

Residential care as an alternative care option: A review of literature within a global context

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Abstract

While there is unequivocal agreement on the need to support families and to avoid all unnecessary separation, there are ongoing debates across policy and practitioner communities nationally and internationally, around the place of residential care within the range of alternative care services which should be available to children who need them. This paper presents the findings of a review of evidence looking at the function, quality and outcomes of residential care based on 111 papers identified for inclusion using systematic searches. The review identifies definitional ambiguity in the use of the terms 'residential' and 'institutional' care in the literature, alongside the different cultural, social and economic contexts, makes generalizing challenging. However, we found insufficient evidence to substantiate claims that residential care is inherently unsuitable. We identify research gaps in the literature, including in relation to quality, children's perspectives and factors that impact upon the suitability of residential care for different children, before discussing implications of the findings for research, policy and practice.

KEYWORDS

alternative care, children's rights, deinstitutionalisation, quality care, residential child care, suitability of care

1 | INTRODUCTION

The 1989 United Nations Convention on the Rights of the Child (UNCRC) is the most widely ratified human rights treaty in the world, constituting a consolidated and comprehensive body of law on children's human rights. While reaffirming some rights already encompassed in pre-existing international human rights instruments, it also covers gaps in areas such as protection from violence and neglect, and alternative care (Cantwell, 2019). Concerns around the high numbers of children in alternative care worldwide, too often for preventable reasons, alongside the quality of such care and a lack of

prioritization in addressing these issues, led to the drafting of the UN Guidelines for the Alternative Care of Children ('the UN Guidelines') (Cantwell et al., 2012; UN General Assembly, 2009). These were unanimously welcomed by the UN General Assembly in 2009. The adoption of the UNCRC and subsequent international instruments, notably the UN Guidelines, has encouraged reforms of child welfare systems across the world.

While there is unequivocal agreement on the need to support families and to avoid all unnecessary separation, there are ongoing debates across policy and practitioner communities. These include national and international considerations of the place and role of

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residential care within the range of alternative care services for children who need them (Porter et al., 2020).

Complicating this debate and associated research is the fact that the terminology denoting and describing different forms of alternative care, particularly residential versus institutional care, has evolved, but usage still varies across policy, research and practice.

To gain a better understanding of the body of evidence about residential care, a rapid evidence review was commissioned by SOS Children's Villages International and conducted by the Centre for Excellence for Children's Care and Protection (CELCIS) at the University of Strathclyde, to explore what the existing evidence tells us about the function, quality and effects on outcomes of residential care for children. This paper presents the findings of the review, and explores the implications for research, policy and practice.

1.1 | The evolution of international policy on care options

1.1.1 | From the UNCRC to the UN Guidelines for the Alternative Care of Children

The UNCRC stipulates that alternative care should be provided for children temporarily or permanently deprived of their family environment. Article 20 favours placement within a family but also refers to the use of 'suitable institutions for the care of children' as an option, 'if necessary'. The terminology used to describe forms of non family-based care, as well as understanding about different forms of care within the range of care options, has evolved in the years since the adoption of the UNCRC. The UN Committee on the Rights of the Child's General Comment No. 3 (2003) presents 'institutionalized care' as 'a measure of last resort' that may have 'an interim role to play' for children orphaned by HIV/AIDS, when family-based care within their own communities is not possible (para. 35). Later, General Comment No. 9 (2006) reiterates a preference for family-based care and argues for the transformation of institutions into 'small residential care facilities organized around the rights and needs of the child', subjected to national standards for care and rigorously monitored (para. 47). This represents a shift in the terminology used to describe these different models of non family-based care and reflects growing consideration for elements contributing to quality care, by making an increasingly clear distinction between 'residential' and 'institutional' settings.

Subsequently, the UN Guidelines (2009) differentiate between residential care and 'large residential settings (institutions)' and call for the elimination of the latter. While they reinforce the principles of the UNCRC, the Guidelines offer more specific, extensive guidance, clarifying that national frameworks of care provision must be able to 'meet the specific psycho-emotional, social and other needs of each child without parental care' (paragraph 53). The Guidelines encourage countries to ensure the availability of a range of options for emergency, short-term and long-term alternative care. Alongside the emphasis placed on prioritizing family- and community-based solutions, they invite

countries to consider and enable informal and formal care arrangements, including kinship, foster and residential care (paras 54, 29).

1.1.2 | The necessity and suitability of residential care for children

In relation to residential settings specifically, the UN Guidelines (2009) encourage States to recognize that their use 'should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests' (para. 21). The Guidelines acknowledge that the objective of such a placement 'should generally be to provide temporary care and to contribute actively to the child's family reintegration', or when this is not possible, to support the child into 'stable care in an alternative family setting' (para. 123). The use of residential care for young children, especially those under the age of 3 years old, is discouraged (para. 22). Residential care provision should be small and organized around the rights and needs of the child, 'in a setting as close as possible to a family or small group situation' (para. 123), with 'sufficient carers (...) to allow individualized attention and to give the child, where appropriate, the opportunity to bond with a specific carer' (para. 126). Furthermore, the UN Guidelines encourage the establishment of 'care standards to ensure the quality and conditions that are conducive to the child's development' and to 'evaluate existing facilities against these standards' (para. 23), to allow for the progressive phasing out of settings not meeting them.

