The inclusion criteria for the systematic review were defined through the review's research questions, aims and objectives and the identified constructs from the SPIDER framework (see Table 1).

To capture fully the experiences of residential care, the participants in the targeted original research were defined as: children, youths and young adults within the age range 12 to 25 years, living in residential institutional care of a continuous or ongoing nature. Consequently, papers relating to short interventions whereby the young person was envisaged to be resident for weeks or a few months were not perceived as able to offer insight into the experience of longer-term residential care. Papers reporting on an age range outside of the selected 12 – 25 years were only included if the findings could clearly be connected to participants within the systematic review's selected age range. Equally, if staff had been a part of the original studies' sample, only papers where

Table 1
The study's inclusion/exclusion criteria:

	Inclusion criteria	Exclusion criteria
Sample	Young people aged 12 to 25 years, resident in a care home, where residency was perceived to be of a period stretching from months to years. Young people whose residency was not related to physical or learning disabilities.	All other ages, as their experiences were not relevant to the research question. Placements with an interventional intent, whereby weeks rather than months were defined as length of residency, as these experiences were not relevant to the research question. Young people whose residency was connected to a physical or learning disability as these groups would have had a residency with specific focus on these disabilities.
Phenomenon of interest	Studies which explored the first-person experiences, perceptions, feelings, effects, impact, or coping related to living in residential care.	Studies which did not engage in an exploration of the experience of residential care from a resident's viewpoint.
Design	Studies which engaged in first-person experiences of mental health, mental illness, mental disorder, or mental well-being related to being a young person living in residential care	Studies which did not engage in an exploration of at least one of these constructs from a resident's viewpoint.
Evaluation	Qualitative research, where data have been gathered through direct contact with the residents of RC and where direct quotes from the participants support the findings. Mixed methods were included if it was possible to isolate the qualitative findings.	Quantitative research. Research which did not engage directly with the residents of RC. Research which did not use direct quotes from residents to support the findings. Mixed methods where it was not possible to separate the qualitative findings from the quantitative findings.
Research type	Explorative, peer reviewed research. Published after 1989.	Research which did not have an explorative intent within its design. Grey literature and non-peer reviewed work. All research published prior to 1990

these findings could be desegregated from the young people's findings were included.

In addition, decisions regarding publication type and publication date of the primary papers were made. The earliest inclusion date for relevant literature was 1990. Earlier journal articles were considered of low relevance as the experiences of residential care prior to this date would not correspond to the experiences young people have more recently (Rew et al., 2000). Only evidence in peer-reviewed journal articles was selected to ensure a clear pathway between the primary research's question and the reported experiences. The research question was explorative and focused on the individual person's experiences, thus the search was focused on papers embedded in the qualitative paradigm (Silverman, 2013).

5.4. Quality appraisal

Quality appraisal of the papers was conducted using the Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research. CASP facilitated a systematic assessment of the trustworthiness, relevance, and results of the published papers. The CASP guidelines use a series of 10 questions to appraise aspects of each paper. The

questions have a response format of: yes, can't tell or no. Comments were placed on the appraisal sheet for each study. To ensure consistency and transparency, two papers were sent to a co-author (JL) for independent appraisal. The appraisals were compared and variations in the appraisal discussed at a consensus meeting between the two researchers who conducted the appraisals and the other two researchers. This meeting served to ensure that the areas of weakness in a particular study, for example failing to report consideration towards the possible effect of the relationship between researcher and participant, could be discussed. While the quality appraisal did note some weak elements within the selected studies, in particular regarding the reporting of ethical considerations (Barter, 2003; Bundle, 2002; Jansen, 2010; Kelly et al., 2019; Schofield et al., 2017), all studies were considered by all appraisers acceptable for this review. Therefore, the generation of themes within the synthesis was based on the findings of all the papers across the quality range.

5.5. Data extraction

Data were defined as all elements of the findings and discussion of each primary paper because thematic synthesis facilitates the synthesis of data from studies with disparate theoretical and methodological foundations (Thomas & Harden, 2008). The data from the 12 papers were extracted through the adoption of an existing data extraction sheet available through the British Psychological Society (2007). To ensure consistency and transparency, two authors (JCM and JL) independently extracted data from two papers. The individual data extraction sheets were then compared, followed by a discussion with all authors to ensure rigour within this phase. Simultaneous to the data extraction, the study characteristics of the primary papers were collated to enhance the understanding of the context in which the studies were sited.

