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**How Young People Portrayed their Experiences in Therapeutic Residential Care in
Portugal: A Mixed Methods Study**

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**How Young People Portrayed their Experiences in Therapeutic Residential Care
in Portugal: A Mixed Methods Study**

Abstract

Purpose: In contrast to the international context of residential care and the preference for family based care, residential care in Portugal is the only option for most young people in the child protection system. Despite this, research in Portugal has yet to focus on Therapeutic Residential Care (TRC), and has rarely considered the narratives of young people. By adopting the conceptual framework proposed by Farmer et al. (2017) and focusing on five critical domains (Setting, Staffing, Treatment Approach, Safety, and Milieu Factor), we aimed to identify a subset of factors that contribute to youth improvement. **Method:** This convergent parallel mixed methods study involved conducting semi-structured interviews with 14 young people, mostly females (71%), aged 14-18 years ($M=16.3$, $SD=1.8$) at five TRC facilities in Portugal. Young people and staff also completed a sociodemographic questionnaire and the youth self-report or child behaviour checklist to assess internalising and externalising symptoms. **Results:** Content analysis revealed mostly positive perceptions and experiences across the domains (Setting, Staffing, Treatment Approach, Safety, Milieu Factor and Profile Characteristics). However, half of the youth reported being vulnerable to peer contagion and females with higher internalising and externalising symptoms reported more negative perceptions and experiences of TRC. **Discussion:** These findings highlight that creating an organisational social context that supports participatory approaches to assessing quality may provide invaluable insights into how services can be responsive to young people's needs. Focusing on establishing high-quality relationships with staff, peers, family, and the community may be key to ensuring the long-term success of TRC.

Keywords: therapeutic residential care; mixed methods; young people's perceptions and experiences, internalising and externalising symptoms, quality

How Young People Portrayed their experiences in Therapeutic Residential Care in Portugal: A Mixed Method Study

Purpose

This convergent parallel mixed methods study examined young people's perceptions and experiences of Therapeutic Residential Care (TRC) in Portugal (qualitative) and their profile characteristics and psychopathology (quantitative). 14 young people in five of the seven existing TRC facilities provided a core view of the quality of TRC from their perspective. The conceptual framework proposed by Farmer et al. (2017) (Setting, Staffing, Treatment Approach, Safety, and Milieu Factor) was adopted, and additional critical domains that emerged from the voices of the young people themselves were identified. After introducing the context of the study, the key concepts, factors, and approaches for assessing quality were reviewed to explain the rationale and purpose of the study. Lived experience research such as this study privileges young people's perspectives and may even be more critical in the Portuguese Residential Care (RC) context. The findings can be used to promote the meaningful participation of young people and inform policy and practice to ensure that services are youth-friendly and fit for purpose. Furthermore, whilst this research focused on TRC in Portugal, its findings have broader implications for the development of TRC internationally, given the continuing interest and growing efforts in cross-national synthesis of research knowledge (Courtney et al., 2009; Whittaker et al., 2015).

The Context of Residential Care in Portugal

Worldwide, there is limited evidence on how TRC achieves treatment goals: TRC remains too much of a "black box" (Castro, 2023; Harder & Knorth, 2015; Leipoldt et. al., 2019). The "black box" metaphor regarding the quality of RC, which is an international phenomenon (Bravo & Del Valle, 2009), proves to be even more the reality in Portugal (Barbosa-Ducharne & Soares, 2023; Rodrigues et al., 2013) and requires immediate attention

as the Portuguese Child Protection System (CPS) has some particularities which make it singular (Negrão et al., 2024).

Contrary to the international context, in practice, RC in Portugal is not used as a “last resort”, but is the only option for most young people. In Portugal, there are two types of out-of-home care: foster care and RC. Contrary to most European CPS, foster care is almost non-existent (approximately 3% of children in out-of-home care are in foster care), even for infants and toddlers, despite recent legislative changes (e.g., Law No. 142/2015; Decreto-Lei n.º 139/2019) to promote foster care placements (Delgado et al., 2017). Therefore, RC continues to be the primary form of out-of-home care placement for children and youth (ISS.IP, 2023).

According to Portuguese law, child and youth RC is defined as an out-of-home response prescribed by the CPS, which aims to ensure the safety, well-being, and development of abused and/or neglected children and youth (Law No. 23/2023). Consistent with the literature worldwide (Águila-Otero et al., 2020; Connor et al., 2004), adolescents in Portuguese RC report higher levels of mental health, when compared to their peers in the community, and females present more psychological maladjustment than males (Rodrigues et al., 2014b, 2019). The history of abuse may explain the complicated presentations of females in RC (Castro et al., 2023). According to a recent meta-analysis, a history of abuse, specifically sexual, emotional, and physical abuse, was associated with higher internalising and externalising symptoms (Magalhães & Camilo, 2023). Furthermore, a national report indicated that 24.1% of young people in RC exhibited behavioural problems, 6.8% were diagnosed with a mental disorder, and 1.1% suffered from drug addiction (ISS.IP, 2023). Young people in RC also received treatment for their emotional and behavioural problems; for example, 39% received regular support from a psychologist, and 26.7% took psychiatric medication (ISS.IP, 2023).

YOUNG PEOPLE'S PORTRAYAL OF THERAPEUTIC RESIDENTIAL CARE

Indeed, the past 20 years have seen the emergence of highly specialised RC services with a pronounced therapeutic component, in which 1.9% of young people in out-of-home care were placed (ISS.IP, 2023). Furthermore, the number of young people requiring specialised RC services has significantly increased by 118% over the last eight years (ISS.IP, 2023), indicating that an approach with a strong therapeutic component is needed to address the needs of the most traumatised young people with more complex needs in the CPS.

This gradual shift was marked by an amendment to Portuguese Law, meaning that settings were defined according to young people's needs (non-specialised vs. specialised) rather than the expected length of stay in care (temporary vs. long-term placement) (Law No. 142/2015). Specialised homes in Portugal were specified as (a) emergency shelters, (b) RC settings to address therapeutic or educational needs (targeting young people with severe mental health problems or disabilities), and (c) autonomous apartments (Law No. 142/2015).

In non-specialised (generalist) residential settings, the aim is to create an environment that resembles as much as possible a family context based on therapeutic milieu assumptions (i.e., a relational space where interactions are intended to meet the needs of the children and youth in care) (Silva et al., 2022). Specialised RC centres aimed at addressing the therapeutic or educational needs of children and youth with severe mental health problems and disabilities guide their interventions using specific therapeutic models (Silva et al., 2022).