The principles of necessity and suitability of alternative care are therefore at the heart of the UN Guidelines (Cantwell et al., 2012) and should guide the design and delivery of alternative care systems. Adhering to these principles requires the prevention of unnecessary entry into alternative care and closer attention to supporting and strengthening families. The necessity principle thus aims to ensure that children are only placed in alternative care when this is genuinely required. The suitability principle complements this by requiring that children in need of alternative care have access to carers and an environment suitable to their unique individual needs and circumstances (Cantwell et al., 2012). So, while there is a presumption that family-based care will most often best meet a child's needs, there is also a recognition that a range of care options, including residential care, is necessary to ensure that the needs of all children can be effectively met. Indeed, the UN Guidelines recognize that 'residential care facilities and family-based care complement each other in meeting the needs of children' (para. 22). They are also clear, however, that institutional care does not meet the suitability principle and that greater attention to what constitutes suitability of residential settings is required.

1.1.3 | Understanding of residential versus institutional care

Efforts to identify the characteristics of suitable and unsuitable alternative care settings have continued, including further clarification of what constitutes residential, as distinct from institutional care. The

Common European Guidelines on the Transition from Institutional to Community-based Care (Ad Hoc Expert Group, 2009; European Expert Group, 2012) acknowledged that some definitions of institutional care consider the size element, but ultimately, the defining feature is the presence of an 'institutional culture'. This is essential for understanding the key characteristics of this form of care, differentiating between types of arrangements and appreciating their ability to meet children's needs, respect and promote their rights and offer a level of choice, participation, autonomy and dignity. These characteristics are isolation from the broader community, residents being compelled to live together, children having insufficient control over their own lives and the decisions that affect them and the requirements of the organization taking precedence over children's individual needs (European Expert Group, 2012).

Acknowledging the challenges of providing widely accepted definitions, the Geneva Working Group on Children in Alternative Care (2013) focused on identifying the basic characteristics of different formal alternative care settings for children. In a discussion paper, it described institutions as residential care settings '*where children are looked after in any public or private facility, staffed by salaried carers or volunteers working predetermined hours/shifts, and based on collective living arrangements, with a large capacity*'. What distinguishes institutional care from other forms of residential care is the nature of the care provided (Geneva Working Group, 2013). Thus understood, an institution cannot be considered a suitable form of care from a child rights perspective and in line with the UN Guidelines. The 2019 United Nations Global Study on Children Deprived of Liberty (Nowak, 2019) also refers to characteristic of 'institutional culture' as given by the European Expert Group and, more recently, the UN CRPD General Comment No. 5 (2017).

Despite these efforts to provide clarity around terminology and descriptors of different forms of residential alternative care, differences in the use and definition of terms persist and clearly distinctive terminology has not yet been universally adopted.

1.2 | Debate on the suitability of residential care

One of the most significant impacts of the UN Guidelines (2009) was to offer a framework for the provision of quality and suitable alternative care to be provided for a child only when necessary—with efforts directed primarily at preventing the recourse to alternative care whenever possible. It formalized and strengthened global understanding of the harmful effects of institutional—thus unsuitable—care settings on children's well-being, development and outcomes and promoted 'progressive elimination' in the context of an 'overall deinstitutionalization strategy' (para. 23). The global community is unanimous in supporting this agenda (Geneva Working Group, 2013; Goldman et al., 2020; UN General Assembly, 2019; van IJzendoorn et al., 2020). However, in pursuit of it, different standpoints have emerged in relation to the role of residential care. The UN Committee on the Rights of Persons with Disabilities (UN CRPD, 2017), for example, considers that 'large or small group homes are especially dangerous for children' with

disabilities (para. 16) and equates family-like care (small group homes) with institutions, thus always unsuitable.

This is a subject of ongoing discussion between the UN Committees on the Rights of the Child and on the Rights of Persons with Disabilities. The 2019 UNGA Resolution restates and affirms many of the considerations in the UN Guidelines (including the need to avoid placement in institutions) but, other than referring to community-based options, makes no mention of residential care (UN General Assembly, 2019; para. 22, 23 and 35). Similarly, the Global Study on Children Deprived of Liberty mentions that provision of quality temporary, specialized care in a small group setting, for the shortest appropriate period may be necessary, but efforts should focus on ensuring children are cared for in families (Nowak, 2019).