5.6. Synthesis

The findings and discussion from each primary paper were imported into Atlas.ti (Atlas.com, 2021), a qualitative data management programme (Woolf & Silver, 2017). The thematic synthesis (TS) followed the three phases suggested by Thomas and Harden (2008): phase one was a line-by-line coding of the primary studies' findings and discussion, with the coding conducted individually on each paper. The papers were selected in alphabetical order according to the study's first author and each paper added new codes to the synthesis as the paper's particular focus brought new information. Each code had an explanation of what the code included and what the code excluded. For example, the code "trust" included: the young person's perception of trust and reference to trust between themselves as resident and others, for example carer, peer, institution, authority, and family. Excluded: Non-residents' perceptions of and reference to trust, all references to issues not pertaining to trust. In phase two the phase one codes were placed into related groups to construct descriptive themes. Phase three facilitated the development of 'theory-driven' analytical themes, thus this review, as suggested by Thomas and Harden (2008), went beyond the 'data-driven' descriptive themes within phase two. Thus, the review question provided a theoretical structure within which it became possible to develop analytical themes (Fig. 1 shows the coding process).

The synthesis involved continuous reflection on the context of the original studies (Thomas & Harden, 2008), while maintaining the purpose of synthesizing original findings to create findings fundamentally different from those within the individual primary papers (Thorne et al., 2004). The nature of the primary studies, while all engaged with the experience of residential care, offered varying contexts for the elicitation of the primary findings, within methodology, demographics and the research question. Thus, it was necessary to revisit the original findings to ensure a clear representation of the original participant's viewpoint was maintained as analysis developed. To encourage rigour in the maintenance of context for each of the original studies, a reflexive diary

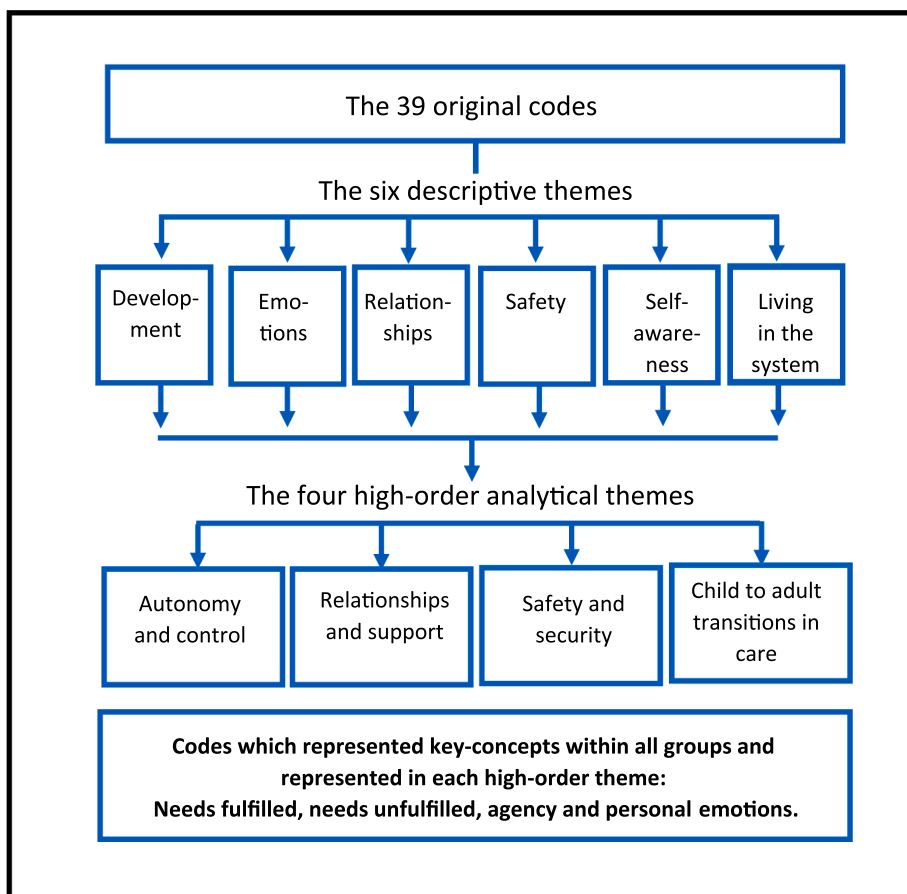


Fig. 1. The sequence of steps within the synthesis illustrating how the 39 original codes were collated through patterns to groups, to analytical themes, and finally, to key-concepts with the transcending codes applying to all high-order analytical themes.

was maintained by the first author during the synthesis phase (Booth et al., 2016).

