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Short-Term Effectiveness of Residential Out-of-Home Care for Children and Youth—A Scoping Review

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Abstract

A scoping review on the short-term (during care) outcomes of residential care at the user level (children and their families) was conducted. The objective was to understand the extent and type of recent research focusing on outcomes during residential care placement as a child protection intervention and map the findings of the original studies. In six databases, 2,693 records of recent peer-reviewed articles with an abstract in English were found. A total of seventeen original studies were included in the review. In the studies, three distinct types of interventions were identified—implemented interventions, innovations and service as usual (SAU). The findings revealed variations in researchers' definitions of the concept of effectiveness and heterogeneity in methodology. Three studies were randomised control trials, two were quasi-experimental and twelve other designs were quantitative, qualitative or mixed methods studies. Most of the interventions in the original studies, brought about positive change in different dimensions of the wellbeing or functioning of users. The most robust designs were used in studying previously assessed interventions designed to combat specific problems. Whilst studies on SAU have demonstrated improvements in various aspects, the inherent complexity and diversity of residential care make the assessment of effectiveness a challenging task.

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Introduction

In Western countries, out-of-home care (OHC) is organised in diverse ways, encompassing kinship care, foster family care and residential care ranging from small group homes to large institutions. Whilst definitions are debated with variations across regions, residential care is often considered a last resort for children with significant psychosocial challenges (Bullock and McSherry, 2009; Chow *et al.*, 2014; Dozier *et al.*, 2014; Harder *et al.*, 2017; Leloux-Opmeer *et al.*, 2017).

The success of residential care and its capacity to improve well-being for children and youth can be challenged based on many outcome studies. Register-based studies of OHC indicate that, in the long run, children in care are worse off compared to the general population in terms of, for example, health, employment and educational attainment (Cameron *et al.*, 2018; Kääriälä *et al.*, 2018). A systematic review of quantitative outcome studies found that children with a history of OHC in the Nordic countries have higher risks for adversity (Kääriälä and Hiilamo, 2017). Reviews on outcomes for children in residential care compared to children offered other interventions (e.g. Lee *et al.*, 2011; Li *et al.*, 2019; Gutterswijk *et al.*, 2020) also indicate that children and youth in residential care have less favourable outcomes than those in foster family care. Prior reviews have focused on family foster care (Goemans *et al.*, 2015), compared outcomes between foster care and kinship care (Winokur *et al.*, 2014), and assessed the outcomes of treatment foster care (Macdonald and Turner, 2008), whereas less attention has been paid to the specific context of residential care.

The short-term effectiveness of residential care has been addressed for example in reviews on organisational-level interventions indicating that certain training programmes can enhance professionals skills and work environments (Eenshuistra *et al.*, 2019). Although evidence regarding the effectiveness of trauma-informed organisational models is limited, trauma-informed care may yield positive outcomes for children in out-of-home care (Bailey et al., 2019). Regarding child-level outcomes in residential care, Knorth *et al.* (2008) found that residential placement may reduce problematic behaviour in children, yet no single intervention programme proved universally effective. The evidence on short-term effectiveness is highly limited and based on two meta-analyses of studies conducted over a decade ago; evidence regarding the effectiveness of evidence-based treatment over

standard services is also conflicting (De Swart *et al.*, 2012; Strijbosch *et al.*, 2015).

Objective of the scoping review

Previous reviews on the short-term effectiveness of residential care treatment have focused on specific interventions or aspects of care, and as there are no recent reviews including studies with different methodologies, we reviewed the most recent literature on the short-term effectiveness of residential care for children and youth in general. We expected a wide range of study designs amongst the included original studies and, therefore, we opted to conduct a scoping review to comprehensively map and synthesise existing research. The review was conducted in accordance with Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco *et al.*, 2018).

The objective was to understand the extent and type of recent (ten years) research focusing on short-term outcomes (during placement) of residential care in child protection to inform practice. We reviewed the types of study designs that have been used when exploring the effectiveness of different interventions and mapped the findings of the original studies.

Method

A protocol including the population, concept and context (PCC) was defined prior to the study. To inform the protocol, a preliminary search was conducted of Cochrane Database of Systematic Reviews, PubMed, SocINDEX and ASSIA in February 2023. No recent systematic reviews or scoping reviews assessing the short-term outcomes of residential care as a child protection intervention were identified. In the protocol, the population, concept and context were formulated as follows.