Van IJzendoorn et al. (2020) suggest that this 'disagreement as to whether policy should focus on eliminating, transforming or improving' (p.703) is linked to a need for consensus on how evidence related to care settings is interpreted. Taking a wider view, interpreting the available evidence requires scrutiny of what forms of alternative care are being researched or evaluated and how these are defined, characterized and measured. Scrutiny is also required of the methodologies used for drawing comparisons between care settings, and thus of their robustness in attending to possible bias, including when interpreting findings and taking account of confounding variables such as the experiences or effects upon children of occurrences prior to their entry into alternative care.

Acknowledging these complex issues, this paper takes as its starting point the standards and principles regarding the provision of a range of alternative care options. We accept that, no matter the effectiveness of child welfare systems, there will always be a need for some children to have access to alternative care, which understands their circumstances, meets their needs and upholds their rights. These principles cannot be upheld in institutional care, which we see as significantly distinct from high-quality residential care. We see a need for careful appraisal of the role, quality and effects of residential care in a global context to support greater understanding of its suitability (or not) for some children, in some circumstances.

Throughout our discussion and conclusions, we use the term 'residential care' to refer to settings that meet the quality criteria outlined in the UN Guidelines detailed above, in contrast to unsuitable institutional care. In the findings section, we reflect the terminology used by the original authors.

2 | OVERVIEW OF THE STUDY METHODS

Within this backdrop, in 2020, we set out to address the following research questions:

1. What is the function of residential care as part of a range of alternative care options?
2. What facilitates 'quality' care in residential care?
3. What effect does residential care have upon outcomes for children and young people?

We used a rapid review methodology developed by Khangura et al. (2012) which has been used within the context of various disciplines (Blakemore et al., 2017; Kadykalo et al., 2020). This approach aims to gather and report evidence in a shorter timeframe than traditional systematic reviews and to focus on the purpose and usefulness of the evidence in practice. While rapid review approaches do not have the same degree of rigour as traditional systematic reviews and may be more susceptible to bias (Tricco et al., 2015), the approach described by Khangura et al. (2012) emphasizes its strong focus on meeting the needs of the 'knowledge users'. We followed the eight steps described by Khangura et al. (2012), which include processes to engage stakeholders in the definition of focus and process for the review, to ensure it meets their needs. The search strategy incorporated a range of terms representing the concepts of: 'residential child care' (including institutions), 'children' and 'effectiveness', with a number of synonyms and similar phrases for each. The finalized search string was defined as follows:

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

The search was applied to four key databases (Applied Social Science Index and Abstracts; Social Science Database; Social Sciences Citation Index; Cochrane Database of Systematic Reviews) within a 5-year period (2015–2019). We recognized that this would include the most up-to-date research and that these would be likely to discuss relevant findings from earlier studies.

We limited our search to three languages (English, French and Spanish) but found relatively few articles in French or Spanish. This may have been a result of using primarily English language databases or of fewer studies being reported in these languages. Additional searches were therefore conducted in prominent journals in French and Spanish, including 'Enfances, Familles, Générations'; 'Les Cahiers de l'Actif'; 'La Revue Internationale de l'Éducation Familiale' and 'Revue Française de Sociologie' in French and 'Sociedad e Infancias' and 'Revista Latinoamericana de Ciencias Sociales, Niñez y Juventud' in Spanish.

A total of 1759 abstracts (1435 in English, 281 in French and 43 in Spanish) were identified, and 283 duplicates were subsequently removed. Inclusion and exclusion criteria were then applied, ensuring that the included articles were studies which:

- were systematic reviews or primary research
- involved children and young people aged under 18 only
- focused on those living in group-based residential care, due to separation from their parents (not, e.g., youth offender institutions or boarding schools), and cared for by adults unrelated to the children or each other
- Met the search criteria related to language and date of publication

A further 1273 articles were excluded at this stage, and the remaining 203 were subject to full text review. Researchers recorded relevant information from the full text articles on a proforma

designed by the team to capture information needed for the review. At this stage, a further 92 papers were excluded, resulting in 111 full text papers being included. A flowchart of this process is given in Appendix A. Analysis was then conducted which consisted of thematic synthesis guided by our targeted research questions. Selected key findings are presented in this paper, so not all of the 111 papers are referenced in this article. A full list can be found in Porter et al. (2020).

Limitations to this review must be acknowledged and taken into account when considering the findings and conclusions, most significantly in relation to the language and timeframe constraints. While we believe that the 2015–2019 search parameter has included findings from the most recent relevant studies, a wider timeframe would have yielded additional articles of interest. We also accessed articles through a limited number of databases and other approaches, which will have excluded any relevant articles which were not indexed in these databases or included in our additional Spanish and French journal searches. Furthermore, the nature of rapid reviews is such that a large team has been involved, and information has been extracted from articles in a way which cannot fully account for the context and nuance of the original research. Nevertheless, we have sought to include key points and relevant factors from each of the reviewed papers.