6. Findings

6.1. Results of the search strategy

The search strategy located 1726 papers from which, after removal of duplicates and screening for meeting the inclusion criteria, 12 papers were included for the thematic synthesis (see Fig. 2).

6.2. Study characteristics

The twelve studies had the following geographical locations: England (3), Scotland (2), Sweden (2), Ireland (1), Norway (1), USA (1), Australia (1) and South Africa (1). The demographic and methodological characteristics of the included studies (Table 2) highlighted the limited geographical scope of the included papers as only one paper from a country with a lower economic status, South Africa (Nurcombe-Thorne et al., 2018), could be located. Two papers were mixed methods (Bundle, 2002; Stevens, 2006) from which only the qualitative findings were included in the synthesis. Equally, two papers (Barter, 2003; McCarthy, 2016), where both staff and young people’s experiences were investigated, only have the findings pertaining to the young people within the synthesis.

7. Thematic synthesis

The analysis identified four analytical themes: Autonomy and control: Relationships and support? Safety and security and Child to adult

transitions in care.

7.1. Autonomy and control

The synthesis suggests that young people’s experiences of living in residential care elicited mixed perspectives from those prospering in a cooperative environment, to those who felt trapped in a system which had a perceived presence of power and control. None of the papers highlighted material needs such as clothing, food or shelter. Within this theme the unmet needs were conceptualised by the young people as being rooted in institutional and authoritarian control. Across the papers there were examples that, within residential care, shared decision-making was not experienced as normative. A participant from McCarthy’s (2016) stated:

... I’ve never been in a situation where a social worker makes a decision and you say “Well, I’m not really happy about that.” I’ve never heard them say “well, maybe we can negotiate”. It’s “well, that’s the decision, that’s it”. (McCarthy, 2016, p. 375).

As this quotation suggests, control was reported by some young people as problematic, and the lack of freedom of movement with the constant expectation of following a timetable was experienced as constricting. The participants in the studies also offered insight into the additional control placed upon them by external authorities, who were not present in their daily life within care, but had the capacity to exert influence on the young people as they monitored and judged progress; as explained by this young person in Kelly et al. (2019):

My case manager comes all the time and talks to me and checks on how I’m doing. She then tells the Judge if I’m doing good or not. The Judge then decides when I get to go home. If she tells the Judge I’m