Critically, only recently 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).

This has provided a clear base for determining current programme quality and establishing future research, programme development, and policy directions (Daly et al., 2018).

Whilst TRC in the USA and UK encompasses a broad spectrum of youth services, including psychiatric residential treatment facilities (Pecora & English, 2016), and includes a variety of potential referral sources (e.g. CPS, mental health system, criminal justice system [Castro, 2023, 2024]); Portuguese TRC is exclusively for young people in the CPS, and includes young people with severe disabilities and those who present with high-risk behaviours such as drug use, suicidal behaviour, inappropriate sexual behaviour, or a history of running away and prolonged absences (ISS.IP, 2023). According to Portuguese law, each TRC unit (i.e., group) can host up to 15 young people, although this number may be exceeded on an exceptional and duly justified basis (Decree-Law No. 164/2019). This number varies worldwide. For example, Australia has opted for a small-scale service that serve up to four children and young people at any one time (Kor et al., 2021).

Quality of Residential Care System of Children in Portugal

Given the context of Portuguese RC, there has been limited investment in determining the quality of RC in Portugal. Scientific publishing regarding the quality of Portuguese RC is scarce, presents immense variability (Negrão et al., 2024), and does not focus on TRC (e.g. Rodrigues et al., 2014b; 2019).

Previous studies (e.g. Rodrigues et al., 2014a, 2014b, 2019) have adopted the Portuguese comprehensive evaluation system for RC (ARQUA-P). ARQUA-P is a translated and adapted version of the ARQUA's research methodology (Del Valle, 1997). It is an ecological evaluation system that uses mixed methods (with a focus on quantitative analysis) and multiple sources of information (e.g. young people and caregivers), aiming to assess the needs and psychological adjustment of children in RC and the quality of services provided by

institutions, and to understand the relationship between these variables (Rodrigues et al., 2014a).

Young people positively evaluated RC in all ARQUA-P dimensions, including ‘overall quality’ (Rodrigues et al., 2014b, 2019). However, young people evaluated the dimension ‘respect for rights’ and ‘normalisation and integration’ significantly less positively than their caregivers (Rodrigues et al., 2014b). The findings revealed significant correlations between the dimensions of RC quality assessment and measures of young people’s psychological adjustment, life satisfaction, personal well-being, and self-esteem (Rodrigues, 2019). Females evaluated the quality of RC units’ services significantly lower than boys in almost every dimension, including ‘overall quality’ (Rodrigues et al., 2014b; Rodrigues et al., 2019).

For too long, the assumptions of conventional wisdom that RC is harmful, that research shows that it is harmful, and that it should only be used as a last resort or eliminated altogether have dominated the conversation (Anglin & Henderson, 2023). What may be especially important in the Portuguese context is to shift the conversation to how high-quality RC can be achieved, especially when other out-of-home placement options are not available, and to ensure that young people have a voice and an influence in policy and practice. Furthermore, research on out-of-home care in Portugal is yet to focus on TRC. Thus, little is known about how TRC operates and how treatment goals are achieved. Judging the quality of the interventions implies recognising and clarifying all variables involved (Farmer et al., 2017). Focusing on young people’s perceptions and experiences and adopting a qualitative approach to data analysis may provide more information about how the results are achieved.

Conceptual Framework

International research has highlighted that, to gain more durable positive treatment results, we need to know more about how the results are achieved, rather than merely

investigating the achieved results (Harder & Knorth, 2015). However, 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; Castro et al., 2023, 2024; Farmer et al., 2017; James, 2011, 2013; Lee & McMillen, 2008; Rodrigues et al., 2019, 2014a) suggests that a myriad of potential factors should be considered when assessing the quality of RC, and that four key domains may provide a core view of quality: Setting, Staffing, Treatment Approach, and Safety (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). For example, regarding the Setting domain, homes with more age/interest-appropriate items (e.g., equipment, toys, games, books) showed better outcomes by the time of discharge than those with less adequate items in this arena, even after considering the home's treatment model and the severity and demographics of the youth (Farmer et al., 2017). Regarding the Staffing domain, the providers and their selection, training, and support are key, regardless of the treatment approach/model adopted (Anglin & Henderson, 2023). Regarding the Treatment Approach domain, behaviourally focused treatment was associated with a reduction in CBCL scores (Badura Brack et al., 2012; Scholte & Van Der Ploeg, 2000). Finally, the Safety domain is also particularly prominent, such as 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).

This conceptual approach would allow for a more exploratory approach regarding young people's experiences of TRC, and additional domains identified as critical would be based on the voices of young people themselves (Castro et al., 2024).

Current Study

Background

This convergent parallel mixed methods study examined young people's perceptions and experiences of TRC (qualitative) and their profile characteristics and psychopathology (quantitative). Integrating such data may provide insight into how young people with different profile characteristics perceive and experience TRC, and provide crucial clues on how quality can be strategically enhanced for young people with different needs. 14 young people (up to 18 years old) residing in five of the seven existing TRC facilities in Portugal participated in this study. Qualitative and quantitative data were collated in person during a day visit to each participating TRC facility over a four-month period (September-December 2022).

Prior to this study, a quantitative and qualitative systematic review (Castro et al., 2023, 2024) was published to inform this study. The quantitative systematic review provided a comprehensive summary and evaluation of the current state of knowledge and development worldwide regarding the identification of critical factors associated with the success of TRC (Castro et al., 2023). The qualitative systematic review adopted the Farmer et al., (2017) four-pronged conceptual framework (Setting, Staffing, Treatment Approach, and Safety) to identify quality indicators from young people's beliefs and experiences of TRC for the first time (Castro et al., 2024).

The findings from the later study indicated that the four domains were robust and provided a practical framework, but insufficient when identifying quality indicators that can assess how well services engage young people as another critical domain emerged: the Milieu

Factor (i.e., a factor that supports healing and growth—the change work and recovery of mental ill-health and emotional distress [Ennals et al., 2021]) and appeared to be especially important for young people in CPS (Blind for review). This is particularly relevant for young people in the Portuguese context, as it is exclusively for young people in the CPS. According to young people in the CPS, services that have the milieu factor are more likely to respond to their complex needs and make a lasting difference in their lives (Castro et al., 2024).

Therefore, five domains (Setting, Staffing, Treatment Approach, Safety, and the Milieu Factor) were adopted.