3 | KEY FINDINGS

Given that we intend to strengthen our understanding of residential care within a global context, we have drawn out some observations regarding the nature and coverage of the papers reviewed alongside an overview of the key themes addressed in relation to each of our substantive research questions.

3.1 | The nature and coverage of evidence base reviewed

The papers included in the review cover data collected in 68 countries around the world (Figure 1). The most frequently represented country is Romania (18 papers), followed by the USA (13 papers) and the UK (10 papers). This reflects the European/US bias present in much academic work, as well as the impact of the Bucharest Early Intervention Project (BEIP), which is the data source for the majority of the papers that include Romania.

While the research covers different geographical regions, the distribution of research throughout the world is not equal. Of the papers included, 56 (49%) reported on research or data collected exclusively within Europe. Exclusively North American research contributed an additional 14 papers (12%), South America 11 papers (10%), Asia and Africa an additional six each (5% each), while there were just two papers based on exclusively Australian data (2%). The remaining 20 papers (17%) represented data collected in more than one geographical region.

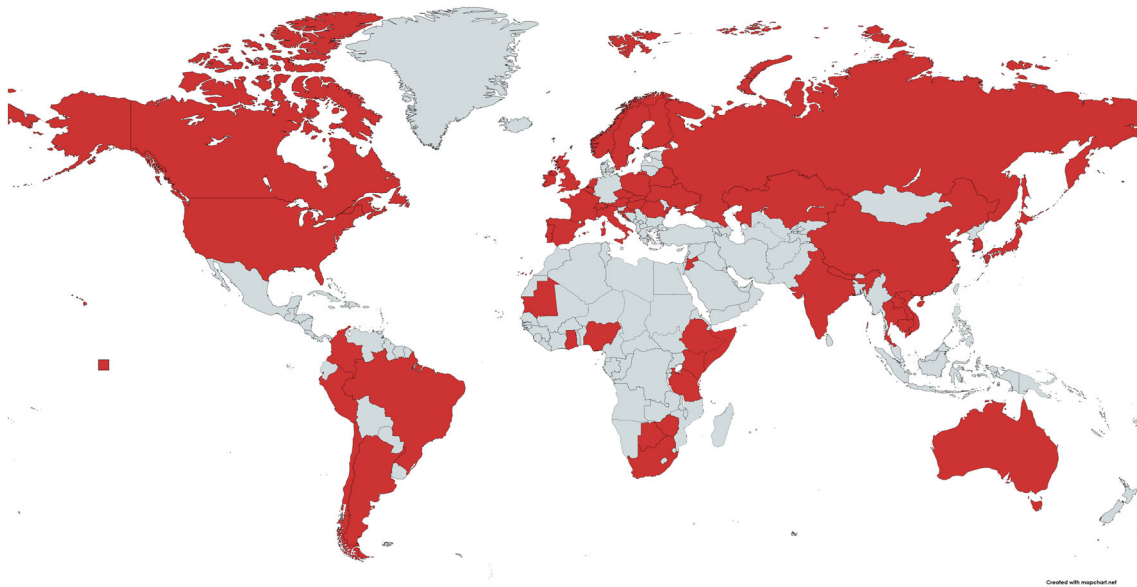
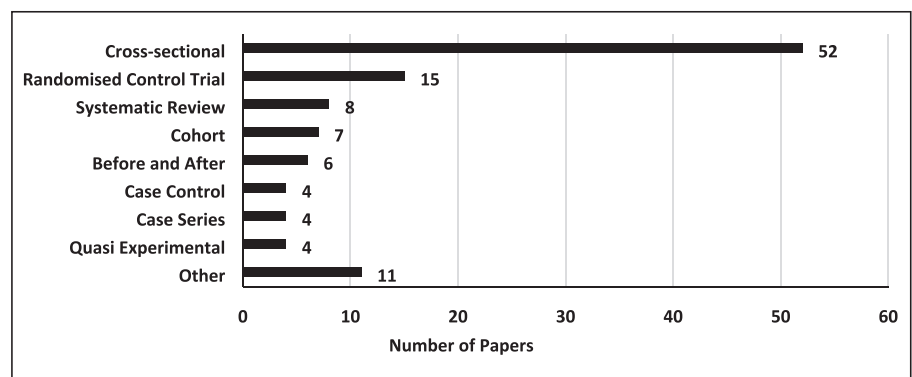


FIGURE 1 Map highlighting countries represented in the review

FIGURE 2 Frequency of different methodologies used in the reviewed papers



One hundred and three of the 111 papers included in the review are primary studies, with eight systematic reviews. Figure 2 shows how frequently different methodologies were employed in the papers.

The prevalence of cross-sectional studies represents a weakness in the evidence base, as they are subject to a large number of potential confounding variables. In the context of residential care, the most obvious is that the placement of children and young people within residential care may be (indeed, it probably is) selecting those children with the greatest needs. Cross-sectional studies can only tell us what the differences in the populations are and can say little about the causality around these differences.