The population is school-aged children and youth (six to eighteen years). We excluded infants and toddlers due to the distinct care requirements stemming from their developmental stage. Residential care in this review is limited to child protection interventions. Children and youth placed in care often exhibit mental health needs, substance abuse or delinquent behaviour, but residential care in the context of health care (hospitalisation), disability or juvenile delinquency was excluded. Different judicial systems treat children with delinquent behaviour differently. For this study, we included residential care facilities providing child protection services and excluded correctional facilities, with inclusion based solely on this criterion irrespective of children's admission reasons.

We included all studies that, by the author's or authors' definition, studied effectiveness or outcomes, with any study design (qualitative, quantitative or mixed methods). Original studies had to apply predefined short-term (during care), user-level (child, parent or family) outcome measures with the ultimate target of change being related to the child. This allowed interventions with different targets of change to be included (e.g. child behaviour, professional practice and interpersonal relations), as this was not predefined. In addition, reviews with a spelled-out protocol that met the inclusion criteria were considered. The context was confined to Western countries to enhance the applicability of findings across diverse service organisations and delivery systems in Western countries and societies.

Search strategy

The search strategy (Supplementary file S1) included keywords consisting of three sets describing the population (S1, children), context (S2, residential care) and concept (S3, outcome evaluation or effectiveness study). In addition to the predefined terms, database-specific keywords were used when applicable.

The six databases searched were SocIndexFullText via EbscoHost, ASSIA via ProQuest, Medline via OVID, APA PsycInfo via OVID, Social Services Abstracts via ProQuest and Web of Science. The search was conducted in February 2023 and included peer-reviewed articles published between 2013 and 2023 with an abstract in English.

Study selection

One researcher initially pre-screened all articles by reviewing their titles and abstracts to exclude clearly irrelevant articles. Subsequently, two independent authors conducted a comprehensive review of the abstracts included in the first phase. The full texts of selected citations were assessed in detail against the inclusion criteria by two independent reviewers. Any disagreement that arose between the reviewers was resolved through discussion, and with a third independent reviewer. The selection process adhered to the predefined inclusion and exclusion criteria.

Data extraction and synthesis

Data extraction from the papers included was carried out by three reviewers utilising a data extraction tool designed for the review. The data extraction framework was formulated and refined during the

