A systematic review of quality indicators in therapeutic residential care drawn from young people´s beliefs and experiences

Abstract

Young people´s perspectives on service quality in Therapeutic Residential Care (TRC) are commonly excluded or overshadowed by those of adults which has led to calls for better youth self-report indicators of quality healthcare. In response, we performed a systematic review of peer-reviewed literature to identify the most important quality indicators for young people by reviewing the literature on their beliefs and experiences regarding TRC and building on the four-pronged parsimonious framework (setting, staffing, treatment approach, and safety) proposed by Farmer et al., (2017). Following PRISMA guidelines, a systematic literature search was conducted in March 2022. Of the 17, 815 records screened, 15 articles, composed of 15 samples were included. A total of five domains and 13 quality indicators were identified: 1) Setting; 2) Staffing (professional skills and access to specialist support [doctor/therapist]); 3) Treatment approach (effective transition and aftercare support, rest and time to think, life skills, behavioural improvement, access to education and farm animals as therapeutic aides); 4) Safety (staff actions and structure and stability), and 5) Milieu factor (trusting relationships, family involvement, and relationship continuity). These four domains provide a practical framework for better-oriented treatment. The additional domain identified as the milieu factor places the critical quality indicators of TRC (e.g., trusting relationships) from the perception of the youth themselves, at the centre of attention, and encourages services to assess the extent to which they have the milieu factor, so they can strategically adapt and be responsive to the needs of young people. Policy and service delivery implications are discussed.

Keywords: Therapeutic residential care; young people´s beliefs and experiences; quality; youth-friendly care; systematic review

Introduction

Therapeutic Residential Youth Care (TRC) concerns the treatment and care of young people outside their family environment and aims to provide services to protect, care for, and prepare young people to return to life in the community (Harder & Knorth, 2015). Young people placed in TRC often display serious behavioural problems (e.g., 80% of young people were found to fall within the clinical range for externalising disorders [Trout et al., 2008]) and in many cases come from families with multiple complex problems, including unstable and difficult relationships, abuse, and conflict (Águila-Otero et al., 2020; Boel-Studt, 2017; Nijhof, 2011).

Residential care has many names, including variations in settings, treatment models, staffing patterns, size of living units, and length of stay (Castro et al., 2023; Daly et al., 2018). These variations and the overlapping of life and the treatment context in residential institutions are a continuous challenge in terms of understanding its elements, quality, and efficiency (Gazilj et al., 2021). For the first time, an international consensus statement provided a definition of TRC and its key elements: “TRC involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialisation, support, and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources.” (Whittaker et al., 2015, p. 24). By defining TRC, research reviews documenting the effectiveness of TRC practices and models can now provide a clear base for determining current programme quality and establishing future research, programme development, and policy directions (Daly et al., 2018).

Recent reviews of TRC models suggest that young people have more favourable outcomes than others in general residential care in terms of mental health, general well-being, school attendance, family contact, and community participation (McPherson et al., 2019; Pecora & English, 2016; Whittaker et al., 2015). Another review of 27 pre-and quasi-experimental studies of youth outcomes following TRC showed that programmes emphasising behavioural-therapeutic modalities and family involvement showed the most promising results; however, there was very little evidence supporting the maintenance of long-term treatment gains (Knorth et al., 2008). These reviews found that what constitutes TRC and its implementation remains a lacuna (Knorth et al., 2008; Whittaker et al., 2015). There is limited evidence for how TRC achieves treatment goals: TRC remains too much of a "black box" (Harder & Knorth, 2015).

However, while outcome studies are one piece of the quality puzzle, efforts to identify quality indicators and develop performance standards are needed (Lee & McMillen, 2008). This is because some people get better despite poor care and some get worse despite the best care; outcomes are not always the most valid indicators of service quality (McMillen et al., 2005). Further, a residential programme's poor performance on an outcome measure provides little guidance about what went wrong so that it can be addressed (McMillen et al., 2005). Some quality of care researchers prefer to assess quality through service processes rather than, or along with, outcomes (for example, Brook et al., 1996).

Nonetheless, no single model has been systematically established or widely applied to understand how quality can be achieved in social service settings (Lee & McMillen, 2008). An overview of the various findings and frameworks (Anglin & Henderson, 2023; Donabedian, 2003; Farmer et al., 2017; James, 2011; James et al., 2013; James, 2017; Lee & McMillen, 2008; Megivern et al., 2007) suggests that a myriad of potential factors should be considered when

assessing quality in residential settings and that four key domains may provide a core view of quality: safety, treatment, staffing, and setting (Farmer et al., 2017). This four-pronged conceptualisation covers a parsimonious set of domains and constructs that are relatively self-evident in their importance, measurable in fairly nonburdensome ways, and covers both safeguards against abuse and facilitators of positive change (Farmer et al., 2017).