The inclusion of 15 randomized control trials (RCTs) and eight systematic reviews in the articles reviewed is a strength due to their robust methodologies that enable trends in the literature to be identified with confidence. However, the RCTs are dominated by the BEIP study, which accounts for 10 of these papers.

The different language used around residential care, as previously described, was a challenge for this review. Different countries and contexts can mean many different things by the terms 'residential

care', 'institutional care', 'foster care' and others. To include as much relevant literature as possible, we did not exclude papers based on terminology, rather by looking at the definition of the terms and practical reality of the settings that the research described. However, individual papers frequently gave little or no detail on the context in which their studies took place, simply referring to 'institutional care', 'residential care' or variations thereof, without providing a rationale for their choice of terminology. Examining the descriptions of care settings provided in the different papers highlighted that one third failed to present even minimal information about the setting in which their data was collected. There were no clear differences in the distributions between geographic areas. The high proportion of papers which failed to provide even relatively basic information regarding the context in which their data were collected is a cause for concern.

Given that significant emphasis is placed on the importance of small-scale, family-like environments for the care of children and young people, the inability to distinguish findings between potentially very different care settings represents a challenge to the interpretation and identification of meaning which can be drawn from the

literature and how these can be used to develop or improve alternative care services in practice. The literature included in our review provided us with a great deal of information from within specific settings and contexts, which made it difficult to identify overarching themes or findings. While this was particularly true of the studies looking at outcomes, with a lack of papers considering outcomes holistically, it also applies to the literature on use and functions and quality in residential care.

3.2 | The use and functions of residential care

Few studies explicitly addressed questions relating to the purpose of residential care. The studies that did address this in the context of children separated from their parents presented residential care as a societal approach to the protection of children and young people, as part of a continuum of support (Bogdanova, 2017; Bunea et al., 2017; Jedwab et al., 2019; Lino et al., 2016; Palsson, 2017; Vaz Garrido et al., 2016). The uses of residential care were varied. They included, *inter alia*, 'respite' for parents (Luksik, 2018); instances where alternative family-based care has broken down appeared unlikely to offer emotional containment and stable support for a child (Grey et al., 2018; Wright et al., 2019) or was not available (Gayapersad et al., 2019; Wright et al., 2019); intensive support or 'treatment', linked to the severity of social, emotional and behavioural needs (Boel-Studt et al., 2018; Eenshuistra et al., 2019; Hurley et al., 2017; Jedwab et al., 2019; Luksik, 2018; Schuurmans et al., 2018; Vejmelka & Sabolic, 2015); and recovery and rehabilitation for children who have been subjected to neglect and abuse, trafficking or sexual exploitation (Brown et al., 2018; Hickie & Roe-Sepowitz, 2018; Rafferty, 2018). In some instances, multiple uses of a setting co-existed.

With the caveat that studies rarely discerned how different country contexts interacted with reasons for entry into residential care specifically, its usage to promote recovery, rehabilitation or 'treatment' of children appeared to be a feature of North America and European (North and West) research, while situational factors appeared to be more present (but not exclusively) in research from other areas of the world. Various situational factors associated with separation from parents were discussed, such as death or severe illness of parent(s) during war, epidemics (specifically HIV/AIDS), natural disaster or migration (Caserta et al., 2017; Nsabimana et al., 2019; Pandya, 2018); dire economic situations, poverty or hardship (Baptista et al., 2017; Mota et al., 2017); state policies, societal or cultural norms leading to child abandonment; and family violence, breakdown or substance abuse (Jaramillo et al., 2016; Jozefiak et al., 2017; Rakhlin et al., 2017).

Some variation in relation to the age profile of children and young people was noted, with some studies taking account of past usage of institutional or residential care for babies and infants or referencing mandated exclusion of usage during a child's early years. Much of the North American and European (North and West) studies referred to the usage of residential care with youth populations.

3.3 | Quality of care

While many papers addressed quality elements, few papers had a stated primary focus on what constitutes or enables 'quality' in residential care. However, several studies did explore or assess factors that related to how well children and young people are supported, how positively they experience residential care in its different forms and how this contributed to their growth, development and well-being.

Children's experience of the relationship with their residential carer(s) is fundamental to their growth and development and is critical to their recovery from prior experiences of attachment, separation and loss and the detrimental effects of neglectful or abusive parental care (Steels & Simpson, 2017; Wright et al., 2019). Studies described such practice in terms of carers' capacity to express warmth, engagement, sensitivity, affection and playfulness during routine caregiving activities to the children they care for, as well as providing structure and boundaries via routines, rules and a measured disciplinary style (Chernego et al., 2018; Garcia-Quiroga & Hamilton-Giachritsis, 2017; Steels & Simpson, 2017; Swerts et al., 2019). Furthermore, Vejmelka and Sabolic (2015) note the importance of retaining relationships and contact after children leave care.