Following ethical approval from the ethics committee of the university (Ref:28/2022), a presentation of the research project to the directors of all seven existing TRC facilities in Portugal was conducted by the lead author online via Zoom, and the nature and requirements of the study were outlined. Specifically, services were informed of the (a) objectives of the study, (b) what participation in the semi-structured interview consisted of, (c) the number of participants required, and (d) the recruitment process and requirements regarding obtaining authorisation from the legal representative of all young people below the age of 18 and the young people themselves. Directors from each TRC facility confirmed their voluntary participation via email.

Qualitative and quantitative data were collected by the principal author (with no affiliation to the TRC facilities). All authors had no conflict of interest and this research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Sampling-Sites

All seven existing Portuguese TRC facilities targeting young people with severe emotional and behavioural problems were invited to participate, and *not* those targeting young people with disabilities or unaccompanied minors. The two TRC settings that did not

participate were unable to do so, as the young people at the time of data collection did not fit the study's requirements (e.g. young people below the age of 18). Therefore, this study focused on the majority of TRC facilities in Portugal, all of which were private, non-profit TRC facilities that treated 62 young people ($M=12.4$, $SD=2.07$). Three were in a rural setting, two were in an urban setting, three were female-only settings, and two were male-only settings. At capacity, these settings could host between 13 and 22 young people. At the time of data collection, not all TRC facilities were at maximum capacity and hosted between 10 and 15 young people. The average length of stay in TRC ranged from 3 months-325 months ($M=32.4$, $SD=87.3$).

Four of the five facilities had a treatment model with a strong cognitive-behavioural element and included a token economy. One facility adopted the treatment model developed by the Mulberry Bush School, UK, which has a strong psychodynamic element. All young people had access to a psychiatrist every fortnight, weekly individual and group therapy (except in one TRC facility), weekly psychoeducation and independence group (except in one TRC facility), daily community reunions, weekly assemblies, and one TRC also offered animal therapy and speech and language therapy.

Each TRC facility consisted of a director (a social worker or psychologist responsible for the coordination of the care worker team and general oversight of the TRC facility), a care worker team (a social worker or psychologist responsible for developing a case plan for each child or youth), a caregiver team (responsible for supporting the daily routines of young people in TRC), a general service team, a psychiatrist, a psychologist, and teachers available on-site. However, one TRC facility did not have a psychologist, as the previous psychologist had left, and the position was not filled. All staff members had access to external and regular supervision, except in one TRC facility in which supervision was provided when deemed necessary. All TRC facilities had a predefined training schedule for all workers.

Sampling-Participants

A maximum of five young people who met the requirements of this study and resided at each of the five TRC facilities were invited to participate (43.3% of young people). Consequently, 15 young people volunteered to participate (24.2% of all young people), and one young person dropped out during the semi-structured interview because they were uncomfortable with being recorded, resulting in the participation of 14 young people (22.6% of all young people).

Table 1 provides a breakdown of participants' sociodemographic characteristics. Young people had an age range of 14-18 years ($M=16.3$; $SD= 1.8$), were mostly female ($n=10$; 71.4%), and Portuguese ($n=13$; 92.9%). 35.7% of young people had a disability (e.g., intellectual disability, cognitive delay) and regarding their education, most young people had access to an alternative curriculum ($n=7$; 50%) and two repeated school years ($n=5$; 35.7%). Most young people had entered TRC for less than a year from the point of data collection ($n=7$; 42.9%), and all young people were referred to TRC due to serious behavioural issues. All the participants were taking psychiatric medication under the supervision of a psychiatrist. The main reason for their protection was emotional and physical neglect ($n=7$; 50%), but most had experienced multiple forms of abuse ($n=11$; 78.6%). All young people had a history of residential placements and an intervention plan in which the primary objective of the majority was family reunification ($n=10$; 71.4%). Most of the young people had regular family visits ($n=11$; 78.6%).

Measures

During each session delivered in person, each young person was asked to complete a sociodemographic questionnaire, participate in a recorded semi-structured interview, and complete the YSR. For every young person who participated, a staff member completed a sociodemographic questionnaire and the CBCL about that young person.

Sociodemographic Questionnaires

Young people and staff completed a Portuguese sociodemographic questionnaire created for the purpose of this study and based on the findings of the quantitative systematic review (Castro et al., 2023). The questions were either open or choice questions. The sociodemographic questionnaire was not pre-tested with young people or staff in TRC prior to data collection. For young people, the sociodemographic questionnaire included quantitative and qualitative data on key profile characteristics, such as sex (male, female), nationality, disability, and access to education. For staff, the sociodemographic questionnaire included quantitative and qualitative data about young people's key profile characteristics, such as age, length of stay, reasons for child protection (emotional and physical neglect, physical abuse, sexual abuse), intervention plan (family reunification, institutional reintegration, autonomy), and family contact (family visits, home visits, emails and phone calls, no contact).

Semi-structured Interview

The Portuguese semi-structured script was specifically elaborated by the authors of this study to identify a subset of factors that contribute to youth improvement in TRC and was not pretested with young people prior to data collection. The questions were anchored within four critical domains (Setting, Staffing, Treatment Approach, and safety) (Farmer et al., 2017) and the findings of a quantitative systematic review that identified non-specific and specific treatment factors and their association with psychopathology (Castro et al., 2023). The first block consisted of a warm-up question (*To start this interview and to get to know you better if you had to introduce yourself to someone what would you say?*). Proceeded by a block of open-ended questions devoted to their experience with TRC for each critical domain (e.g., Staffing: *How would you describe your relationship with the staff?*). Semi-structured interviews were designed to help young people explore their subjective experiences of TRC

and to identify factors that are important for improving TRC from their perspective. For each interview, the same structure and sequence of thematic blocks and questions were followed. Finally, young people were encouraged to make final comments (*We are now coming to the end of this interview, but I would like to give you the opportunity to make any additional comments or ask a question?*). A copy of the semi-structured interview script is available from the corresponding author, upon request.

The recorded interview for each participant lasted between 4 min and 32 sec– 25 min and 43 sec ($M=12$ min and 13 sec, $SD=10$ min and 24 sec) and was performed in a private room in the TRC facility in the presence of the main researcher only.

Questionnaire Focused on the Characteristics of the Residential Setting

The director from each participating facility completed a questionnaire that focused on the characteristics of TRC. This included an overview of the programme (e.g., size, service offered, model/approach to treatment), questions about staffing (e.g., professional expertise, training, supervision), and physical aspects of the facility (e.g., size, ownership, type, location).