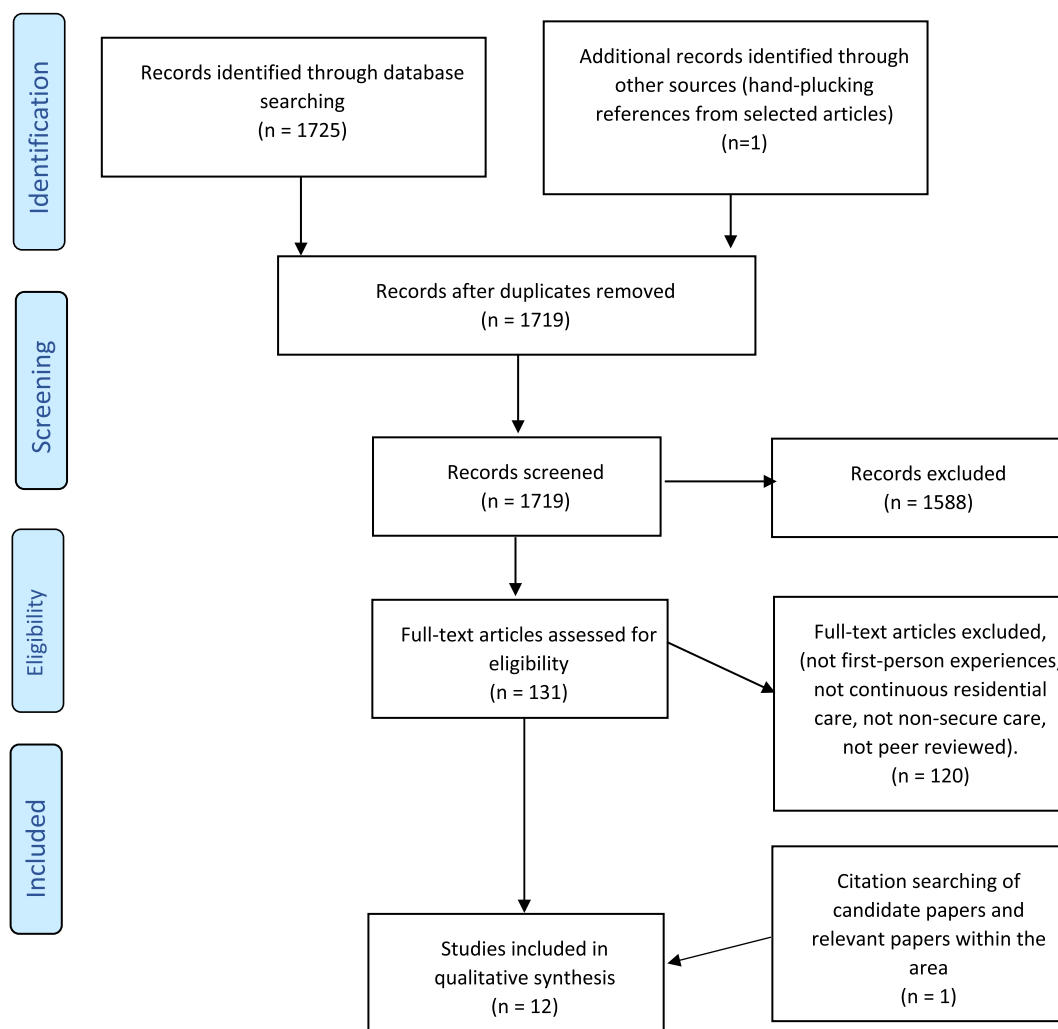


Fig. 2. The sequence of steps in the search strategy resulting in the 12 included studies.

doing good then I may get to go home (Kelly et al., 2019, p. 260).

Equally, control of freedom of movement was reported as problematic for some of the young people, as explained by this young person in Nurcombe-Thorne et al. (2018):

The thing is, I have always loved my independence ... and [the CYCC: child and youth care centre], I'm going to describe it very clearly; it's like a mini jail ... and those walls are like prison walls and you cannot get out unless the warden comes, puts you in the car, and takes you out ... or a friend comes and fills in a hundred forms and then only can take you out." (Nurcombe-Thorne et al. p. 643).

Additionally, for this young person in Kelly et al. (2019) limitations on freedom of movement were coupled with a general feeling of being apart from wider society and usual activities such as shopping and connecting to others via a cell phone: "It would be nice if I could have friends over to the house like other kids or go to the mall. I can't even have a cell phone." (Kelly et al., 2019, p. 260).

In addition to experiences of control from carers and authorities the young people perceived control over where they were placed as stressful which in turn impacted on the young person's well-being. For example, participants in Nurcombe-Thorne et al. (2018) perceived a direct link between the care home's control of where they lived and the experience of not belonging, as explained by this young person:

Changing house-parents all the time ... was difficult. And most of the time it was because of your age. And then [in] that [new] house you

[are] going to be the newest or youngest again. Um ... to move from house to house, I have to say, was not so nice. Mmm ... you don't feel like you belong anywhere. (Nurcombe-Thorne et al., 2018).

However, the young people who related the experience of joint cooperation with their voice being heard offered a more positive experience, as explained by a young person in Henriksen et al. (2008):

My KSM [key staff member] designs my treatment plan and then we talk about it together. He is helping me to plan for the future, and he got me a spot in a practical vocational training programme. My KSM really cares about me (Henriksen et al., 2008, p. 154).

While this theme includes examples of constructive cooperation between young people and residential care, which were related as a positive aspect of residential care, it also identified the experience of reduced well-being through limited freedom, unexplained decisions, and concerns regarding the outcome of decisions about the young people over which they had no influence.

7.2. Relationships and support

This theme represents the findings concerning the young people's relationships with peers, residential care staff, and their own families. The impact of these relationships varied from positive to burdensome. The shared peer situation was experienced by many as a positive aspect of residential care, giving a sense of community, as well as a safety net in

Table 2
Demographic and methodological characteristics of the studies included in the synthesis.