The delivery of relationship-based care does not, however, happen spontaneously and is dependent on the presence of staff and organizational and physical environment factors. Staff factors were found to begin at the point of recruitment. Levy and Reuven (2017) advocate the importance of tapping into and testing for carers' underpinning values and beliefs to enable recruiters to foresee inappropriate or insensitive approaches to care and discipline. Their study found that a strong 'belief in a just world', where 'individuals deserve what they get and get what they deserve', may result in a higher tendency to respond in disciplinary encounters with physical power assertion and love withdrawal (Levy & Reuven, 2017). Boel-Studt et al. (2018) suggest that carers' view of 'change as a continual process' may also be an important belief to assess for.

In addition to studies recognizing the importance of carers' underpinning values and beliefs, many studies also set out the range of knowledge and skills that carers need. Key knowledge areas were found to span understanding of children's rights; attachment, attachment behaviours and the emotional needs of children (Hueche et al., 2019; Vacaru et al., 2018); the impact of neglect and abuse; the importance of family origins and ties (Llosada-Gistau, Casas, & Montserrat, 2017; Neagu & Sebba, 2019); trauma and practices that promote recovery from trauma (Baker et al., 2018; Rafferty, 2018); child developmental milestones and the role of carers in stimulating their achievement (Major, 2018); and the workings of child protection and alternative care systems and supports. Where a specific evidence-based treatment model is used, staff will need training and support to deliver that model as intended (Cameron & Das, 2019; Hurley et al., 2017).

Further to the knowledge areas above, studies highlighted the importance of personal qualities. Warmth and sensitivity have already been referred to, but other qualities include being able to work

effectively with others. Eenshuistra et al. (2019) note the need to work collaboratively with children, young people and other professionals when undertaking assessments and case planning, providing emotional support and behavioural interventions, engaging children in daily activities and building children's life and vocational skills. Other studies found professional self-awareness and self-control (Major, 2018; Vaz Garrido et al., 2016), and strategies that focus on the management and reduction of the use of restraint (Deveau & Leitch, 2015), to be further critical skills for carers.

The final staff factor found as integral to the quality of care is supervision (Baker et al., 2018; Eenshuistra et al., 2019), particularly supervision that provides a space for reflection and working through the psychological effects of caring for a group of children (Vejmelka & Sabolic, 2015). This should take account of vicarious trauma (Bailey et al., 2019) and caregiver perceptions of helplessness in the caregiving task, because these can contribute to a reduction in social and cognitive stimuli for children (Barone et al., 2016).

To enable staff to deliver relationship-based care, supportive organizational factors also need to be in place. Many studies found smaller ratios of children to caregivers as fundamental to care that is physically, psychologically and emotionally present and responsive to a child's developmental needs (Garcia-Quiroga & Hamilton-Giachritsis, 2017; Mota et al., 2016). Without this, larger ratios were found to lead to difficulties for children in establishing a secure attachment (Batki, 2018; Chernego et al., 2018; Garcia-Quiroga et al., 2017; Rafferty, 2018; Sánchez-Reyes et al., 2019). Other studies found a conducive organizational culture important. Cultural recognition of carer well-being is one aspect of this, such as the provision of adequate vacations and staff trauma supports (Bailey et al., 2019; Baker et al., 2018), while another is moving away from a risk-averse culture that can undermine carers' capacity to be physically, psychologically and emotionally available to children (Brown et al., 2018). Where organizational factors are attended to and supportive, staff 'burnout' and turnover can be reduced, which in turn sustains relationship continuity for children (Bailey et al., 2019).

The physical environment of residential care settings is a further key factor. At its most basic, we would expect to see physical spaces providing cleanliness and health and safety (Farmer et al., 2017). Small size of facility could also be viewed as an accepted, basic characteristic, with Leipoldt et al. (2019) finding that a smaller size of facility creates more space for a constructive focus on behavioural issues. However, quality relationship-based care extends beyond cleanliness and size of setting. Various studies note the importance of a 'family-like' environment (Mota et al., 2016; Vejmelka & Sabolic, 2015), one that offers children an experience of daily life comparable with that of the general child population (Llosada-Gistau, Montserrat, & Casas, 2017). Small-sized settings are an aspect of this but so too are physical environments with appropriate levels of stimulation that enable the development of nurturing relationships and children's engagement in different activities and day-to-day routines (Garcia-Quiroga & Hamilton-Giachritsis, 2017). Engagement in different activities extends beyond the residential setting itself and ought to comprise access to healthcare, education (including support for learning)

and wider community activities and resources (Llosada-Gistau, Casas, & Montserrat, 2017; Steels & Simpson, 2017; Vejmelka & Sabolic, 2015).