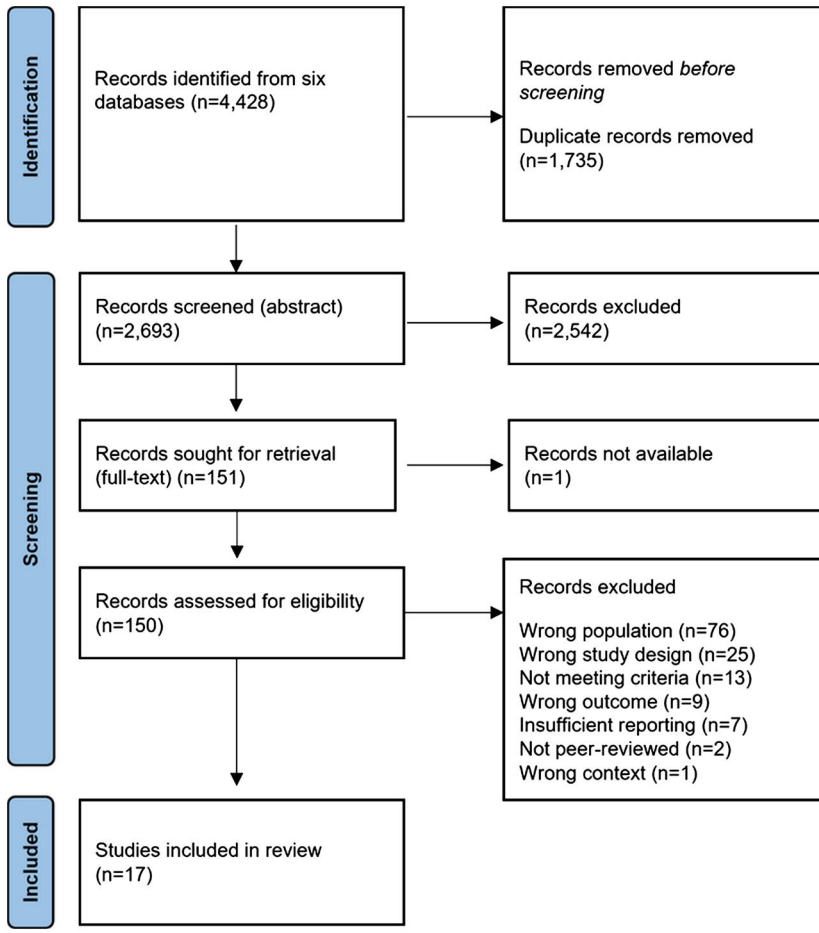

Figure 1. PRISMA flow chart.
Alt text: A total of 4,428 records were identified from six databases. After removal of duplicates 2,693 records were screened. Of these 2,524 were excluded based on the abstract and 151 were retrieved as full-texts. Records were excluded bases on for example wrong population, study design or context. Of the records assessed for eligibility seventeen were included in the review.

analysis. It included details on the participants, concept, context, study methods, intervention target and theory of change as well as on key findings. The results are presented descriptively in accordance with the aim of scoping reviews that map and identify evidence and characteristics but align to a descriptive analysis (Pollock *et al.*, 2023).

A total of 2,693 individual studies were identified and screened. Based on titles and abstracts, 151 full-text articles were screened for inclusion. For our final sample, seventeen studies were included (Figure 1).

The most common reason for exclusion was 'wrong population' (e.g. study participants did not meet the specified age criteria or did not reside in a residential care setting, or studies did not distinguish residential care from other forms of OHC). To meet the short-term outcome criterion, all measuring points had to be in the period when the child was still in residential care. Therefore, a few studies with a measurement point at a time after leaving the residential unit or care (e.g. Löfholm *et al.*, 2020) were excluded. Studies that were not outcome evaluations or effectiveness studies (e.g. descriptions of a programme or population characteristics or studies of prevalence) were excluded based on study design. Some screened studies examined variables related to the quality or content of out-of-home care as mediators or moderators (e.g. Blakely *et al.*, 2017; Shalem and Attar-Schwartz, 2022). These studies were excluded.

Reviews were deemed eligible if more than half of the original studies met the inclusion criteria of this review. None fulfilled this criterion.

Results

Descriptives of the included studies

Study designs

In our sample, three of the studies were randomised controlled trials (RCTs), two quasi-experimental and twelve applied other types of study designs (Tables 1–3). The latter group of studies focused primarily on 'service as usual' (SAU) (Table 3) and included various designs, such as quantitative surveys, qualitative and mixed method or pilot studies without a control group as well as subgroup analysis.

Measures and sample sizes

Sample sizes varied from 8 (Känkänen *et al.*, 2022) to 1,082 youth (Portwood *et al.*, 2018). Whilst large samples are preferred as they provide more reliable findings, some interventions start on a small scale. New innovations are first implemented with a limited number of participants.

Validated (with author reference to reliability and validity studies) outcome measures were used in thirteen studies. Some studies included a variety of qualitative and quantitative measures. One study used only qualitative methods. Four quantitative or mixed methods studies used only non-validated outcome measures developed either previously or for the study in question.

Intervention types

Three distinct types of interventions were found.

Firstly, five studies (Gross *et al.*, 2015; Hoogeveen *et al.*, 2017; van Lieshout *et al.*, 2019; Mitchell *et al.*, 2022; Salceda *et al.*, 2022) focused on 'implemented interventions' (Table 1), which consisted of interventions developed and previously tested in other contexts and subsequently implemented and evaluated within a residential care setting.

Secondly, four studies (Oman *et al.*, 2016; Domon-Archambault *et al.*, 2020; Parry *et al.*, 2021; Känkänen *et al.*, 2022) focused on 'innovations' (Table 2), comprising interventions specifically developed for the study's unique circumstances. It is worth noting that one of the interventions (Gross *et al.*, 2015) featured an innovative component but was categorised as an implemented intervention. Furthermore, one study (Mihalo and Valenti, 2018) integrated an innovative aspect of feedback on working alliance into SAU but was categorised as a study of SAU.

Thirdly, in eight studies, residential care was examined as SAU (Table 3), that is, care provided in each context without the incorporation of additional interventions or innovations aimed at enhancing outcomes (Lee, 2013; Carra, 2014; Chow *et al.*, 2014; Mihalo and Valenti, 2018; Portwood *et al.*, 2018; Rau *et al.*, 2020; Colonnesi *et al.*, 2022; Gonzales-Garcia et al., 2023), but some addressed aspects of the care provided.