Regarding the four critical domains, safety is particularly prominent in the literature with quality indicators, including rules and structures that promote safety, discipline that is fair and not excessive, and safeguards that reduce the fear of abuse by staff or other youth (Anglin, 2004; Megivern et al., 2007). Critically, existing sources agree that quality must include youths' assessments of the setting's safety (Farmer et al., 2017). Examples of key quality indicators for the treatment approach domain include an identifiable treatment model/programme (James, 2011), family-focused interventions (e.g., Geurts et al., 2012; Sunseri, 2020), and a focus on growth and development (Ennals et al., 2021). Staffing is another central domain in the literature, as regardless of the treatment approach/model adopted, it's the providers and their selection, training, and support that are the key quality indicators (Anglin & Henderson, 2023). The setting domain includes attributes of the physical environment that promote and indicate quality practices (Harder & Knorth, 2015) such as facility size and the extent to which it provides a welcoming home-like environment (Anglin, 2004).

Recently, researchers have called for increased focus on the perspective of individuals who receive child and youth services (Gharabaghi & Anderson-Nathe, 2015; Magalhães et al., 2022) as their views have often been overshadowed and excluded by those of adults (Gilligan, 2015). While it is true that paragraph 1 of Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) gives children the right to express their views freely in all matters

affecting them and for their views to be given due weight in accordance with their age and maturity; the process of translating this article results in a gap between the stated article and its realisation within policy and practice contexts (Robinson, 2021). Individual interpretations and biases can dictate which aspects of the article are translated, and this is particularly significant when it comes to enacting the article in practice (Robinson et al., 2020). For example, when children are viewed as being dependent upon adults, they are more likely to be perceived as incapable of forming their own opinions (Tisdall, 2018) and insufficiently competent or mature to be holders of their own rights (Robinson, 2021). Further, professionals may perceive young people's behavioural and emotional problems as hampering their ability to implement participation (McPherson et al., 2021). In such circumstances, children are viewed as not having 'the independence of mind and ability to act on their own choices' (Archard 2020a) and their views are unlikely to be accorded '*due weight*', with the outcome that their voices become marginalised or silenced (Robinson, 2021). However, children in residential care as service consumers are capable of expressing their needs and assessing the care they receive (Pérez-García et al., 2019).

Nevertheless, few adolescent-oriented measures of healthcare quality, satisfaction, or experience of TRC are based on young people's perspectives (Ensign, 2004; Tylee et al., 2007). Therefore, the conceptual framework proposed by Farmer et al., (2017), which has not been explored from the perspective of young people, could capture their core perceptions of quality in TRC and help identify any additional critical domains that emerge. In turn, this could crystallise the crucial elements of TRC and provide a bird's-eye view of service quality through their eyes, promoting an opportunity for an attentive audience and, ultimately, an influence on the service provided to them. Providing youth with an active role may have an empowering effect when they

become aware that their voice can create change (Cunningham & Rious, 2015; Kim, 2016). In addition, including youth's perspective in research may provide an understanding or priorities that differ from their caregivers, practitioners, and policymakers (Holland, 2009). In fact, it may be especially important to ask children about their experiences of TRC because they do not always have relationships with stable adults who can provide a reliable account of their lives (Dunn et al., 2010).

This systematic review aims to build on the extent to which the identified domains (setting, staffing, treatment approach, and safety domains) may be necessary and/or sufficient to adequately examine programmes' quality (Farmer et al., 2017) from the perspective of young people. In the current landscape of social services, resources are scarce and must be efficiently allocated to the most effective treatments, demonstrating the quality of care provided within a residential programme takes on increased importance (Lee & McMillen, 2008). Identifying these quality indicators would allow focused attention to those elements that, from the perception of the youth themselves, are considered relevant when moving from a narrative of incipient healing to one of healing (Beiza et al., 2015). Consequently, the main questions addressed in this review were: 1) What quality indicators within the four critical domains (setting, staffing, treatment approach, and safety domains) emerge from the beliefs and experiences of youth in TRC? 2) Do other critical domains emerge from the beliefs and experiences of young people in TRC?