Authors	Number of participants	Participant age range	Participant gender variation	Location	Research area	Methodological approach	Data collection
Barter (2003)	71	8 – 17* Staff ***	Male: 45 Female: 27	England 14 homes	Exploration of the meaning and context in which young people experienced peer violence.	Qualitative, combining personal experiences with abstract discussions.	Semi-structured interviews. Use of vignettes.
Bundle (2002)	22	13–16	Male: 12 Female: 10	England one home	Clarification of what a specific group of teenagers in residential care see as important in the area of health information.	Mixed methods. Results given both as a narrative and as a tabular count of the different points raised.	Semi-structured interviews and questionnaires.(only the qualitative section was represented in the synthesis)
Emond (2003)	13	12–17	Mixed gender	Scotland two homes	Exploration of the ways in which young people in residential care offer one another support.	Ethnography	Fieldwork (researcher resident, observatory).
Henriksen et al. (2008)	46	14–20	Male: 23 Female: 23	Sweden 13 homes	Exploration of obstacles and opportunities for establishing a therapeutic alliance between residents and key staff members.	Qualitative research underpinned by psychoanalytical theory.	Semi-structured interviews, with follow-up interview one year later.
Jansen (2010)	12	14–18	Male: 3 Female: 9	Norway four homes	Investigated how youths in residential care understand and are positioned regarding child protection and development.	Qualitative, analysis conducted from a process of subjectivation model.	Repeated (3) interviews over 15 months. First interview life mode.
Johansson and Andersson (2006)	6	15–17	Male: 3 Female: 3	Sweden one home	Exploration of adolescents' experiences of living in residential care.	Qualitative case study. Idiographic approach.	Semi-structured interviews. Retrospective, Interviews.
Kelly et al. (2019)	20	12–17	Male: 11 Female: 9	USA Group homes and shelter placements.	Exploration of youths' own conceptualisation of their social emotional well-being.	Qualitative, incorporating use of the developmental systems lens.	Semi-structured interviews.
McCarthy (2016)	6	12–18 Staff ***	Not stated	Ireland, one organisation with four addresses.	Young people's experience of participation in decision-making processes.	Case study, qualitative.	Semi-structured interviews of both residents and staff.
Moore et al. (2017)	27	10–21*	Male: 18 Female: 9	Australia, three jurisdictions.	To understand how young people, perceive and experience safety in residential care.	Qualitative nested study, utilising constant comparison.	Semi-structured interviews.
Nurcombe-Thorne et al. (2018)	6	19–21	Male: 2 Female: 4	South Africa, number of homes unaccounted for.	Exploration of participants' perceptions of their experience of residential care.	Qualitative exploratory approach	Retrospective. Semi-structured interviews.
Schofield et al. (2017)	20	20–26**	Male: 13 Female: 7	England, residential care homes run by one organisation.	Investigation of young peoples' experiences of the transition to adulthood from children's homes run by a voluntary sector organization.	Qualitative using narrative analysis	Individual narrative interviews.
Stevens (2006)	24	15–19	Male: 16 Female: 8	Scotland, multiple residential care homes	The aims of this study 1) develop and pilot a methodology to encourage participation and focus of care environments. 2) Generate information to inform on the monitoring and inspection process.	Mixed methods(only the qualitative section was represented in the synthesis)	Focus group, repeat sessions and questionnaire

*Only quotations from young people aged > 12 were included in this study, conclusions drawn from the youngest participants were not represented in the synthesis.

**Quotations and direct reference to the young people of 26 years of age were not represented in the synthesis.

Staff*** Quotations and findings related to staff interviews were not represented in the synthesis.

adverse times, as explained by a resident in Emond (2003).

You're never by yourself, you can always find someone that understands you, there's always someone you can trust, you know like one of the residents so that's nae (not) so bad (Emond, 2003, p. 328).

While examples such as the one above were well-represented in the papers, not all peer relationships were positioned as positive. In the papers investigating safety, peer relationships were sometimes experienced as a source of fear and insecurity.

Within this theme loneliness and exclusion emerged as negative parameters of residential care. For example, loneliness was connected by this young person to feeling different from other residents: "I've experienced things that I can't share with others, feel like an outsider. I can control my distress better and keep a lot of things inside myself" (Johansson & Andersson, 2006, p. 314). For some of the young people loneliness was connected to the experience of not being close to the staff in a familiar and family-orientated fashion, as described by this young person: "Nobody feels like family, and I feel like I am something that

could be thrown away. I just need to know that I matter ya know? The staff always cook dinner, but what about how I'm feeling?" (Kelly et al., 2019, p. 260). Thus, the lack of family life was perceived as uncaring and alienating.

Relationships with carers were varied. Experiences of carers being supportive and understanding were evident in the findings, as portrayed by this participant in (Schofield et al., 2017):

They help you realise that you can do things and you might act like a spoiled brat and you might not want to go to school, you might get kicked out of school but they..... sort of try and tell you, "You can do that" –they don't give up on you (Schofield et al., 2017, p. 786).