Youth Self Report

The Youth Self Report (YSR) for ages 11-18, validated and applied to the Portuguese population (Achenbach et al., 2014), integrates the Achenbach System of Empirically Based Assessment (ASEBA), and was completed by young people to screen for emotional and behavioural problems over the last six months. This self-report questionnaire consists of three parts. The first 17 items relate to interests, competencies, and social activities, and the second consists of 112 items that use a *Likert* scale in which young people select one of three options when answering each item (0= not true, 1= sometimes true, and 2= true or mostly true). These 112 items are associated with problems on a syndrome scale in eight different categories: anxious/depressed, withdrawn/depressed, somatic complaints, social problems,

thought problems, attention problems, rule-breaking behaviour, and aggressive behaviours.

The first three subscales refer to 'internalising' symptoms, and the last two refer to 'externalising' symptoms. Overall, behavioural and emotional functioning is measured by the total problem score and includes first-order scales that have been empirically validated or *the Diagnostic and Statistical Manual of Mental Disorders* (DSM-V; American Psychiatric Association, 2013)-oriented scales and second-order scales such as internalising and externalising symptoms. Lastly, it includes one open question to further understand their feelings, behaviour, and interests.

To capture the key emotional and behavioural problems of young people in TRC from their perception, only the second part of the questionnaire and second-order scales (internalising and externalising symptoms) were analysed, as this is frequently used to calculate consistency among informants.

Child Behaviour Checklist 6-18

The Child Behaviour Checklist (CBCL) for ages 6-18, validated and applied to the Portuguese population (Achenbach et al., 2014), is a component of ASEBA and was completed by staff (primary caregiver) to screen for emotional and behavioural problems over the last six months. This behaviour checklist consists of three parts. The first is a competency scale that focuses on activities, socialisation, and school. Followed by 113 items of structured questions using a *Likert* scale in which staff selected one of three options when answering each item (0= not true, 1= sometimes true, and 2= true or mostly true). The first three subscales refer to 'internalising' symptoms, and the last two refer to 'externalising' symptoms. These 113 items are associated with problems on a syndrome scale in eight different categories: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour and aggressive behaviour. Overall, behavioural and emotional functioning is measured by the total problem

score and includes first-order scales that have been empirically validated or the DSM-V (American Psychiatric Association, 2013)-oriented scales and second-order scales, such as internalising and externalising symptoms. Finally, it includes two open questions to further understand young people's problems and their strengths from the perspective of the primary caregiver. As with the YSR, only second-order scales (internalising and externalising) were analysed.

Data Collection and Analysis

Young people were only able to participate after informed consent was obtained from their legal representatives. Before participation, young people were informed about the nature of the study so that they could also make informed decisions on whether to participate. They were informed that participation was voluntary and confidential and that their personal data would be processed exclusively for this study and based on their informed consent. The limits of confidentiality were explained to each participant, as this was especially important considering the sensitive topic at hand and the vulnerability of young people. Data protection was ensured throughout the entire process, according to Act 3/2018 of Personal Data Protection and Guarantee of Digital Rights, and in Portugal, according to Law 58/2019, 8 August, regarding Personal Data Protection.

Individual CBCL and YSR scores were stored in a Microsoft Excel spreadsheet, and internalising and externalising scores were calculated manually. Sociodemographic data were also stored in a Microsoft Excel spreadsheet. Databases were pseudonymised on a personal laptop, where access was encrypted using a password.

All semi-structured interviews were conducted in Portuguese, recorded with permission from all the participants, and transcribed and anonymised verbatim. Portuguese transcripts were uploaded to MAXQDA, and content analysis was conducted. The steps followed in the content analysis were as follows: (i) successive readings of the transcripts, (ii) text coding

and definition of the categories of analysis, (iii) separation of the text according to the categories of analysis, and (iv) articulation of the content into results according to the research objectives. The recorded interviews were stored in SharePoint and could only be accessed by the research team.

Content analysis was conducted in an attempt to “stay true” to the text and achieve trustworthiness (Morse & Richards, 2002). The qualitative data were coded by the principal author (EC) into mutually exclusive categories and sub-categories, which were associated with descriptions and meaningful examples of young people's statements. A discussion was held with the secondary author (EM) until final codification was reached. Subsequently, a codebook was created based on the final categorisation and all transcripts were re-reviewed using the codebook. To ensure analysis reliability, an independent researcher (MP) coded 30% of the material separately. The Cohen Kappa coefficient was used to assess inter-coding agreement. A coefficient of 0.83 was obtained, indicating an almost perfect agreement (Landis & Koch, 1977). Disagreements were discussed and resolved by using an expanded codebook definition. Finally, EC and EM participated in the process of interpreting the obtained results to ensure an adequate and contextualised understanding of the phenomenon studied through the unique vision of young people. For each category, meaning units considered particularly illustrative were selected (i.e., excerpts of participants' responses/data that were coded in qualitative data analysis). For parsimony reasons, only the subcategories reported by five or more young people were detailed in the text; all categories are described in Table 2. Following the content analysis conducted in Portuguese, young people's supporting statements associated with each reported category and subcategory were translated into English by the main author of this study, who was bilingual in both Portuguese and English.

Results

Quantitative

Results from the YSR internalising symptoms scale revealed that most young people were found to fall within the clinical or borderline range ($n=10$; 71.4%) and were mostly female (80%). The results from the CBCL were similar, most young people were also found to fall within the clinical or borderline range ($n=11$; 78.6%) and were mostly female ($n=8$, 72.7%). Regarding the three categories of the YSR internalising symptoms scale, the results were similar to those of the CBCL, except for the somatic complaints category. In the YSR, most fell within the clinical or borderline range of the anxious/depressed category ($n=10$; 71.4%), less than half fell within the clinical or borderline range of the withdrawn/depressed category ($n=6$; 42.9%), and most fell within the clinical or borderline range of the somatic complaints category ($n=10$; 71.4%). In the CBCL, most fell within the clinical or borderline range of the anxious/depressed category ($n=9$; 64.3%), less than half fell within the clinical or borderline range of the withdrawn/depressed category ($n=6$; 42.9%), and a minority fell within the clinical or borderline range of the somatic complaints category ($n=2$; 14.3%).

On both the YSR and CBCL externalising scale, most were found to fall within the clinical or borderline range ($n=9$; 64.3%) and were mostly female (66.7%). Regarding the rule-breaking behaviour category on the YSR and CBCL externalising symptoms scale, half were found to fall within the clinical or borderline range ($n=7$; 50%). In the aggressive behaviours category, most were found to fall within the clinical or borderline range on the YSR ($n=8$; 57.1%) and CBCL ($n=9$; 64.3%).