The nine innovations and implemented interventions sought to achieve either behavioural change improvement in the emotional functioning or general psychological well-being of the child, with the target of change being the child, parent or practitioner. In terms of theoretical background, most interventions aiming to change behaviours (e.g. dating violence, sexual risk behaviours) fell under the umbrella of learning theories: either cognitive behavioural theory (van Lieshout *et al.*, 2019), social cognitive theory (Oman *et al.*, 2016) or operant conditioning theory (Gross et al., 2015). One intervention exported to the residential care context, multidimensional family therapy (MDFT), is based on family and systems therapy (Hoogeveen *et al.*, 2017) but is also informed by components of cognitive behavioural theories related to behavioural change. Two innovative interventions were built on mentalisation and attachment theory (Domon-Archambault et al., 2020; Parry *et al.*, 2021), commonly used as background theories in trauma-informed care, aiming to improve emotion regulation and emotional well-being.

In some studies, a clear theoretical basis for the intervention was either not stated or not defined at the outset, but relevant research background was highlighted. Research findings informing the interventions studied were related to the significance of alliances for treatment outcomes (Mihalo and Valenti, 2018) or the benefits of social support, particularly peers, in supporting grieving youth (Mitchell *et al.*, 2022). In

Table 1. Implemented interventions.

	Context	Study design	Sample and data	Intervention	Target of change of intervention	Outcome measures
1. Gross *et al.* (2015). USA.	Residential group care facilities: family-style homes (up to eight adolescents).	Other. Pre- and post-test, no control group.	Children (11–17 years old) ($n = 143$). Teaching parents ($n = 52$).	Teaching Family Model point-card token economy (behaviour management strategy).	Behaviour and emotional functioning of child.	CBCL Externalising Problems Symptoms (CBCL-EP), Symptoms and Functioning Severity Scale Externalising Problems (SFSS-EP), Behavioural and Emotional Rating Scale-2 Strength Index (BERS-2-SI). Other: Archival outcomes and treatment implication.
2. Hoogeveen *et al.* (2017). The Netherlands.	Secure residential group care.	Quasi-experimental. Retrospective cohort study, random sample, baseline and exit documents.	$n = 50$ adolescents (12–18 years old), $n = 26$ outpatient group, $n = 24$ inpatient group.	Implemented intervention. Multidimensional Family Therapy (MDFT).	Behaviour of child and parent.	Rating documents: externalising behaviour, family functioning, school attendance and performance. Validated measure: Satisfaction Scales for Adolescents and Parents.

(continued)

Table 1. (continued)

	Context	Study design	Sample and data	Intervention	Target of change of intervention	Outcome measures
3. Mitchell *et al.* (2022). USA.	Three group homes.	Other. Experimental. Mixed methods. A two-group RCT with a pre-test–post-test-design (baseline and post-intervention after 6 weeks) and a structurally equivalent comparison group. Qualitative assessment of the intervention.	42 youth (12–16 years old, $M = 14.52$). Focus groups ($n = 3$) after post-intervention assessments. Weekly survey for group, participants and facilitators.	Youth-led and youth-driven peer grief support programme [L.Y.G.H.T.] adapted from a previous model to meet the needs of youth in foster care.	Social relations between parents and practitioners and behaviour of practitioner.	Children's Hope Scale (CHS) The Inventory of Social Support (ISS) The Rosenberg Self-Esteem Scale (RSES) The Strengths and Difficulties Questionnaire-Self Report (SDQ). 12-item survey with five questions on the survey from the SDQ and seven questions from the Trauma-Informed Program Scale (partly validated). Facilitator survey created for the study to assess fidelity to the intervention. Qualitative data: Focus group topics relating to feedback on programme.

(continued)

Table 1. (continued)

	Context	Study design	Sample and data	Intervention	Target of change of intervention	Outcome measures
4. Salceda *et al.* (2022). Spain.	Group home for 13–18-year-old girls.	Other. Qualitative.	Girls (15–18-year-olds) ($n = 13$) and social workers ($n = 7$). Observations, focus groups, in-depth interviews and records of school results (n = 8).	Monthly 2-h Dialogic Literary Gathering, built on the classics of world literature and facilitated by a social worker.	Academic performance and social relations between child and parents/family/peers.	Qualitative data: Self-perceived academic dimension, prosocial dimension. School results.
5. van Lieshout *et al.* (2019). The Netherlands.	Twenty regular residential youth care units.	Experimental. Cluster randomised trial with a waiting list control group. Pre-test, post-test and 6-month follow-up measurements.	Boys (12–17-year-olds, M = 14.8) ($n = 177$).	Innovation. Make a Move, a sexual harassment prevention programme consisting of eight weekly group meetings.	Behaviour of child, attitudes and skills.	Fourteen previously validated scales (e.g. self-esteem, empathy and adverse sexual beliefs) to measure antecedents of sexually offensive behaviour.