Method

Inclusion and exclusion criteria

The inclusion and exclusion criteria are presented in Table 1. The definition of TRC (Whittaker et al., 2015, p. 24) was adapted and included "A purposefully constructed multi-

dimensional living environment designed to enhance or provide treatment, education, socialisation, support, and protection to children and youth with identified mental health or behavioural needs." Most studies do not include the extent to which the TRC programme works in partnership with families and in collaboration with a full spectrum of community-based formal and informal helping resources (Leipoldt et al., 2019). In addition, referral sources may vary i.e., CPS, criminal justice, and mental health system.

Evidence acquisition

This review adhered to the protocol for the preferred reporting items for systematic reviews and meta-analyses (PRISMA-P; Shamseer et al., 2015) and followed the five steps to conducting a systematic review: framing questions for a review, identifying relevant work, assessing the quality of studies, summarising the evidence, and interpreting the findings (Khan et al., 2003). A systematic literature search was conducted in March 2022 in the following eight databases, with no limits imposed on the year of publication: Academic Search Complete, APA PsycArticles, APA PsycInfo, Psychology and Behavioural Sciences Collection, ERIC, MEDLINE, Scopus, and Web of Science. The keywords used in the search were based on the Person, Intervention, and Outcome (PICO) model and are illustrated: a) child* OR adolescen* OR juvenile* OR youth* OR teen* OR young* AND b) "residential care" OR "therapeutic residential care" OR "institutional care" OR "group care" OR "group home" OR "residential treatment" AND c) experience* OR belief* OR perception* OR perspective* OR meaning OR quality OR qualitative. The search terms between the PICO statements were entered with an AND statement and the search was performed on the field "AllText", except for Scopus, which was performed on the field "Title and abstract".

Procedure

The search was conducted in each database (Scopus and Web of Science) and EBSCO (Academic Search Complete, APA PsycArticles, APA PsycInfo, Psychology and Behavioural Sciences Collection, ERIC, and MEDLINE). The results were uploaded to EndNote, where duplicate records were identified and removed. The resulting records were subsequently uploaded to the Rayyan QCRI for screening.

The author (EC) screened all records yielded by the search against the inclusion criteria based on the title and abstract only. An independent researcher (MP) screened 30% of the records and achieved an inter-judge agreement of 99.6 %. Cases of inclusion uncertainty (n=10) were discussed with EC, MP, and the second author (EM) until a consensus was reached. The eligibility of the remaining studies was determined by EC reading the full text (n= 44), and the reference lists of the included studies were screened by EC, resulting in no further studies being identified.

Data synthesis and presentation

The inclusion flowchart presents the number of identified records at each screening stage (see Figure 1) (Page et al., 2021). A total of 17,815 studies were identified, with a final selection of 15 studies. First, studies were characterised by the treatment model (e.g., Teaching-Family Model [TFM]) or "therapeutic intervention". "Therapeutic intervention" refers to a specific therapeutic component in TRC or practice (e.g., Cognitive Behavioural Therapy [CBT]) which may be delivered as part of the treatment model or as an add-on to maximise improvement. A "therapeutic intervention" may stem from a variety of therapeutic approaches and aims to have a therapeutic effect (i.e., reduce internalising and externalising symptoms) (Castro et al., 2023).

General study characteristics were also extracted, such as country, study design, participant statistics, and study domains (see Appendix A, Table 1S: Characteristics of studies – methodology and study domains). The methodology of the included studies was characterised using a modified quality checklist (Greenhalgh & Taylor, 1997) (Table 2: Quality Appraisal).

Adopting the conceptual framework proposed by Farmer et al., (2017), content analysis was used to extract quality indicators from young people´s beliefs and experiences regarding TRC. This conceptual framework provides a straightforward and relatively easy approach to identifying quality indicators (Farmer et al., 2017). The spreadsheet was divided into four sections (setting, staffing, treatment approach, and safety), and quality indicators were extracted from young people´s beliefs and experiences. The analysis and results were discussed with another investigator on the research team to validate the results further. The results were described by presenting the number of studies that reported each quality indicator.