Qualitative

In addition to the five critical domains (Setting, Staffing, Treatment Approach, Safety, and the Milieu factor), an additional domain was deemed critical and was identified as profile characteristics. Table 2 shows the categories and subcategories discussed in the semi-structured interviews and provides information regarding the number of participants that

reported each category and subcategory and the number of quotations associated with each category and subcategory (*f*), and the number of participants by category (*n*). Fictitious names were used to ensure the anonymity of young people.

Setting Domain

Resources

When describing their day, more than half (57.1%) of young people listed the available resources with an emphasis on digital media use, such as having access to a mobile phone and a computer and being able to use social media platforms, such as WhatsApp and Facebook (e.g., “I go and watch television, go on my mobile, I have breakfast, go to the computer, we have two hours of the internet, Instagram, Facebook, WhatsApp, I have lunch and I play with the girls, we dance sing and watch Netflix.”, Elizabeth, 15 years old). Young people also described the different rooms available in TRC for different activities (e.g., “We have a kitchen, we have a cafeteria, we have two classrooms, one right classroom and one left classroom each with their own room, we have the care workers office there, and we have the Director's office.”, Jenny, 17 years old).

Staffing Domain

Staff support

All young people spoke of receiving much-needed emotional and behavioural support due to the staff's empathetic approach (e.g., “When I'm having a crisis, they are there, talking to me, calming me down. Those things.”, Mandy, 15 years old). The overall perception amongst young people was that the support provided by staff was pivotal to their progress and that staff had the necessary skills and availability to provide the support they required (e.g., “I have the necessary help and I always know that they will be there to help me. When I came here, I started to improve gradually, and my behaviour has improved thanks to the

people who are here to help me. If it was not for them, I would not have good behaviour.”, John, 14 years old).

Communication skills

All young people viewed staff as possessing crucial communication skills (e.g., “They listen and give advice.”, John, 14 years old) which correlated with their evaluation and characterisation of staff. This suggested that young people who viewed staff as possessing the necessary communication skills, such as being able to listen and give advice, experienced positive relationships with staff in TRC (e.g., “I speak to them when I am feeling bad, for example, imagine I want to run away, make a mistake, I speak to the caregiver and I let them know I am not feeling well and I need to speak to them. After speaking to the caregiver, I can improve my behaviour by listening to their advice, and I feel good speaking with them. It is very good that the staff can help us, which is their job and not only that, but they also really like us a lot and I like them.”, Hannah, 16 years old).

Treatment Domain

Admission experience

Most (64.3%) young people indicated that they had experienced a smooth transition into TRC which for young people meant receiving the necessary information in the form of an explanation by staff beforehand (e.g., “Yes, they do explain.”, Ryan, 14 years old). What appeared to be most important was a conversation with staff and sufficient time to process the transition. In one case where the young person had experienced an unprepared admission, a lack of communication and preparation by staff in the previous placement was emphasised (e.g., “Nobody warned me that I was coming here, nobody warned me, I used to run away a lot in the other institution, nobody warned me. So one day, I woke up, got up, saw my closet empty and saw some bags in another room and I thought, well I am going to go to my new life, but it was not the day after all but the next.”, Chloe, 17 years old).

Behavioural management strategies

The token economy was the primary behavioural management strategy described by less than half (42.9%) of young people and was described by young people in various forms, such as points system, colour system, and different floors to indicate the level of privileges (e.g., “We have colours and we are evaluated. We evaluated our day using colour. Depending on the colour, we are allowed to do things or not.”, Ryan, 14 years old). Young people appeared to be motivated to cooperate and modify their behaviour with the view of obtaining privileges and leaving TRC as soon as possible (e.g., “...because here everything functions and has rules and we must abide by those rules, and by abiding by those rules correctly, we receive points that are essential for our departure from here. In other words, if we are well-behaved and do everything correctly, we will obtain points, which is every Thursday, we obtain points and receive a weekly evaluation...when we obtain 152 points, if I remember correctly, we will be able to get out of here.”, Elizabeth, 14 years old).

Safety Domain

Feeling safe

All young people affirmed that they felt safe in TRC (e.g., “Very safe.”, George, 17 years old), and that the presence of staff enhanced their feelings of protection in TRC and the outside world (e.g., “I feel they can protect me from the external world.”, Kyle, 17 years old).

Rules and regulations

When asked whether they agreed with the rules and regulations, less than half (42.9%) of young people appeared to learn how to accept the rules over time and did not want to change any rules despite the associated restrictions and things they did not like (e.g., I think that's the rules are okay as they are.”, Chloe, 17 years old). Young people's belief that staff were doing their best and flexible to their needs appeared to offer comfort to young people, and young people gave the impression that they felt listened to and had some control

over their environment (e.g., “Well, there are rules and regulations and everything is not the way you would want it to be, but not everything is bad and they try to give you the most comfort possible and at the moment I am okay with my room, with the people, with the environment of the house and if there is anything I need I try to see with the care workers if they can change it or not or if they can change the environment of the house...”, Hannah, 16 years old).

Milieu Factor Domain

Relationship with peers

Most (64.3%) young people indicated how building trusting relationships with peers was challenging in TRC due to the severity of young people's internalising and externalising symptoms (e.g., “There are girls here that create problems and disturb the environment of the house and cause conflict, which is not good for the girls.”, Hannah, 16 years old). All young people implied that witnessing others' maladaptive behaviour harmed them and the environment, which in turn harmed their connection with their peers (e.g., “The environment, it depends, if there is a person feeling down, we will all be in the same mood and the environment gets heavier between us. If someone else is fine, I am fine, and we are all fine, the environment will also be fine.”, Ryan, 14 years old).

Relationship with the family

Less than half (35.7%) of the young people emphasised the importance of continuing their relationship with their family and shared experiences of continued contact (e.g., “I continue to speak to my mother and father. We speak on a mobile phone through WhatsApp and video call and my sister comes and gets me from the bus station. It was my birthday recently, and I really enjoyed being with them.”, Chloe, 17 years old). Having an ongoing connection with the family appeared to bring great happiness; communication and home visits were something to look forward to, while strengthening the connection with the

community. The ability to go on home visits was particularly important to young people in TRC and those that did gave accounts of positive experiences and was seen as highly desirable and a motivating factor to improve behaviour (e.g., “What helps me improve my behaviour is speaking with my mum.”, Carol, 16 years old). Indeed, half of the young people had home visits which may indicate higher-functioning parents and a higher probability of family reunification, which was the objective of most young people's intervention plans.