Table 2. Innovations.

	Context	Study design	Sample and data	Intervention	Target of change of innovation	Outcome measures
1. Domon-Archambault *et al.* (2020). Canada.	Residential care in two units of one agency.	Other. Pilot study. Pre- and post-measures, no control group.	Childcare workers (n = 9), children (6–12-year-olds) (*n* = 8).	Mentalisation-based training programme for residential care workers.	Behaviour and emotional functioning of both child and practitioner.	Empathy Quotient (EQ), Child Behaviour Checklist (CBCL), Adaptation of the Parent Development Interview-Revised (PDI).
2. Känkänen *et al.* (2022). Finland.	State-run residential care units.	Other. Qualitative and quantitative. Three qualitative interviews (beginning, middle and end of intervention). One questionnaire.	Adolescents (15–17 years) (*n* = 8)	Drama workshop, thirteen sessions (1 year) built on the novel *Crime and Punishment* by Fyodor Dostoyevsky in cooperation with the Finnish National Theater.	Emotional functioning of child.	Qualitative interviews: Nussbaum's Ten Central Capabilities. Quantitative data: Toronto Alexithymia Scale (TAS-20).
3. Oman *et al.* (2016). USA.	Forty-four residential group homes in three states with 13–18-year-old residents. Homes were a mixture of child welfare and juvenile system facilities.	Experimental. Cluster RCT with pre- and post-measurement, group homes as the unit of randomisation.	Youth (*n* = 1037; M = 16.2 years).	'Power Through Choices': a 10-session, sexual health education programme delivered twice per week.	Health promotion and behaviour of child.	Youth self-report, measuring knowledge, attitudes, self-efficacy and intentions regarding sexuality and sexual behaviours. Some psychometric validation was applied.

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Table 2. (continued)

	Context	Study design	Sample and data	Intervention	Target of change of innovation	Outcome measures
4. Parry *et al.* (2021). UK.	Four residential homes functioning as 'a family unit', integrated into the local community.	Other. A mixed method design with qualitative and quantitative data. Quantitative data was measured at five points, pre-, during and post-intervention.	Children (5–12-year-olds, M = 8.9) Average intervention duration 19.9 months.	Restorative Parenting Recovery Programme (RPRP), a model of care based on attachment theory, positive psychology and trauma-informed care.	Behaviour of practitioners, emotional functioning psychological well-being of child, environment and social relations of child.	The Restorative Parenting Recovery Index (RPRI) developed for the programme: child's progress on self-care, relationships and attachments, self-perception, self-management, self-awareness and emotional competence. Qualitative data: staff experience, motivations and interpretations in relation to the RPRP.

Table 3. SAU

Authors, year, country	Context	Study design	Sample and data	Outcome measures
1. Carra (2014). Italy.	Public and third sector residential care facilities (average six residents).	Other. Comparison across different types of units.	Phone interviews with managing organisations ($n = 133$) and online survey ($n = 187$) for residential care facilities. Questionnaire ($n = 97$) for young people aged over 10 years.	Youth questionnaire created for the study: subjective well-being and length of stay in residential care.
2. Chow *et al.* (2014). USA.	Thirty group homes.	Other Exploratory study. Retrospective subgroup analysis, 'within-subjects design'.	Sample $n = 180$ young people. Registry data ('charts') T1 (admission) and T2 (chart review or discharge)	Child and Adolescent Needs and Strengths (CANS).
3. Colonnesi *et al.* (2022). The Netherlands.	Out-of-home care: foster care (foster families or kinship care), family homes (4–6 children) and residential care (8–10 children).	Other. Subgroup analysis.	$N = 138$, foster parents ($n = 42$), family-home parents ($n = 11$) and residential care workers ($n = 85$); children ($n = 68$ girls, $n = 70$ boys, 2–18 years, M = 13.42). Caregivers' verbal descriptions, questionnaires.	Mind-mindedness measure, Children's Revised Impact of Event Scale, parental version (CRIES), Parenting Stress Questionnaire (SDQ).
4. Gonzalez-Garcia *et al.* (2023). Spain.	Residential care.	Other. Subgroup analysis within sample.	492 children and youth (8–17 years old) living in RCC for at least 24 months and receiving mental health services. Questionnaires.	The Child Behaviour Check List (CBCL), Questionnaire on sociodemographic, family and treatment information (developed for the study).