Results

Study characteristics

The characteristics of the included studies are listed in Table 1S (see Appendix A). Most studies were performed in the USA (n= 7; 46.7%), four studies were performed in Europe, two studies were performed in Australia and one study was performed in South America and Israel. Sample sizes ranged from 5–405 participants. This review involved 1003 youth (age range 5-25). Most studies specified the therapeutic intervention (n= 5; 33.3 %), followed by those that specified the treatment model (n= 4; 26.7%), and those that did not specify the treatment model or therapeutic intervention (n= 6; 40 %). The treatment models included the TFM (n= 2; 13.3 %), Youth Care Plus (n= 1; 6.7%), and Integrated Care Model (n= 1; 6.7%). The therapeutic

interventions included farm animals as therapeutic aides (n=1; 6.7%), milieu therapy (n=1; 6.7%), multidisciplinary team with specialised training in child sexual abuse and therapy sessions (n=1; 6.7%), individual, strengths-focused support and coaching (n=1; 6.7%), and access to a range of therapies and one-to-one key working sessions (n=1; 6.7 %). The studies employed an array of analytical approaches, including thematic analysis (n=7; 46.7%), grounded theory (n=2; 13.3%), exploratory (n=2; 13.3%), descriptive statistics (n=2; 13.3%), naturalistic (n=2; 13.3%), descriptive and phenomenological approaches (n=1; 6.7%), and template analysis (n=1; 6.7%). Data were collected through semi-structured interviews (n=8; 53.3%), followed by closed and open-ended interviews (n=3; 20%), focus groups (n=2; 13.3%), open in-depth interviews using an autobiographical life story method (n=1; 6.7%), in-depth interviews (n=1; 6.7%), structured interviews (n=1; 6.7%), and a questionnaire (n=1; 6.7%). Most studies specified the referral source as either the Child Protection System (CPS) (n=6; 40%) or mixed (n=5; 33.3%), followed by those who were referred voluntarily (n=2; 13.3%), or where the referral source was not specified (n= 2; 13.3%). Most studies focused on quality indicators related to the milieu factor domain (n=11; 73.3%) and treatment approach (n=8; 61.5%), followed by the staffing domain (n=5; 33.3%), setting domain (n=3; 20%), and safety domain (n=1; 6.7%).

Quality Indicators

A total of 13 quality indicators associated with five critical domains were reported in 15 studies (see Table 3). In addition to the four critical domains identified by Farmer et al., (2017), another domain emerged as critical and was identified as the milieu factor in which young people perceived trusting relationships as a crucial component of TRC.

Setting

Available resources (n=4). The available resources identified as important to young people were physical resources such as meals, the bedroom, sports equipment, computers (Pérez-García et al., 2019; Schaefer, 1972), skills-building (e.g., carpentry and mechanics), and leisure activities (e.g., trips) (Gallagher & Green, 2012; Pérez-García et al., 2019; Schaefer, 1972).

Staffing

Professional skills (n=5). Young people listed several crucial professional skills for care workers and educators. This included the ability of care workers and educators to provide a fine balance between rules and freedom (Harder et al., 2017; Pérez-García et al., 2019). In addition, the staff took time to get to know them which indicated that they cared and was highlighted as an essential skill when establishing rapport (Ennals et al., 2021; Kor et al., 2021). Showing empathy, being available for support, being careful with the upkeep of the household, being reliable, honest, resistant to stress (Harder et al., 2017), and listening well (truly understanding what the young person means) (Ennals et al., 2021; Harder et al., 2017) were also identified as key professional skills for care workers. These slightly differed for educators which included being supportive, having expertise (knowing what he/she is doing), inspiring, and having a good sense of humour and patience (Harder et al., 2017). Young people also pointed out that being left in the dark without a discussion about the reason for the changes in placement engendered a sense of powerlessness and diminished self-worth (Kor et al., 2021). Young people also pointed out specific needs that should be met by educators which could inform practice, such as the need for least-intrusive behavioural management, preventative strategies for behaviour, differentiated instruction, and recognition (Somers et al., 2021).

Access to specialist support [Doctor and Therapist] (n=2). Young people highlighted that they found having access to a doctor for medical support helpful (Field et al., 2021), and that a therapist was someone of great relevance in the healing process and promoted positive changes in their lives (Beiza et al., 2015).

Treatment approach

Effective transition and after-care support (n=3). Young people felt that transitions from placement should be delivered over time instead of one single event (Field et al., 2021; Kor et al., 2021) and that the aftercare provided was either not helpful or discontinued prematurely (January et al., 2018).

Life skills (n=2). Young people expressed wanting to learn life skills to successfully live independently, such as public transport, driving, cleaning, washing, budgeting, shopping, and cooking (Ennals et al., 2021; Nickerson et al., 2006). Supported opportunities to practice skills individually and in groups were valued as they established independence (Ennals et al., 2021).

Rest and time to think (n=1). Young people highlighted the need for time and space to regain control over their lives and discover what fits in with who they are or want to be as a person (Bramsem et al., 2019).

Behavioural improvement (n=1). When asked what they hoped to gain from treatment, adolescent responses included improving behaviour (e.g., developing a better attitude and learning coping skills) (Nickerson et al., 2006).