Relationship with staff

Less than half (42.9%) of young people emphasised how they experienced a positive connection with staff and a small minority (14.3%) highlighted a better relationship with some rather than others (e.g., “It depends on the professional. I like them all because they help me a lot, but some are slightly more annoying than others are. I think it is our relationship, depending on the day, when they are in a good mood. If they're in a good mood, it's all good.”, Elizabeth, 15 years old). Young people indicated that they respected staff and appreciated the challenging nature of their job (e.g., “...we have to listen to their side, working with 20 youth in one shift is not a great thing.”, Chloe, 17 years old). Young people were able to empathise with staff, which is crucial when building trusting relationships; curiously, they were less empathetic towards their peers. Young people's acknowledgement and value placed on the relationship with staff is not surprising considering the nature of the support offered by staff, the interpersonal skills possessed by staff, and the dedication shown by staff in challenging circumstances, as reported by the young people themselves.

Profile Characteristics Domain

Inability to accept placement

Less than half (35.7%) of young people mentioned risk profile characteristics and specifically perceived that the treatment delivered would not be able to help them and were unable to perceive any benefits (e.g., “I do not feel safe because I do not like being here. I am

safe in the outside world anyway.”, David, 16 years old). Overall, those who felt this also expressed a strong desire to go home and did not agree with being in TRC, (“I am in this house, but they can’t help me. I want to go home; my life is there.”, Chloe, 17 years old). The desire to go home appeared to correlate with young people’s perception that they did not need the treatment provided. These two beliefs could undermine the efficacy of the treatment provided and indicated a strong inability to accept placement resulting in young people being less responsive to treatment.

Limitations

The interview script and sociodemographic questionnaire were not pre-tested on young people and staff in TRC before data collection which could have introduced bias in the results. Further work is required to validate the semi-structured interview script for the Portuguese population and worldwide in TRC. Young people’s perceptions and experiences of TRC were only captured at one point in time; therefore, it was not possible to assess the evolution of young people’s perceptions and experiences of quality in TRC.

Discussion

The study focused on a small number of young people in the majority of TRC facilities in Portugal. The four domains proposed by Farmer et al. (2017) provided a birds-eye view of the quality of TRC in Portugal and a practical framework to assess how well these services were engaging young people. According to these results, young people’s perceptions and experiences of TRC have many similarities and were mostly positive. Despite the severity of young people’s internalising and externalising symptoms, as reported by the YSR and CBCL (with a slightly higher proportion of young people falling in the clinical or borderline range on the internalising scale), TRC appeared responsive to their emotional and behavioural needs.

Specific profile characteristics of young people appeared to influence their perception of quality amongst sites, that is, sex and severity of internalising and externalising symptoms, regardless of the different modalities used. The findings revealed that females who had higher internalising and externalising symptoms had more negative perceptions and experiences of TRC than those with lower internalising and externalising symptoms. For example, negative subcategories in various categories across the domains, such as communication skills, participation experience, rules and regulations, and relationship with family, were reported by females only. Furthermore, peer contagion was identified as a problem affecting peer relationships, with eight of the nine comments made by females. However, both females and males highlighted that they were unable to accept treatment because they were unable to see the benefits of treatment and wanted to go home. Overall, these findings are consistent with previous quality research in Portuguese RC where females evaluated the quality of RC units' services significantly lower than males in almost every dimension, including 'overall quality' (Rodrigues et al., 2014b).

Given the heterogeneity of young people in TRC, it is important to identify the combinations of risk and protective factors these young people present to ensure that the service is responsive to their individual needs. This may be particularly important for females who may present with higher internalising and externalising symptoms (Castro et al., 2023). TRC should include general components with relevance to the majority of youth and specified approaches targeted at subgroups (Boel-Studt, 2017; Castro et al., 2023).

The Milieu Factor domain emerged as particularly critical and focused on the extent to which young people experienced trusting relationships. Children and young people in RC have accumulated lived experiences where they may have learned that relationships with adults are a source of threat rather than safety (Holmes et al., 2018). Subsequently, they may struggle to form relationships that are trusting, culturally safe and have lasting impacts on

their life trajectories (McPherson et al., 2024). The milieu factor and emphasis on trusting relationships are consistent with studies of milieu-based services (Green et al., 2019; 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).

Indeed, trusting relationships with peers (Scholte & van Aken, 2006), staff (Harder et al., 2013; Pinheiro et al., 2024) and family involvement (January et al., 2018; Kor et al., 2021) are crucial when considering the outcomes of TRC and beyond. Crucially, findings from this study extend the importance of trusting relationships beyond relationships in TRC and the family and emphasise the connection with those in the community, which research is yet to explore in more detail and yet an intrinsic part of the definition of TRC (i.e., “...and in collaboration with a full spectrum of community-based formal and informal helping resources” [Whittaker et al., 2015, p. 24]).

Distinguishing this critical domain allows focused attention to the 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 (Castro et al., 2024). 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 (Blind for review). When evaluating the extent to which TRC in Portugal has the milieu factor (i.e., trusting relationships with staff, peers, family, and the community), young people had a very positive relationship with staff, and there was evidence of strong family involvement for most, the difficulty appeared to lie in their connection with their peers and forming trusting relationships with other young people with emotional and behavioural problems in TRC. Previous research has found that young people's vulnerability to peer victimisation is heightened when they are placed with others who have entrenched behavioural and emotional

difficulties (Moore et al., 2016). Many of these adolescents' aggressive or hostile behaviours might indicate maladaptive expressions of a desire for proximity and acceptance, given that this is the only model of "affection" they know (Crittenden, 1992). The influence process often occurs outside of awareness; young people may not intend to influence their peers, but they engage in relationship behaviours that satisfy immediate needs for an audience or companionship, and these behaviours inadvertently influence themselves or others (Dishion & Tipsord, 2011).

Therefore, not only do staff need to prevent and protect young people from peer victimisation which young people reported staff did well, but they must also cultivate trusting relationships among peers, contributing to a sense of safety in TRC. Highly trained staff may be particularly important to counteract peer contagion, as in a Boys Town study; Family Teachers who had more programme experience had fewer problem behaviours in their home (Huefner & Ringle, 2012). This is the product of experience and ongoing training, and is verified through evaluation and a recertification process (Huefner & Ringle, 2012). The results of this study support the view that direct-care staff with longer tenures are more effective in helping behaviourally troubled youth control unwanted behaviours, which is consistent with research showing that adult oversight is a protective factor in correcting for negative peer influence (Laird et al., 2010; Vieno et al., 2009).