The staff and organizational and physical environment factors outlined above are all put forward as characteristics of quality, relationship-based residential care. A number of studies highlight that children and young people should be the primary actors who assess and determine the quality of their care and the extent to which their care is impacting on their lives and well-being (Gander et al., 2019; Llosada-Gistau, Casas, & Montserrat, 2017; Swerts et al., 2019). A final key ingredient of quality, relationship-based residential care is therefore the extent to which children's and young people's voices are sought, listened to, valued and acted upon.

3.4 | Outcomes of residential care

Three quarters of the reviewed literature addressed the psychological, social and emotional outcomes for children and young people but presented a mixed picture consisting of a 'mosaic' of different methodologies, research questions, populations and care settings, all highly dependent on the cultural, political and socio-economic contexts studied. As with other areas of this review, there was a continual conflation and confusion as to the nature of the setting presented, with some papers explicitly looking at institutional settings with poor care, while others looked at recognizably residential settings, and a large number did not describe the setting in any detail.

The papers which focused on the psychological and biomedical elements of development highlight a theme of deficit and disadvantage. Combined with a large number of studies in large-scale institutional settings (e.g. the BEIP), this leads to the risk of overlooking the potential benefits that may be conferred on some children and young people, in some contexts (Wright et al., 2019) of small-scale, individualized, high-quality residential care.

A substantial proportion of the papers on outcomes for children in residential care were informed by the BEIP, a large-scale RCT, which used a suite of standardized measures to study the effects for children and young people who were resident in Romanian orphanages. These were large-scale institutions providing low-quality care, with high child to caregiver ratios, minimal personalization of experience and 'severe psychosocial deprivation' (Almas et al., 2016:1859).

The evidence from the BEIP (with the caveat that its findings are limited to the impacts of the particular environment in which it took place) and more piecemeal evidence from other comparative studies indicate that children and young people who are either initially placed or subsequently move to family-based environments are able to match children who were never removed from the home, making up ground on disadvantages (e.g. reduced prevalence of psychiatric disorders or promoted healthy brain and socio-emotional development) (Almas et al., 2015, 2016; Humphreys et al., 2015, 2018; Troller-Renfree et al., 2018).

It is nevertheless clear from multiple papers that children and young people in institutional care experience negative outcomes or

are at a disadvantage compared with their peers living in 'family-based' care environments (such as foster care or formal/informal kinship care) or birth families. This disadvantage was measured in relation to a variety of domains, including behavioural (Humphreys et al. 2018; MacKenzie et al., 2017; Nsabimana et al., 2019; Troller-Renfree et al., 2016), socio-emotional (Almas et al., 2015; Batki, 2018; Bick et al., 2017; Jaramillo et al., 2016; Mota et al., 2016; Perego et al., 2016; Sherr et al., 2017; Troller-Renfree et al., 2015), psychological (Almas et al., 2016; Barone et al., 2016; Deambrosio et al., 2017; Humphreys et al. 2018; Kennedy et al., 2016; Mota et al., 2017; Rakhlin et al., 2017; Rodrigues et al., 2019; Sherr et al., 2017; Troller-Renfree et al., 2018; Wade et al., 2018) and medical (Perego et al., 2016; Slopen et al., 2019). Too few studies compared noninstitutional residential care to other settings, to understand if these disadvantages also arise in such residential settings.

There remain other significant gaps in the literature around outcomes. These relate to how the relationship between function, quality and outcomes is assessed, a lack of examination of which children or young people benefit the most from different types of residential setting and relatively limited research on the longer-term social and emotional outcomes for children and young people who have experienced residential care.

4 | DISCUSSION

In the initial sections of this paper, we outlined the shift in language in the international policy arena and the distinction made between institutional and residential care. At the same time, we illustrated the lack of clarity in definitions of residential care and institutional care in recent international research. We also noted divergent positions in both understanding and acceptance of the use of residential care.

The definitional ambiguity is replicated throughout the academic research literature that we reviewed and highlights the challenges in studying the evidence in this area. Despite explicitly addressing issues related to residential care, the terms 'institutional care' and 'residential care' were used effectively interchangeably across the papers included. The term institutional care was used for settings which met the criteria to be called residential care and those which were explicitly institutional or where no information was given on the nature of the setting, as was the case with the term 'residential care'. This led to the review incorporating studies related to institutional care, such as the BEIP. However, in this discussion, we are interested in drawing out what the findings mean for residential care that is appropriate, necessary and constructive, as identified in the UN Guidelines (para. 21).

Far from being a question of semantics, this lack of clarity in definitions and use of terminology obstructs the capacity to fully appraise the use and function, quality and outcomes associated with different models of residential care. It may also help to perpetuate the interpretation of a commitment to 'deinstitutionalization' as representing the prevention and decommissioning of all forms of residential care provision, without a sufficiently solid foundation of evidence.