Access to education (n=1). When young adults were asked why they were positive about school, they drew attention to the specific benefits they had gained. These composed of improvements in their general learning, securing qualifications, developing emotionally, acquiring a sense of being 'normal', and making friends (Gallagher & Green, 2012).

Farm animals as therapeutic aides (n=1). Young people reported that petting animals helped regulate their emotions when they were feeling sad (Mallon, 2001).

Safety

Staff actions(n=1). Young people stated that they felt safe when care workers were physically present and actively engaged (i.e., not in the office for prolonged periods) (Kor et al., 2021).

Structure and stability (n=1). Young people reported that their experience of safety was cultivated by structure and stability in the living environment. Without these, young people revealed that it could trigger traumatic memories of abuse and neglect (Kor et al., 2021).

Milieu factor

Trusting relationships (n= 5)

Young people consistently stressed that trusting relationships with peers, staff and family were vital to their recovery (Bramsen et al., 2019; Ennals et al., 2021; Gallagher & Green, 2012; January et al., 2018; Pazaratz, 1999; Pérez-García et al., 2019) Youth identified unhealthy relationships as a key barrier contributing to their return to TRC (January et al., 2018). When

asked what they hoped to gain from treatment, adolescent responses included improving their relationships with family and peers (Nickerson et al., 2006).

Family involvement (n=5). Young people reported missing and worrying about their families (Bramsen et al., 2019; Kor et al., 2021; Schaefer, 1972), and most young adults thought that parents should be involved in various degrees of contact (Sulimani-Aidan & Paldi, 2020). The absence of fathers in family contact was also keenly felt by young people (Kor et al., 2021). Lack of family contact or knowledge of why contact with other family members could not happen seemed to exacerbate ambiguous loss for some young people (Kor et al., 2021). All youth noted that building and maintaining trusting relationships with family members and their peers in the community was challenging but vital, and if not achieved at discharge from TRC, could result in their return (January et al., 2018).

Relationship continuity (n= 3). Young people expressed that they felt more secure in establishing relationships with staff when staff turnover was low (Beiza et al., 2015; Kor et al., 2021). Most young people found it helpful to stay in touch with the staff post-discharge (Gallagher & Green, 2012).

Discussion

This study identified the aspects of TRC that were most important to young people by reviewing the literature on young people´s beliefs and experiences of TRC within four critical domains (setting, staffing, treatment approach, and safety) and identifying quality indicators and additional critical domains. A total of five domains and 13 quality indicators were identified: 1) **Setting**; 2) **Staffing** (professional skills and access to specialist support [doctor/therapist]); 3)

Treatment approach (effective transition and aftercare support, rest and time to think, life skills, access to education, farm animals as therapeutic aides); 4) **Safety** (staff actions, structure and stability) and 5) **Milieu factor** (trusting relationships, family involvement and relationship continuity).

The four domains proposed by Farmer et al., (2017) were robust and provided a practical framework for identifying quality indicators that can assess how well services engage young people. An additional domain emerged as critical and was identified as the milieu factor in which young people perceived trusting relationships as a crucial component of TRC. This is consistent with studies of milieu-based services (Pecora & English, 2016) in which trusting relationships support healing and growth–the change work and recovery of mental ill-health and emotional distress (Bjørlykhaug et al., 2020; Ennals et al., 2021). The additional domain encourages services to assess the extent to which they have the milieu factor and strategically work towards this. As according to the young people, services that have the milieu factor are more likely to respond to their needs.

Relationships, including those between family and peers, were even more critical for young people in TRC, as indicated by their beliefs and experiences. It could be said that relationships, or more specifically, a breakdown in relationships, are the crux of the reason why many children are in TRC (Gallagher & Green, 2012). It's not surprising that "real" relationships emerged as what matters most to young people (Bramsen et al., 2019; Ennals et al., 2021). For it is "real" relationships where young people connect via interest not illness which creates a sense of belonging, normalcy and feeling known as a person beyond a diagnosis (Ness et al., 2017).

Furthermore, although trusting relationships were reported by young people in different settings (i.e., CPS, mixed, voluntary) as a critical quality indicator, specific quality indicators in

the milieu factor domain may be particularly important to certain groups of young people in TRC, such as family involvement and relationship continuity for young people in the CPS. Although challenging, the key to helping children with serious mental health problems in the CPS may also lie in treating the family as a whole and improving its overall functionality rather than providing more client-focused interventions (e.g., individual or group therapy) (Sunseri, 2004; Sunseri, 2020). The shift to increase family involvement may not only address the youth's struggles but also contextual factors that may be underlying the emotional manifestations of their struggles, such as pressures to conform to traditional gender roles (Farley et al., 2020).