Regarding the Setting domain, access to internet-enabled digital tools (mobile phones, tablets, gaming consoles, and PCs) appeared to be particularly important to young people. Indeed, digital media use for young people in TRC has been found to facilitate elements of the five Cs associated with positive youth development: *connection, confidence, competence, character, and caring* (Good, 2023; Gustavsson & MacEachron, 2015), which is particularly important for young people in TRC given the restrictions to the community and the important relationships they may have in this context. In this study, young people described social

media as a way to maintain community relationships. According to young people, what may be crucial here is not a complete restriction of internet-enabled tools, but ensuring that young people have online opportunities for social connection, learning, and digital skill development whilst safeguarding youth from harm (Good, 2023).

Most strikingly, young people only mentioned their participation in daily chores and provided no further examples. Young people's voices appeared to indicate that they did not understand the extent to which they could participate, what participation was, or the power that their participation had to bring about change. It could be that young people were not fully participating to the extent they should and could be. The ability to engage youth in services remains a salient issue (Lindsey et al., 2014), and, as previously highlighted, youth may be involuntary clients and/or those who are not engaged in services (Boel-Studt et al., 2018), a salient risk profile characteristic for this population. For example, the daily assembly, a distinct moment for young people to participate was only mentioned once, and its description was consistent with existing research in that assemblies were seen as a means for "asking for" and raising concrete demands rather than an effective vehicle for stimulating organisation and participation (Monserrate et al., 2021). However, a lack of engagement can inhibit treatment effectiveness and leave open known risks of poor service outcomes (Wulczyn et al., 2007). Using a youth-centred approach to implement a flexible incentive-based participation programme may minimise challenges to engagement in services among youth in TRC (Boel-Studt et al., 2018). However, given the importance of participation, and considering that factors that promote engagement among youth in residential and high-level care settings are scarce (Boel-Studt et al., 2018), more research is needed to promote and enhance young people's participation experiences.

Regarding the Staffing domain, specific interpersonal skills, such as good communication skills and the particular virtues that enable better communication and

relationship building, such as empathy, have been strongly associated with a positive therapeutic alliance with staff (Harder et al., 2011). Research highlights that, to achieve a trusting relationship, staff should be empathic, flexible, honest, respectful, reliable, and friendly (Harder et al., 2013; Wampold, 2015) which is consistent with the voices of young people in this study. Perceiving staff as empathetic was crucial to feeling emotionally and behaviourally supported. Given the importance of good interpersonal skills by staff, specifically good communication skills, it seems crucial to promote and maintain these skills among all staff during TRC as a prior condition to achieve enduring behavioural change with young people. However, according to young people and existing literature, this goes beyond training initiatives and includes staff dedication. However, it can be difficult to retain educated staff in TRC because of the complex roles and responsibilities that lead to a high turnover rate, including but not limited to low pay, demanding work conditions, lack of recognition of the value of their work, and lack of input in important decisions (Krueger, 2007). To retain workers who are important intermediaries for clinicians, there must be an increase in job satisfaction and commitment, which, in turn, will lead to a longer stay in the organisation (Rose et al., 2010).

Young people discussed their experiences of treatment, and more than half (57.1%) reported a smooth admission, with numerous reports of receiving the necessary information and preparation before being admitted to TRC. Every element of the transition from current placement to the new placement requires careful consideration of young people's vulnerability and emotional needs. Literature suggests that admission to the TRC should be a gradual process rather than an event for this group of care leavers (Field et al., 2021; Kor et al., 2021). Young people should be fully informed and able to participate in the process as when they participate, and their voice is heard they gain more control over what is happening to them.

Regarding the treatment offered in TRC, the token economy is a behaviour modification technique that is based on the principles of operant conditioning and was the central behavioural management strategy adopted by staff. Research suggests that token economies are effective for young people in TRC, including those who are non-responsive to treatment (Fields et al., 2004). However, in practice, many of these programmes are poorly conceptualised and operationalised, limiting their effectiveness and resulting in calls for the use of more individualised, child-centred approaches (Mohr et al., 2009). The key to effectively delivering a token economy may lie in staff competencies and the extent to which they have the necessary interpersonal skills to deliver it fairly and efficiently in the context of a trusting relationship.

Young people's experience of safety was cultivated by structure and stability in the living environment and staff actions (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). Targeted efforts to enhance the milieu factor would have a positive effect on all four domains, including safety, as one of the main challenges for young people in TRC may be their relationships with their peers.

Practice Implications for Social Work

The findings of this study have several implications for policy and practice in social welfare systems. Specifically, this study highlights that young people can provide invaluable insights into the quality of TRC. Adopting this conceptual framework may support participatory approaches which, in turn, may assist in giving young people a voice and an influence. With this in mind, social work practices and policies should be adapted to ensure that the voices of young people are taken into account so that TRC is youth-friendly and fit for purpose.

Focused attention on the Milieu Factor domain can inform the selection of interventions for young people. For example, peer groups or peer-led educational programmes may effectively boost self-esteem (Kaveh et al., 2014) and help adolescents build healthy peer relationships. Furthermore, working more closely with families in the community where possible (e.g., offering family therapy and family support) (Castro et al., 2024) may be key to improving family functioning and thus improving family involvement and young people’s relationship with their families (Castro et al., 2023). What is crucial here is treating the family as a whole (Sunseri, 2004, 2020), a critical relationship in the Milieu Factor domain for young people, especially when the end goal is family reunification, which is the case for most in this study. Critical to the success of any TRC intervention is to understand the practices that might potentially interrupt the trajectory towards isolation, poor social connections, and fractured trust, as well as the policies that frame and support those practices and related conditions (McPherson et al., 2024).

Directions for Future Research

Based on young people’s perceptions and experiences, further research is needed to build on the conceptual framework proposed by Farmer et al. (2017), and focusing on the staff perspective. Investigating these two perspectives will assist in uncovering valuable information about their unique perceptions and experiences to further improve TRC. The sample should be expanded to include other TRC facilities in Portugal and worldwide. Children possess unique insights – ones that can and should contribute to the development of child welfare practice, planning, and policy (Fox & Berrick, 2007). Further research should capture young people’s perceptions and experiences of TRC at multiple points in time and explore female and male perspectives regarding TRC quality to be responsive to their needs.