However, the establishment of a positive relationship with carers was not always straightforward for the young people. Moore et al. (2017) reported how the young people felt that building a rapport with staff was difficult - there was always the risk of getting moved or rejected. Equally, just as young people could get moved from home to home, so could carers. Indeed, Moore et al. (2017) suggested young people offered the experience of continual rejection and abandonment as a rationale for avoiding further relational commitments. In addition, the findings include the identification of an additional group of young people who, while they accepted their time in care, did not perceive a need for relationships with the carers they met. This is exemplified by a quote from a participant in Henriksen et al. (2008): "I could manage without them also" (Henriksen et al. 2008p. 153).

Relationships with the biological family were also perceived as complex, with the need to maintain contact, visit and interact with family expressed as being important for some of the young people. However, few direct references to the biological family were given. Most references to close family members were connected to support concerning social services, legalities and evaluations of family and residential care communication.

Friendships outside residential care were rarely mentioned, with the findings suggesting a general avoidance of relationships outside their immediate context and family. A suggestion of collective isolation from family and the wider society was represented across the papers. The only exception to this were some of the participants in Kelly et al. (2019) who reported a commitment to mainstream education, which appeared to facilitate a more integrative approach to society outside of residential care.

Different effects of being placed in residential care on relationships, where peers were lived with as pseudo-family members, were experienced. For some of the young people there was a strong fellowship through being in the same situation. For others these contacts were hard to find, and loneliness became a part of the experience.

7.3. Safety and security

This theme was well represented across all papers. While two papers were dedicated to investigating aspects of safety in care, the remaining papers had findings which positioned safety as an important factor for the young people in residential care. While none of the papers reported any incident of physical abuse by staff, physical and psychological violence from peers appeared common.

For the young people who lived in homes where violence was habitual, violence was positioned as both a norm and a necessity. To be perceived as strong enough to avoid being a victim was explained by this participant: "I think that if you stay in resi [residential care] long enough you either become a bully or a victim. It's just how it is. You do it so you don't get bullied yourself" (Moore et al., 2017, p. 215). However, while peer violence was reported as a norm it was not considered a natural aspect of peer relationships generally; for example, the young people in Barter (2003) expressed the belief that this was unique to living in care. They also believed that residential care should be safer than home, and in this respect felt underserved by residential care.

Violence was experienced psychologically as well as physically.

Abusive language, personal verbal attacks and witnessing violence on others suggested trauma from these events had impacted upon well-being, as stated by this young person in Barter (2003):

I think having names called to you is worse... because it hurts you more and it's, like if you had a fight and you cut yourself, the pain goes and it heals, but having, being called whatever is always at the back of your head. (Barter, 2003, p. 43).

Moore et al. (2017) suggested that the older participants in their study believed that the impact of witnessing violence limited their sense of safety and reported that some participants felt anger when peers were not protected as well as experiencing re-traumatisation when witnessing self-destructive or painful behaviour from peers. This was explained by this participant in Moore et al (2017):

Actually, one of the worst things that ever happened in our ... unit at ... was when ... one of the younger boys that was there, he had problems, but the workers knew that that day was going to be a hard day for him, but they didn't keep an eye on him. We walked in, threw our bags in our room, we got into the toilets to a suicide scene ... thankfully he survived, but not the safest or best thing to walk in on ... We weren't offered counselling, but I ended up seeking out counselling when I was 19 for that and other issues ... they could have dealt with it better. (Moore et al. 2017, p. 215).

In addition to reports of violence from peers, the young people also reported experiences of staff utilizing hierarchies to exert control within residential care and, equally, reports of staff waiting before intervening when peer fights occurred. Such experiences were positioned as stressful and causing continued anxiety.

However, there were also reports of homes where residents and staff were united in building a home where violence, bullying and oppression did not happen. Equally the young people acknowledged the importance of both privacy and contact as necessary parameters for safety, as this young person from Stevens explained: "I feel safe because I've got a lock on my door....The staff come and speak to you and that makes you feel safe and secure. It's good in there." (Stevens, 2006, p. 63). This quote suggests well-being is established through the establishment of a safe space where staff were positioned as trusted, respectful of boundaries and welcome.

7.4. Child to adult transitions in care

This theme describes young people's experiences of maturing through late childhood, adolescence and into early adulthood within the context of residential care. It was noted within this theme that the findings generally came from the older participants who offered a well-considered evaluation of their maturing and the transitions they navigated. The findings suggested the young people who were satisfied with residential care offered positive narratives of maturing and an evolving capacity to make decisions they believed would enhance their future prospects. Schofield et al. (2017) noted a link between the establishment of a trusting relationship between the young person and carer and the gaining of an appropriate sense of agency whereby positive transformation became possible. In addition, the findings revealed that the young people who had achieved scholastic success reported how effort and agency provided progress towards their goals, as told by this young person in Schofield et al. (2017): "At the time I had no intention of going to university, but she (worker) said, "Well why don't we put it in your Pathway Plan?" (Schofield et al., 2017, p. 785). This young person related how goal setting could be a cooperative process where carers could give encouragement towards a continued focus on progression and achievement.