In addition, relationship continuity was not only defined by the continuity of placement but also by the continuity of relationships with residential care practitioners during placement and post-discharge. The complexities surrounding the factors which influence relationship continuity, such as frequent staff turnover (Munro, 2001), make it a subject requiring research which moves beyond simply counting the number of placements children experience (Usher et al., 1999).

Regarding the setting domain, young people highlighted available resources, such as leisure (e.g., trips) as an important feature of TRC. This is consistent with the literature that suggested that leisure activities can play an important role in facilitating the development of trusting relationships (Gilligan, 2007) which this review identified as paramount for the success of long-term treatment outcomes.

Young people highlighted quality indicators in the staffing domain such as professional skills and access to specialist support. Young people provided a clear overview of the skills that professionals in TRC should possess which could be practically used for skills training. It is important to note that these professional skills are essential for staff to navigate a range of

tensions and conflicting responsibilities (Gallagher & Green, 2012). For example, they need to develop trusting relationships with children, at the same time as having to uphold the duty to share sensitive information about those children with colleagues and facilitate children's friendships and leisure activities, but also ensure that these do not lead to harm to the child or anyone else (Gallagher & Green, 2012). This emphasises how important it is for staff to be adequately supported and satisfied in their role so that staff retention is high and young people feel safe in forming trusting relationships. Young people also point out that having access to specialist support such as a doctor and therapist is paramount in their recovery (Beiza et al., 2015; Field al., 2021), and building trusting relationships with their therapist is a turning point in both the psychotherapeutic and healing processes (Field al., 2021).

Regarding the treatment domain, young people indicated the need for the transition from TRC to be a gradual process. It is both unethical and counterproductive to provide a young person with high-needs intensive support, only to end their placement or other support services abruptly at 18, regardless of their ongoing needs and expressed wishes (Field al., 2021), which is the case for some in TRC. Furthermore, tailored aftercare services post-discharge may be required to meet the unique needs of each youth and their caregiver(s).

Young people shed light on the treatment approaches they found helpful and did not highlight a specific therapy, such as CBT or treatment approach. The findings highlighted that young people may respond well to therapeutic modalities that focus on their personal and developmental needs while in TRC (i.e., rest and time to think, access to education, animals as therapeutic aids) and what they want to achieve (i.e., behavioural improvement, autonomy and trusting relationships [milieu factor]). Rest and time to think was identified by mostly male participants in the CPS, where the prevalence of youth experiencing multiple traumatic events,

such as abuse, neglect, and violence, can be as high as 92% (Briggs et al., 2012). Considering the prevalence of complex trauma, having time to explore may be ideal during this time of life but may not be a reality for these youth (Munson et al., 2013). In samples of young people aged 18-21, the development of agency, sense of control, and independent living skills were priorities (Hooper et al., 2000; James, 2011; Rivard et al., 2005) and suggested that for older youth, working towards achieving autonomy may be highly motivating. Behavioural improvement was noted in a study with a mixed sample of mostly male participants; young people in TRC present with a high prevalence and severity of externalising disorders (Trout et al., 2008), and females tend to respond better to treatment (Farley et al., 2020). Providing an opportunity for young people to actively select the appropriate treatment options may be particularly important for young people in CPS, as they are often involuntary clients and/or who are not engaged in services (Boel-Studt et al., 2018). Furthermore, it is essential to focus on the patterns of co-occurring risk and protective factors in different subgroups to promote the success of TRC and tailor interventions accordingly.

Only one study reported quality indicators related to the safety domain in a sample of young people in the CPS (Kor et al., 2021). In this study, young people spoke about safety in terms of prevention of abuse and harm (e.g., the need for care workers to act proactively to prevent and respond to peer victimisation for them to feel safe) (Kor et al., 2021), as well as the need for predictability, such as a structured and stable environment (Kor et al., 2021). Although safety from abuse and harm is vital, studies have consistently shown that the residential care experiences of many children and young people are marked by a lack of safety, sustained violence, and ongoing threats of physical, emotional, and sexual abuse (Attar-Schwartz & Khoury-Kassabri, 2015; Finkelhor et al., 2016; McLean, 2015). Therefore, as many have

experienced significant trauma, abuse, and loss before entering and during their time in out-of-home care, children and young people need their residential care to be safe to enable them to overcome the effects of their past abuse and to positively grow and develop (Bath, 2015a; Bath, 2015b; Hawkins-Rodgers, 2007; Holden et al., 2010). This is particularly important if the aim of residential care is to be therapeutic and to help young people heal and grow during their time in care (Bath 2015a; Bath, 2015b). A targeted approach to increase the milieu factor and strengthen trusting relationships with peers, staff, and the family may assist in young people´s sense of safety, as healing starts by creating an atmosphere of safety (Bath, 2015a; Bath, 2015b), and an atmosphere of safety begins with trusting relationships.