(continued)

Table 3. (continued)

Authors, year, country	Context	Study design	Sample and data	Outcome measures
5. Lee (2013). USA.	One residential treatment centre (80 beds) for 6–13-year-old children with emotional and behavioural needs. A locked facility providing intensive services.	Other. Pre-and post-test (mean length of stay 20.94 months).	77 foster children 6–13 years old. Administrative data with GAF scores at intake discharge.	Global Assessment of Functioning (GAF).
6. Mihalo and Valenti (2018). USA.	Residential treatment centres offering therapeutic treatment. Five programmes for youth aged 10–17 years.	Other. Partly experimental, independent samples. Family workers and members ratings of family functioning and the quality of working alliance over the course of 1 year.	Family members ($n = 114$) of youth in treatment. Family workers ($n = 22$). 179 matched pairs of family member and family worker.	Working alliance as mediating variable: Working Alliance Inventory, Short Form (WAI-SF). Other: Family functioning form with five items.
7. Portwood *et al.* (2018) USA.	37 sites in residential group care settings, (45.3 per cent of youth in low, 9.5 per cent in moderate and 16.7 per cent in high management programmes) and 28.4 per cent in residential treatment.	Quasi-experimental Repeated measures design: intake and 3-month follow-up. Additional follow-up at 6 and 12 months for children remaining in care.	1,082 youth in residential group care; ($n = 903$) ($M = 13.97$ years, $SD = 2.43$), compared with those in foster care ($n = 179$; ($M = 13.65$ years, $SD = 2.73$).	Children's Global Assessment SCALE (CGAS), Child Behaviour Checklist (CBCL) and Youth Self Report (CBCL-YSR), Revised Children's Manifest Anxiety Scale (RCMAS).
8. Rau *et al.* (2020). Germany.	Youth in residential care treatment in twenty-five units of the Christlichen jugenddorfwerks.	Other. Subgroup analysis. Measuring outcomes over a period of 18–24 months. Three groups, with different reasons for admission: A) mental health and behavioural problems, S) problems in school context, O) no mental health problems, other reason.	Sample 1 (quality of life): 510 children ($M = 16.4$ years, $SD = 3.8$). Sample 2 (social competence): 479 children ($M = 16.4$ years, $SD = 3.8$).	Quality of life (ILK). Social competence questionnaire, non-validated (developed for the study).

addition, two arts and culture-based interventions were identified. These utilised drama and literature and were based on the capabilities approach (Känkänen *et al.*, 2022) or on egalitarian dialogue (Salceda *et al.*, 2022).

As the aim of residential care is holistic, aiming at improvement in the psychological, social and emotional functioning and well-being of the child, no specific theories of change were explicitly stated or sufficiently described in most studies on SAU. The residential care facilities providing the care studied differed in size and included units of public, private and third-sector providers. The units ranged from group homes to residential treatment centres. These studies evaluated outcomes at one point only (Carra, 2014), change over time (Chow *et al.*, 2014; Portwood *et al.*, 2018) or the association between one or more independent variables with the outcome(s) (Lee, 2013; Chow *et al.*, 2014; Rau *et al.*, 2020; Colonnesi *et al.*, 2022; Gonzalez-Garcia *et al.*, 2023).

Findings of the original studies

As the study designs and the level of reporting greatly varied, the main findings of the studies (Tables 1–3) are narratively reported.

Implemented interventions

In a 2015 study, Gross et al. analysed the effects of a token economy-based behaviour management model on youth outcomes. The programme reduced externalising behaviours, non-compliance and school problems amongst eleven- to seventeen-year-olds over six months. Positive youth–staff interactions predicted these improvements, whilst skill ratio and reward delivery did not significantly affect outcomes.

Hoogeveen *et al.* (2017) conducted a quasi-experimental study assessing the effectiveness of MDFT as an inpatient treatment for twelve- to eighteen-year-old youth in secure residential care and as a treatment programme for outpatient youth in the same facility. Utilising baseline and exit documents to measure outcomes related to externalising behaviour, family functioning and school attendance and performance, they showed that MDFT reduced adolescents' problems in all three outcome categories, in both the inpatient and outpatient groups.

