

Article

Everyday Care: What Helps Adults Help Children in Residential Childcare?

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Abstract: Over the last decade, there has been an increasing trend towards the use of ‘therapeutic models’ in residential childcare settings in the U.K. and elsewhere. While some have argued that these developments have been driven, at least in part, by free market funding environments and organisational survival needs, others have suggested that many of these models, despite some of their theoretical and conceptual differences, offer a useful approach. Drawing on findings from an ethnographic research project in a residential setting in Scotland, we argue that the underlying processes of implementing and embedding a therapeutic model can create conditions that are conducive to the provision of high-quality, effective, relationship-based practice, which has real benefits for children in their everyday worlds. Moreover, we argue that the model itself is somewhat beside the point. If residential organisations can facilitate safe, ongoing opportunities for staff to (a) think deeply about themselves and others (children and staff), (b) practice ways of being and doing, and (c) be seen and valued, then this can contribute to a practice culture and context in which they feel able to create genuine, caring relationships with children. We argue that it is within these everyday, genuine, caring relationships that children can recover from difficult experiences such as neglect and abuse. In this way, the ‘therapeutic’ focus should be primarily directed at the adults to enable children to get on with being children.

Keywords: residential childcare; therapeutic models; relationship-based practice



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1. Introduction

Recent years have seen an increasing trend towards the use of ‘therapeutic approaches’ in residential childcare settings in the U.K. and elsewhere. Johnson and Steckley [1] suggest that although there are few models developed and designed exclusively for residential care, there has been a general shift in practice focus from behaviour management to a recognition of the value of relationally based practice and of the value of ‘therapeutic interventions’ [2]. Alongside this, organisations providing residential care for children and young people have drawn on these various models and approaches to claim and name their areas of expertise and particular practice skills. In part, these developments may have been influenced by the rise of free market funding environments and the pressure placed on care providers to demonstrate value for money; however, there is some suggestion that many of these models offer a useful approach despite some of their theoretical and conceptual differences. What is less well understood is what these different models offer, which is beneficial for children, young people, and adults living and working in residential care.

Despite recognition that children in the ‘greatest amount of need’ [1] are placed in residential care, there is limited research that explores what this form of care means to children, how it is delivered, and the immediate impact it has on their everyday childhoods. To date, much of the research undertaken with this population has primarily focused on current or future outcomes (often related to indicators of ‘successful’ adulthood). In addition, little is known about the day-to-day experiences of the adults providing care in residential settings [3]. Such limited understanding is particularly challenging given the

level of scrutiny that residential care has been exposed to over the last 20 years. For example, The Scottish Child Abuse Inquiry [4] highlighted the dangerous and abusive practices evident in some residential settings over the last century. Contemporary residential care is, therefore, caught in the tension between the legacy of the past and the current demands for improved outcomes and better services for children [5].

The project on which this paper is based offered a unique insight into what occurs day to day in a residential setting. While there have been a handful of studies that have done this, there are none that have interrogated the new drive for ‘therapeutic care’ and how this translates into the everyday practices of frontline staff and the lived experiences of the children being cared for by them. Rather than being concerned with the long-term outcomes of care, this ethnographic study of a residential setting in Scotland explored the real-time experience and impact of ‘therapeutic’ care on current childhood. The overarching research question that the project sought to answer was ‘what does “therapeutic care” look like in the everyday worlds of children and adults in a residential childcare setting?’ As such, this study took a broad look at the experience of children and adults as both providers and receivers of care. This paper focuses on one key finding that emerged from the data relating to the perspective of adults. In doing so, it analyses the process of implementing and embedding a particular theoretical model and highlights key emergent themes related to the role, identity, and containment of adults in this setting.

1.1. Policy and Practice Context

In the U.K., residential childcare has a long and diverse history linked closely to wider societal changes in attitudes towards children and childhood [6]. For example, after World War II, the Curtis Committee (in England and Wales) and the Clyde Committee (in Scotland) reviewed the provision of care for those children who were unable to be looked after by their own families; the reports of these committees recommended reducing the size of residential care settings so that children were cared for in groups of 20 or less, thus replacing very large group living arrangements [6,7]. At the same time, the dominance of psychological and child development theories foregrounded the importance of the caring relationship in the ‘healthy development’ of children and further encouraged the move towards smaller group living arrangements such as ‘cottage’ models where children were cared for in ‘family-like’ groups [6]. Legislative changes in the second half of the 20th century increased the responsibilities of local authorities in relation to the provision of care for children in the U.K., while residential childcare was absorbed into the newly developing profession of social work (*ibid*).

During this time, several interacting developments combined to situate residential childcare as a less desirable choice for the provision of care to children, resulting in it becoming an option of ‘last resort’ [1]. For example, during the 1980s, ideological preferences for care within families coincided with a newly emerging neoliberal concern for the economy within the welfare state [6]. Alongside this were growing demands embodied in legislation and policy for children to be ‘accommodated’ within family homes [8]. The 1990s saw changes in the practice and understanding of social work following revelations of abuse both within families and residential childcare, with a concomitant increase in political interest in the field [6]. There has also been a sustained discourse on whether residential childcare results in poorer outcomes for children than other forms of out-of-home care, such as foster care, although the evidence for this is complex and inconclusive (for an overview, see [9–11]). Developments like these led to a more managerial and regulatory approach by the government to residential childcare, including a greater reliance on technical and procedural solutions within the policy framework [12,13].