Limitations and future recommendations

To our knowledge, this review is the first synthesis of literature testing the conceptual parsimonious framework proposed by Farmer et al., (2017), with a focus on identifying quality indicators drawn from the beliefs and experiences of young people. A strength of this review is that in applying this framework to young people, TRC can better orient treatment to young people's needs, and findings could be incorporated into teaching and training initiatives to enhance youth-friendly health care (Ambresin et al., 2013). To standardise the quality of qualitative studies, we used a widely accepted assessment tool (Greenhalgh & Taylor, 1997) and found that all qualitative studies were methodologically sound. The consistency of the results from several studies was observed, with eight of the quality indicators supported by several studies.

However, some limitations have been identified, such as not reporting the referral source (Pérez-García et al., 2019; Schaefer, 1972). Therefore, it is unclear what specific population of

young people the findings relate to. In addition, despite the inclusion criteria being broad and including multiple referral sources, that is, CPS, juvenile justice, mental health, and young people's reflections on their TRC experience retrospectively, no specific studies were identified relating to juvenile justice or young people's TRC retrospective reflections. Consequently, qualitative studies that capture the lived experiences of all young people in TRC, including those who have left, are needed to fully identify the quality indicators that are important to young people in TRC and what might be particularly important for a specific group of young people.

An avenue for future research is to test the conceptual framework with staff. From the perspective of young people, the continuity of staff in post is vital for the formation of trusting relationships (Beiza et al., 2015; Kor et al., 2021). Understanding the perspective of staff and giving them opportunities to voice their beliefs and experiences to improve the service provided places value on their experience and may promote staff satisfaction which, in turn, may promote staff continuity and trusting relationships with young people. Further, this promotes the culture of having a voice and feeling respected and enriches the quality indicators identified by young people.

Implications for policy and practice

What are the implications of these findings on the provision and delivery of TRC? Perhaps the most important new finding is the identification of an additional domain to Farmer et al., (2017) framework, identified as the "milieu factor" and the importance of trusting relationships. This has been identified as a distinct domain owing to the critical nature of trusting relationships highlighted by young people in TRC and the multifaceted approach required to cultivate and sustain such relationships in a residential milieu. Not only is a treatment approach

that considers this, but all four critical domains proposed by Farmer et al., (2017) should be considered when promoting trusting relationships, such as a wider staff training focused on managing the complex peer and family dynamics, leisure activities to promote socialisation, etc. Distinguishing this critical domain allows focused attention to an aspect of TRC that is paramount to young people in the long-term. Services can assess the extent to which they have the milieu factor, and strategically adapt to enhance trusting relationships. As according to young people, services that have the milieu factor are more likely to respond to their complex needs and make a lasting difference in their lives.

Young people in the CPS strongly expressed the need for relationship continuity as an important quality indicator in the milieu domain. This suggested that quality services must ensure that staff are carefully selected, valued (e.g., growth opportunities), and well-supported (e.g., adequate training and supervision, adequate procedures, and support systems) so that staff satisfaction is high to ensure a high level of staff retention and, thus, relationship continuity. In fact, relationship continuity may be the key to building trusting relationships and, particularly crucial for young people in the CPS. Indeed, young people in contact with their biological parents while in care experience emotional growth and better functioning in adulthood (Weiner & Kupermintz, 2001). It is possible, however, that these two aspects are connected, and that the continuity of relationships with biological parents facilitates the youth's formation of new relationships with others (Bowlby, 1988).

Further, findings suggested that family involvement may be particularly critical for young people in the CPS. Therefore, when possible, services should attempt to overcome any barriers to visitation or involvement (e.g., paying travel expenses, providing family therapy, offering family accommodation on-site, and using online platforms to facilitate communication). For those

where family involvement is not possible, additional support targeted at building trusting relationships should be provided.