However, for the young people who felt poorly placed in residential care, the opposite appeared to be in action. In addition to the perception of being placed in the wrong home and not being where they wanted to be in their developmental trajectory, they had an uncertainty towards

their future situation. This compounded the experience to being one of both being left behind and lacking the desired help. This, in turn, as suggested by this young person in Kelly et al. (2019), gave rise to a sense of hopelessness towards the future: “I guess I just don’t know where I’ll be when I turn 18 though or what I need to go do. I’m not like the other kids in school who know what they’re doing. I need more help.” (Kelly et al.; 2019, p. 259).

Not all the young people who felt they had gained maturity and development in terms of educational success felt this had been facilitated by their experience in residential care. Some participants believed that the maturing they had achieved was simply a part of the ageing process, as suggested by this young person in Henriksen et al. (2008): “It just happened by itself, I think, it’s not due to them, it is because one matures, gets older” (Henriksen et al., 2008, p. 153). Growth was not only measured by the young people as achieving instrumental success but also the experience of being able to regulate emotions and behaviour, suggesting that as the young person matured, they identified growth in their social skills.

Transitions in residential care also encompassed the transition out of care. In Schofield et al. (2017) the experience of leaving care emphasized the importance of a continuing care presence after residential care. The explicit gratitude for this service suggested that transitioning out of care was a long process where help was needed. In Nurcombe-Thorne et al. (2018), the young people were aware of the lack of help in this transition and gave voice to their concerns.

The findings in this theme demonstrate young people’s ability to reflect on their life course. Some identified the benefit of a good relationship with staff, while others identified burdensome worries and a perceived future they did not have the resources to survive.

8. Discussion

The presented themes demonstrated considerable variation within young people’s experiences from gratitude towards the help they received in care, to the experience of frustration regarding the expectation of fitting in and being cooperative in an environment where cooperation was challenging. These varied findings were noted across all papers and superseded setting, primary research area and age. Thus, it could be suggested that successful residency and outcomes in residential care are connected to the ability of the care home to engage with the young person in a way where it becomes attractive for the young person to engage positively with residential care. This is an important factor when investigating residential care as it raises questions towards the ability of the individual residential care setting to adjust expectations and methods to accommodate the individual needs of each young person.

The findings also revealed a group of young people who were in homes where they, quite possibly due to the actions of their care facility, had developed an understanding of being responsible for their own behaviour. This group also signaled an ability, within the context of their residential care home, to engage with the help offered and continue this positive development. This group were in a position and context to practise agency (Thoits, 2006). They demonstrated an experience of congruency between their perceived needs, development and the opportunities provided by a residential care placement that could support their development of agency. The young people who spoke of scholastic achievement and finding jobs offered an additional insight into their accounts of adjusting their mindset to accommodate the actions needed to support their goals. The second major group within the findings were the young people who experienced the help provided as inadequate. When this occurred, an alternative outcome of reduced well-being and exclusion was identified. These young people experienced a situation where they struggled to mature and appeared to be in a context where help was limited and the opportunity to develop the skills to be purposeful and agentic as they matured was perceived as inaccessible.

The core properties of agency (the belief we have control over our

own life) are complex and acquired through maturing from childhood to adulthood (Bolin, 2015). Thoits (2006) argues for a relationship between good mental health, problem-solving and the ability to exercise agency. Consequently, a finding from this review is that this group, who are young and therefore lack experience in problem-solving and have a lower sense of well-being, possibly with mental health problems, will have greater difficulty in being agentic in decision making. Thus, the findings suggested that some of the young people lacked the necessary help in situations where agency was expected with a follow-up experience of a negative cycle of struggling with agentic application to events which resulted in disappointment, and an increased belief of not being well-placed in care.

Positive well-being was reported as a result of a close supportive relationship between the young person and their carers, when good peer relationships were established and when success could be measured through meeting normative milestones such as good school grades. Positive behaviour, including emotional control, was also perceived as enhancing well-being as this achievement was perceived as enabling stability and social inclusion.