In particular, in relation to outcomes, the available evidence is dominated by seminal work appraising the impact of large-scale, poor quality institutions upon children in Romania and by a larger body of contemporary work relating to residential or institutional care in North America and Western Europe. Given the origins and contexts of the majority of the evidence reviewed, it is important not to simplify or to assume replication of experiences across countries given the variability of the settings studied, as well as the social, economic and cultural contexts (Garcia-Quiroga et al., 2017). This highlights the importance of questioning the power relations that exist in the generation and application of evidence and how this in turn may affect child welfare systems and reforms across the world.

At the heart of studying the role and function of residential care is a desire to explore whether and how different models of care within residential care can be distinguished in order to identify what it may offer children. Perhaps surprisingly, given the volume of research available, the body of evidence included in this review reveals few insights into what governments and care providers have learned about what residential care offers in meeting *specific* needs of individual children—that is, for whom it works, in what circumstances and in which cultural, political and socio-economical contexts. Many of the studies analysed failed to provide definitions or descriptions of the care setting being studied or evaluated and lacked detail, for example, in the ratio between caregivers and children or the nature of the care they offered. As noted above, only the North America and Western European literature appears to offer some consensus and indicates that the usage of (quality) 'residential care' may allow for the provision of intensive supports in promoting recovery from trauma and in addressing social, emotional, and behavioural issues exhibited by older children in particular.

However, we recognize that this differentiation in focus between literature from Europe/North America compared with the rest of the world interacts with the domination of academic discourse by European/North American perspectives. The discussion around residential care risks neglecting the impact of context and culture on how residential care is delivered, experienced and the purposes to which it is put. This risks both the inappropriate transplanting of European or North American models of care into very different cultures and contexts and oversight or devaluing of the learning generated in these environments.

Across the studies analysed, there were some insights into what constitutes quality and conditions conducive to a child's development, but this was seldom a feature of studies, even those intending to be evaluative of the effects of care on children's development and outcomes. Without clear articulation of the fundamental components of quality care or links with an evaluation of how this interacts with children's experiences, opportunities and outcomes, this necessarily limits an evidence-based understanding of how to design and quality assure residential care or how it may fit within a range of alternative care provision.

Nevertheless, the review articulates some quality elements within residential care. Most notably from Farmer et al. (2017) who highlight four domains (safety, staffing, setting and treatment) to focus on in an

effort to improve quality within residential care. A rapid analysis of these quality domains suggests that they revolve around developing or facilitating relationship-based practice. For those who work in residential care, these domains provide a framework to begin a process of assessing and improving quality in practice. It is also worth noting that the quality domains identified are relevant to any care setting. With these domains attended to, residential care can play an important role in the range of alternative care options for children and young people.

At the moment, given the gaps in research, combining other forms of knowledge, such as theoretical frameworks articulating what children require for healthy growth and development (e.g. Bowlby et al., 1989; Dye, 2018; Piaget, 1964), and practice literature articulating the specific attributes and behaviours of high-quality carers may have more to offer those who are concerned with raising and sustaining high standards of residential care.

5 | CONCLUSION

The existing evidence base on residential care designed and delivered within different cultural, social and economic contexts is difficult to interpret and has significant gaps. We found insufficient evidence to substantiate claims that residential care is inherently unsuitable, universally offering low-quality care and negatively impacting children's well-being and developmental outcomes. At the same time, the evidence is insufficient to distinguish what elements enhance suitability for whom, strengthen quality and positively impact children's well-being and developmental outcomes. Going forward, it is essential that these evidence gaps are addressed, as a basis for better informed policy and practice.

Many of the challenges to the effective use of the existing literature on residential care and application of learning result from a lack of attention paid to clearly articulating the context and to making explicit distinctions between types of alternative care setting. While so far challenging to achieve, it is important that definitional ambiguities are resolved, so that we do not equate or conflate residential care with large, unsuitable institutions and that we do not rule it out on principle. Consistency in usage of terminology across research, policy and practice is also desirable, and the UN Guidelines provide a good starting point. We urge researchers to provide core information relating to the definition and character of the setting that they are studying (e.g. carer:child ratios, purpose of the care setting and criteria for placement, how children's rights, for example, to education, are upheld), as well as the context in which the care setting is being offered. With this understanding comes an opportunity to begin assessing what models of care work in which contexts, and most importantly, for which children.

Applying empirical research knowledge to law, policy and practice developments is complex. We argue that it requires caution around interpreting what is insightful for what care setting, what is generalizable across contexts and how findings can be understood within different cultural, social, political and economic realities relevant to a specific child welfare system. In addition to this, as States enhance

alternative care options, we argue for investment in locally embedded research and ongoing evaluation that assess and document for whom residential care is appropriate, for whom it is provided, how children themselves view and experience that care and the components of care that make for quality and effectiveness in ensuring optimal outcomes for children's well-being and development. In so doing, it is essential to keep an open mind as to what residential care can offer for children, in and of itself, and to understand who could most benefit from it, rather than always considering it as a measure of last resort.

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Data is derived from public, but restricted access, resources.

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APPENDIX A: FLOWCHART OF REVIEW AND SELECTION PROCESS