Conclusion

This study provides valuable insights into the perceptions and experiences of young people in TRC settings. Young people's perceptions and experiences of young people at different facilities in Portugal have many similarities and were mostly positive. However, the distinguishing factors influencing young people's perception of quality amongst sites appeared to be the sex of young people and the severity of internalising and externalising symptoms. Females with higher internalising and externalising symptoms were more likely to have negative perceptions of TRC, consistent with previous findings in Portuguese RC (Rodrigues et al, 2019).

Furthermore, these findings highlight the importance of trusting relationships with peers, staff, family, and the wider community, which is of particular importance to young people in TRC, given the limited access to friends, family, and the community at large. To strengthen the milieu factor, particular attention should be paid to peer relationships, as most young people reported experiencing peer contagion. Meaningful participatory approaches to assessing quality should be adopted, as demonstrated in this study, to understand how results are achieved and gain more durable positive treatment results. Policies and practices should be revised to take the voices of young people into account, so that services are youth-friendly and fit for purpose.

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YOUNG PEOPLE'S PORTRAYAL OF THERAPEUTIC RESIDENTIAL CARE

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Table 1
Sociodemographic Characteristics of Young People

Sociodemographic characteristic	Full sample	
	<i>n</i>	%
Sex		
Female	10	71.4
Male	4	28.6
Nationality		
Portuguese	13	92.9
Brazilian	1	7.1
Disability		
No disability	9	64.3
Mild-moderate disability	5	35.7
Access to education		
National curriculum	6	42.9
Alternative curriculum	5	50
No access	1	7.1
Repeated school years		
No repeated years	5	35.7
1 year	4	28.6
2 years	5	35.7
Length of stay		
< 1 year	7	42.9
1 - 2 years	5	35.6
3-6 years	1	7.1
≥ 7 years	1	7.1
Reason for child protection		
Emotional and physical neglect	7	50
Physical abuse	7	50
Sexual abuse	4	28.6
Intervention plan		
Family Reunification	10	71.4
Institutional reintegration	2	14.3
Autonomy	1	7.1
Family contact		
Family visits	11	78.6
Home visits	7	50
Emails and phone calls	10	71.4
No contact	1	7.1

Table 2

Categories and Subcategories in each Critical Domain

Macro-category	Category	Subcategory
Setting	Resources ($n= 8; f= 15$)	Available resources ($n= 8; f= 10$)
		More resources needed ($n= 3; f= 5$)
	Space ($n= 4; f= 6$)	Sufficient space ($n= 2; f= 2$)
		Good exterior ($n= 1; f= 1$)
Staffing	Building renovation ($n= 1; f= 3$)	Building maintenance ($n= 1; f= 2$)
		No changes to the environment ($n= 1; f= 1$)
	Staff support ($n= 14; f= 62$)	Listen and give advice ($n= 7; f= 13$)
	Communication skills ($n= 14; f= 23$)	Provide updates ($n= 3; f= 3$)
Treatment Approach		Need to improve communication skills ($n= 3; f= 3$)
		Honest ($n= 2; f= 5$)
	Staff dedication ($n= 3; f= 3$)	Vocation ($n= 2; f= 2$)
		Professional career development ($n= 1; f= 1$)
Safety	Staff turnover ($n= 3; f= 4$)	
	Inappropriate staff responses ($n= 2; f= 3$)	
	Informal goal setting ($n= 2; f= 2$)	
	Admission experience ($n= 9; f= 18$)	Receive necessary information ($n= 8; f= 8$)
Safety		Need time to adapt ($n= 2; f= 6$)
		Feel welcomed ($n= 2; f= 2$)
		Escorted by police officer ($n= 2; f= 2$)
		Unplanned admission ($n= 1; f= 1$)
Safety	Behavioural management strategies ($n= 7; f= 15$)	Token economies ($n= 6; f= 10$)
		De-escalation techniques ($n= 2; f= 2$)
		Multiple uses of time-out ($n= 1; f= 1$)
		Medication ($n= 1; f= 2$)
Safety		Visitor restriction ($n= 1; f= 1$)
	Participation experience ($n= 7; f= 14$)	Opinions are valued ($n= 4; f= 6$)
		Opinions are valued inconsistently ($n= 3; f= 5$)
		Daily chores ($n= 2; f= 2$)
Safety		Daily assembly ($n= 1; f= 1$)
		Physical exercise ($n= 3; f= 3$)
		Change in eating habits ($n= 1; f= 1$)
	Lifestyle ($n= 4; f= 4$)	
Safety	Feeling safe ($n= 9; f= 16$)	Affirmation of feeling safe ($n= 7; f= 8$)
		Staff protection against peer victimisation ($n= 3; f= 4$)
		Staff protection from exterior ($n= 3; f= 4$)
	Rules and regulations ($n= 7; f= 19$)	Acceptance of rules ($n= 6; f= 11$)
Safety		Blanket rules ($n= 3; f= 3$)
		Change in rules ($n= 1; f= 1$)
	Productive free time ($n= 1; f= 1$)	

YOUNG PEOPLE'S PORTRAYAL OF THERAPEUTIC RESIDENTIAL CARE

Milieu factor	Relationship with the community ($n= 8$; $f= 15$)	Access to the community* ($n= 4$; $f= 5$) Education on-site ($n= 3$; $f= 3$) More access to the community ($n= 2$; $f= 3$) Maintaining relationships through social media* ($n= 2$; $f= 2$)
	Relationship with peers ($n= 8$; $f= 10$)	Peer contagion ($n= 7$; $f= 9$) Positive relationship with peers* ($n= 2$; $f= 2$)
	Relationship with the family ($n= 7$; $f= 7$)	Family involvement* ($n= 5$; $f= 5$) More home visits needed ($n= 2$; $f= 2$)
	Relationship with staff ($n= 6$; $f= 8$)	Staff are valued* ($n= 6$; $f= 6$) Preferential staff ($n= 2$; $f= 2$)
Profile characteristics	Risk profile characteristics ($n= 6$; $f= 8$)	Inability to accept placement ($n= 5$; $f= 6$) Aggressive behaviour ($n=2$; $f=2$)
	Protective profile characteristics ($n= 4$; $f= 8$)	Acceptance of placement ($n= 2$; $f= 4$) Ability to ask for help ($n= 2$; $f= 2$) Future aspirations ($n= 2$; $f= 2$)

Note. $n=$ The amount of young people that reported the phenomena; $f=$ The frequency at which the phenomena was reported by young people; * Protective factors associated with trusting relationships in the milieu factor domain