Trusting relationships with peers also appeared to contribute to a sense of safety in TRC. The need for safety and protection from peer victimisation indicates that more careful assessment is required when making decisions about placement matching (Kor et al., 2020), and that the milieu factor (trusting relationships) should be considered even before placement. The findings also have implications for research and policy and strongly suggested that including young people's perspectives, as well as working together with them as partners may open up promising new areas for innovations in care (Bramsen et al., 2019). Closing the gap in knowledge about the quality of care that youths receive will require both providers and scholars to work collaboratively to identify quality indicators and performance measurements (Whittaker et al., 2006).

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Table 1

Inclusion and exclusion criteria

Category	Inclusion criteria	Exclusion criteria
Intervention setting	Residential therapeutic programme[a]	Foster care, outpatient setting, combined care, medical setting, hospital setting, school setting or prisons.
Research respondents	Young people below the age of 25 currently in a Residential therapeutic programme[a] or Residential therapeutic programme[a] leavers.	Young people above the age of 25 or with disabilities.
Key variables	Qualitative non-structured interpretation of beliefs and experiences about quality indicators in a Residential therapeutic programme[a]	Quantitative scores of beliefs and experiences

Research methods	Empirical studies using any qualitative methods.	Quantitative, case studies and review studies.
Cultural and linguistic range	Studies written in or translated into English, Portuguese and Spanish.	Other languages other than English, Spanish and Portuguese.
Time frame and Publication type	No time frame restriction applied. Scientific peer-reviewed articles.	Conference abstracts, books, chapters, dissertations and reports.

[a] Definition of the residential therapeutic programme: a purposefully constructed multi-dimensional living environment designed to enhance or provide treatment, education, socialisation, support, and protection to children and youth with identified mental health or behavioural needs. Referral sources may vary i.e., child protection system, criminal justice and mental health system.

Table 2

Quality appraisal

	Yes	**No**	**Unclear**
Was a qualitative approach appropriate?	1,2, 3, 4, 5, 6, 7, 8, 9,10,11, 12, 13, 14, 15		
Was the sampling strategy appropriate for the approach?	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15		
What were the data collection methods?	3, 6, 7, 13	1, 2, 4, 5, 8, 9, 10, 11, 12, 14, 15	
How were data analysed and how were these checked?	1, 2, 4, 8, 13	7	3, 5, 6, 9, 11, 12, 15
Is the researcher's position described?	2, 3, 4, 5, 11, 14	1, 5, 6, 7, 8, 9, 10, 12, 13, 15	
Do the results make sense?	1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11, 12, 13, 14, 15		
Are the conclusions drawn justified by the results?	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15		
Are the findings transferable to other clinical settings?	1, 2, 3, 4, 5, 6, 7,8, 9, 10, 11, 12, 13, 14, 15		

Note:1-Beiza et al. 2015; 2-Bramsen et al. 2019; 3- Ennals et al. 2020; 4- Field et al. 2021; 5- Gallagher & Green, 2012; 6- Harder et al. 2017; 7- January et al. 2018; 8- Kor et al. 2021; 9- Mallon, 2001; 10- Nickerson et al. 2006; 11- Pazaratz, 1999; 12- Pérez-García et al. 2019; 13- Schaefer, 1972; 14- Somers et al., 2021; 15- Sulimani-Aidan & Paldi, 2020

Table 3

Summary of quality indicators within each domain

Domains	Quality Indicators	Authors
Setting		Gallagher & Green, 2012; Pérez-García et al., 2019; Schaefer, 1972
Staffing	Professional skills	Ennals et al., 2021; Harder et al., 2017; Kor et al., 2021; Pérez-García et al., 2019; Somers et al., 2021
	Access to specialist support	Beiza et al., 2015; Field et al., 2021
Treatment approach	Effective transition & aftercare support	Field et al., 2021; January et al., 2018; Kor et al., 2021
	Rest and time to think	Bramsen et al., 2019
	Life skills	Ennals et al., 2021; Nickerson et al., 2006
	Behavioural improvement	Nickerson et al., 2006
	Access to education	Gallagher & Green, 2012
	Farm animals as therapeutic aides	Mallon, 2001
Safety	Staff actions	Kor et al., 2021
	Structure and stability	Kor et al., 2021
Milieu factor	Trusting relationships	Bramsen et al., 2019; Ennals et al., 2021; Gallagher & Green, 2012; January et al., 2018; Pazaratz, 1999; Pérez-García et al., 2019; Nickerson et al., 2006

	Family involvement	Bramsen et al., 2019; January et al., 2018; Kor et al., 2021; Schaefer, 1972; Sulimani-Aidan & Paldi, 2020
	Relationship continuity	Beiza et al., 2015; Gallagher & Green, 2012; Kor et al., 2021

Figure 1

Inclusion flowchart