In Oman *et al.* (2016), a teen pregnancy programme yielded significant improvements amongst participating teenagers (mean age 16.2 years) compared to a control group. The intervention, a 10-session twice-weekly sexual health education programme, demonstrated short-term effects across knowledge, self-efficacy, attitude and behaviour areas.

In Mitchell *et al.*'s (2022) study, a grief support programme for twelve- to sixteen-year-old youth showed positive effects compared to a waitlist

control. Medium-to-large effects were observed for youth-perceived hope, social support, self-worth and reduction in perceived problems, with participant surveys revealing a large effect for experiencing a trauma-informed environment.

Salceda *et al.* (2022) evaluated the effects of monthly, two-hour dialogic literary gatherings on educational inequalities amongst girls aged fifteen to eighteen years living in Spanish group homes. The study, primarily qualitative, revealed self-reported enhancements in prosocial and academic skills. No statistical analysis of pre–post-test school grades was conducted.

Innovations

Domon-Archambault *et al.* (2020) did not find any statistically significant effects of a mentalised-based training programme on child workers' empathy and reflexive functioning. Some statistically significant improvements were regardless observed for the children (aged six to twelve years) on anxiety, social attention and internalised problems.

In qualitative interviews, Känkänen *et al.* (2022) found positive effects from year-long monthly drama workshops for youth (fifteen to seventeen years) in residential care with complex needs and severe conduct disorder. Self-reported improvements in overall mood and some development in emotional skills were noted, but no significant changes in alexithymia scores were detected.

In a mixed methods design, Parry *et al.* (2021) assessed the effects of a multisystemic trauma-informed model of residential care on development of children (mean age 8.9 years). The average programme duration was 19.9 months. Statistically significant improvements relating to relationships and, in the first half of the programme, in self-perception and self-care were detected.

Van Lieshout *et al.* (2019) examined the effects of an 8-week sexual harassment prevention group programme on relationship quality and sexual harassment amongst teenage boys (mean age: 14.8 years) in residential care via a cluster RCT. Neither the intervention nor the control group exhibited significant differences in sexual harassment determinants, as measured by the outcome questionnaires at post-test or follow-up.

Service as usual (SAU)

Carra (2014) assessed effectiveness as one dimension of relational quality in residential care units, the outcome being the well-being of children. The researchers concluded (based on interviews and questionnaires) that the relational well-being of children was generally high, but children lacked continuity, wished to engage more with their birth families, and rarely returned to their birth parents.

Chow *et al.* (2014) explored predictors of cross-time differences in functioning amongst youth (mean age fourteen years) in group care lasting at least three months. Group homes benefitted boys by improving protective skills and resources to a higher degree than for girls and younger children with lower initial levels of needs. No significant improvement in mental health and risk behaviour was found.

In Colonnesi *et al.* (2022), residential care workers used fewer mental state descriptors compared to foster parents. General, neutral and positive mind-mindedness amongst caregivers correlated negatively with the conduct problems of the child (mean age 13.42 years). Positive mind-mindedness was associated with children's prosocial behaviour, whilst neutral mind-mindedness was linked to a better-quality caregiver–child relationship and fewer child conduct problems. Negative mind-mindedness was associated with caregivers recognising the child's trauma symptoms, and indirectly, with children's emotional symptoms.

In Gonzales-Garcia *et al.*'s (2023) study, twenty-six per cent of children aged eighteen to seventeen years received mental health services in a residential care facility and exhibited improvement in mental health over two years. However, twenty-four per cent showed worsening mental health. Mental health treatment had a significant impact on the outcomes, but those receiving only partial care showed the most negative change in mental health.

According to Lee (2013), children (six to thirteen years) living in a locked residential care setting showed an improvement in functioning scores by at least one symptom rate between intake and discharge (mean length of stay twenty-one months). Children with lower initial scores benefitted most from care, and none of the children showed a decrease in functioning. For girls, having a mixture of consistent and inconsistent visitors resulted in the least amount of improvement in functioning, whereas visit consistency did not have a statistically significant effect on improvement in functioning for boys.

In Mihalo and Valenti (2018) study, families' ratings of the working alliance in a programme serving ten- to seventeen-year-old children significantly predicted family functioning; however, family worker alliance ratings did not. Higher family member ratings of the working alliance predicted significantly higher family functioning scores. Feedback on family workers' work improved the family ratings of the working alliance. In multiple regression analysis, total alliance scores provided by family members and family workers predicted family functioning scores.