However, the predominant tone within the findings was towards negative emotional states such as fear, anger and sadness which were either directly represented in the findings or represented in the discussion sections within the papers. These were explained by the young people partially as an inevitable part of residential care and of living outside a family unit but also, for some, as a direct result of violence from peers, perceived indifference from the authorities and lack of interest and understanding from carers. The arguably over-representation of these emotions within the young people’s experiences was connected both to instrumental actions such as control and decision making by others and towards internal cognitions and emotions expressed as worry, loneliness and self-doubt.

For the young people who had an over-representation of negative psychological states, the outlook for a stable adulthood was reduced (Westermair et al., 2018). This group can arguably be positioned as under-served by the system of care. For this group residential care did not increase their emotional stability (Stikkelbroek et al., 2016) and, along with this, even appeared to increase negative associations within the realms of trust and safety.

Friendships were considered a major benefit of residential care, offering solace in often difficult situations. Friendship was positioned as giving a sense of belonging, beyond what the relational social capital (the quality of a positive relationship (Read & Laschinger, 2015)) between the young person and the carers could offer. The benefit of peer relations was however marred by experiences related to both peer violence and traumatic events occurring in residential care. Violence in care, as well as trauma connected to pre-care situations and the sequence of events connected to the transitions in and out of care, led to an aura of insecurity and fear for some of the young people. Trauma in childhood can have severe consequences for adult life (Callaghan et al., 2019), including the sense of a foreshortened future, whereby the individual holds a perception of a future bereft of positive meaningful events (Ratcliffe et al., 2014). In addition Callaghan et al. (2019) argue that children who have experienced violence have anxiety towards a future where violence is feared to be continuously repeated.

This discussion raises issues relating to how young people in residential care are either progressing or failing to thrive. However, in between these two groups, a third group was identified; this group gave the appearance of none-engagement with the care home in which they resided. While the findings are comparatively scarce from those within this profile, Henriksen et al. (2008) identified some young people who established an exchange between compliance with residential care and material gain. Whether the lack of information from this group is connected to their reticence to participate in research or because it was only the more extreme views of residential care that were asked about and therein presented in the primary papers is not known from the available information.

Finally only participants in one paper, Nurcombe-Thorne et al. (2018), mention therapy with a psychologist. Whether this is omitted because the young people did not receive this offer, the study they engaged in did not ask about this form of help, or they did not wish to discuss this part of their life is information unavailable to this review.

9. Limitations

The papers were generally located in countries with western values; thus, the findings of this systematic review do not reflect all cultures. This review has only included qualitative studies, findings from other methodologies are therefore not represented in the findings. Young people in residential care are a vulnerable population, choosing to share experiences may be unattractive (Liamputtong, 2007) and therefore it is doubtful that all the experiences the young people have lived through in residential care will have been revealed in the primary studies, which in turn may have affected the conclusions drawn in this systematic review. In addition, by synthesizing other researchers' papers a secondary analysis has been conducted, thus, through the interpretation of other authors' interpretations, limitations on the representation and understanding of the original participants' actual views and beliefs could have occurred (Sandelowski, 2008).

Finally, the decision to include studies where the participant age span was 12 – 26 years of age has meant that this review has only been able to offer a broad insight into the experiences of residential care rather than a precise insight into particular age-related development groups within the care system.

10. Conclusion

Each of the four high-order analytical themes described specific benefits and burdens when living in residential care. In summary the main findings of this review suggest that while experiences in residential care are varied, with positive experiences related, policy and practice makers need to further investigate: the impact on the young people when measures enacted to ensure safety in care, are perceived as controlling and impact on the young people's well-being; how to limit further the experience of being subjected to or witnessing violence within residential care; and, lastly, the at times, uncertain transition out of care needs further consideration by policy makers to ensure that young people are suitably supported during this phase of their lives.

This review has stimulated a discussion on how the young person's agentic capacity (Bolin, 2015), as well as their general well-being, can be affected by the young person's residential care facility's approach to support. This concern allies with the report from The International Work Group for Therapeutic Residential Care (Whittaker et al., 2016), which has highlighted the need for high intensity treatment services for the most challenged children and youth within the care system. Further research on how agency is developed among young people in residential care, as well as research investigating how negative psychological states can be better understood within the realm of residential care would offer valuable knowledge towards improving the experience of residential care by young people.

CRediT authorship contribution statement

Jacqueline Cameron-Mathiassen: Conceptualization, Methodology. **Julie Leiper:** . **Jane Simpson:** Supervision. **Elizabeth McDermott:** Supervision.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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