Portwood *et al.* (2018) found no statistically significant differences in the short-term (three to twelve months) general functioning or mental and behavioural problems when comparing teenagers (mean age 13.97 years) in foster family care and residential group care settings. The functioning level at intake differed, with those placed in family care having higher levels, but both groups progressed at the same rate.

A non-significant trend emerged with individuals in group care showing increased anxiety levels whilst the other group reported decreased levels.

Rau *et al.* (2020) compared youth (mean age 16.4 years) from three groups—those admitted due to mental health and behavioural issues, school-related problems and other reasons—over eighteen to twenty-four months regarding quality of life and social competence. Regardless of who initiated the placement, all groups exhibited equal improvement from their initial scores. Notably, children with mental health and behavioural issues consistently had the lowest scores compared to the other groups.

Discussion and conclusion

We aimed to assess the short-term effectiveness of residential care, exploring study designs and the methodologies employed. Findings revealed variations in researchers' definitions of the concept effectiveness and consequently in their approaches to study residential care outcomes, with non-experimental designs predominating.

The content, scope and length as well as theory of change behind the interventions varied. We categorised residential care interventions into three groups: implemented interventions, innovations and SAU. Implemented interventions brought about some positive change in different dimensions of behaviour, psychosocial functioning and skills (Gross *et al.*, 2015; Oman et al., 2016; Hoogeveen *et al.*, 2017; Mitchell *et al.*, 2022; Salceda *et al.*, 2022). Not all innovations showed expected positive change in the outcomes (van Lieshaut *et al.*, 2019), whilst others improved for example the capabilities and emotional and social skills of the children to some degree (Domon-Archambault *et al.*, 2020; Parry *et al.*, 2021; Känkänen *et al.*, 2022). Studies on SAU indicated that most children benefit from residential care (Rau *et al.*, 2020), some more than others (Chow *et al.*, 2014; Gonzales-Garcia et al., 2023), and the level of positive improvement in different child-related measures is associated with the individual's initial score (Lee, 2013). Whilst studies on residential care as SAU demonstrated improvements in various aspects, the inherent complexity and diversity of both residential care settings and the children and youth therein contribute to a more multifaceted landscape, rendering the assessment of effectiveness a challenging task. The most robust study designs had been used in studying interventions originally developed for and assessed in another context and then adapted to residential care (e.g. Mitchell *et al.*, 2022). These programmes are designed to combat specific problems amongst children and youth in residential care, which also makes measuring outcomes easier.

Most scoping reviews do not include quality assessments (Pham *et al.*, 2014), including this one. Thus, we have presented a descriptive

overview and not a critical appraisal of the existing literature against a specified standard of evidence. Nevertheless, a cursory examination reveals that numerous studies lacked a control group or had excessively small datasets, limiting conclusions regarding effectiveness. Similar observations were made by Giraldi *et al.* (2022) in their review on residential care. Although debate on measuring effectiveness remains heated (Gambrill, 2006; Morago, 2006), especially regarding the complex interventions embedded in complex social services (Lin, 2023), it is generally acknowledged that not all study designs are equally reliable and capable of producing strong evidence. Thus, the extent to which the studies included in this review fulfil the aims articulated by their authors may be subject to debate. To conclude, based on the recent studies reviewed here, it is difficult to draw conclusions on the short-term effectiveness of residential care.

Limitations and future directions

Strict exclusion and inclusion criteria were applied to identify studies concerning short-term effects within residential care settings. This approach excluded studies that extended outcomes beyond the care period. Further, several studies on OHC in general were excluded since outcomes of residential care were not reported separately. Few studies in this review focused exclusively on the topic at hand. Future research should prioritise addressing residential care directly, robustly measuring outcomes, to enhance understanding of effective elements and mechanisms across various contexts. Additionally, to comprehend why interventions succeed or fail in achieving desired outcomes, research should delve into mechanisms, moderators, mediators and contextual influences (Clarke et al., 2013; Evans, 2003). The absence of consensus on key elements, mechanisms and anticipated outcomes of residential care complicates understanding of interventions and poses challenges in determining effectiveness.

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Conflict of interest statement

None declared.

Supplementary material

Supplementary material is available at *British Journal of Social Work Journal* online.

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