Despite recent challenges to the ‘last resort’ narrative surrounding residential childcare, questions remain as to the extent to which it delivers what children need [14]. Children and young people admitted to residential settings are more likely to have had childhoods marked by complex trauma (including emotional, physical, and sexual abuse and neglect) as well as multiple moves within care [15]. Taken together, this can, for some, generate

a range of pain-based and often challenging behaviours as a response. However, the relationships and experiences contained within a residential setting can support children in developing a positive self-identity, self-esteem, and self-respect [14], as well as enduring and meaningful relationships. The sociocultural and historical context for residential childcare is important when considering how services, practices, policies, and procedures have developed in this field. Such contextual factors have influenced residential childcare, which has seen ‘. . . regulation; value for money; risk aversion and evidence of outcomes for children’ become the dominant discourses shaping the sector [16] (p. 658). Indeed, in discussing the rise of therapeutic residential childcare in Australia, Kor et al. [17] argue that, despite its benefits, relationship-based practice has been constrained by a focus on short-term outcomes as well as fears around the boundaries between personal and professional relationships for frontline practitioners. They highlight the vulnerability of both young people and adults in residential childcare settings where the practice is highly scrutinised and ethical dilemmas frequently arise. The vulnerability of adults working in therapeutic residential care has been further highlighted by Brend and Sprang [3], suggesting that consistent exposure to children’s traumatic histories not only contributes to attrition in the workforce but also to a reduction in workers’ capacity to ‘. . . fully engage in helping relationships with children in their care’ (p. 155).

Parallel to demands for improved outcomes for children has been a related and growing interest in ‘therapeutic’ models of care [16,18–20], which call for workers to be ‘caring’ ‘knowledgeable’ and ‘emotionally engaged’ with children.

1.2. ‘Therapeutic’ Approaches in Residential Childcare

Therapeutic approaches to residential childcare practice are not a new phenomenon. Redl and Wineman [21] developed the ‘life space’ model to work with ‘troubled’ children and young people using the everyday group experience as a central tenet of therapy. This approach sought to move therapeutic interventions, based on psychological and psychosocial theories, out of the consulting room and into the actual, everyday ‘life space’ of the children and young people (see [22] for an overview and history of this approach). Currently, therapeutic models or approaches in residential childcare similarly appear not to imitate or replace individual ‘therapeutic’ interventions such as counselling; rather, they seek to embed therapeutic perspectives into the day-to-day practices contained within the residential environment [23].

In recent years, a number of therapeutic models have been developed and are becoming more widely used in residential childcare settings, including, for example, Sanctuary, Positive Peer Culture, Teaching Family, Stop-Gap, Children and Residential Experiences (CARE), Re-ED, and Dyadic Developmental Psychotherapy (see [19,20,24] for reviews of these). While distinct models are underpinned by different theoretical positions and are practiced in various ways, most recognise the potential impact of past experiences on children and argue that healthy and positive relationships are a means of addressing associated issues and promoting recovery. Echoing the position of Redl and Wineman [21], each model seeks to facilitate supportive relationships in an environment whereby everyday opportunities and experiences are ‘therapeutic’ in that they promote the healthy development and ‘recovery’ of children and young people. In an attempt to consolidate best practices in this field, Whittaker et al. [25] presented a definition of therapeutic residential care (TRC) that continues to hold sway within the sector. They suggest that TRC ‘. . . involves the planful use of a purposefully constructed, multidimensional living environment designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources’(p. 94). However, for some, the language of ‘treatment’ and ‘mental health and behavioural needs’ runs counter to the notion of a home as a site of everyday care and can devalue the roles of those who provide it [26].

While there have been some modest results recorded for a small number of therapeutic models [19,20,27], calls for more robust evidence of impact and effectiveness continue. This is somewhat paradoxical in that one of the drivers in the rise in therapeutic models is the increasing demand for ‘evidence-based practice’ in both the residential care and ‘trauma recovery’ sectors [27]. There are considerable barriers to obtaining the type of ‘robust’ evidence that is sought. For example, designing and implementing controlled trials in this field is fraught with logistical and ethical difficulties [28], which take resources, time, and effort to overcome.

However, there are decades of quality empirical evidence relating to factors that contribute to the ‘healthy’ and resilient development of children [29–31]. Central to much of this evidence is the place of genuine, responsive, and attuned relationships. Indeed, while James [27] argues that models are sufficiently distinct to prevent the formulation of a ‘meta model’, she lays out a range of features of residential care that are well evidenced within the risk and protective factors literature. Caring relationships are included in the list, and an examination of the other eight reveals most of them to be contingent on or required to support the development of relationships. Howe [32] (p. 278) argues that ‘... if relationships are where things developmental can go wrong, then relationships are where they are most likely to be put right’. Relationships that ‘go wrong’ are increasingly regarded as being the cause of ‘trauma’, and it is this trauma that residential care is tasked with helping children process, repair, and recover from.

In their critique of the concept of trauma, Smith et al. [26] argue that ‘trauma informed’ approaches to care (which many therapeutic models purport to be) do not go beyond what has long been accepted as suitable health and social care practice. Moreover, they argue that privileging a psychological worldview through a focus on trauma-informed practice devalues the highly skilled work currently undertaken in residential childcare. They go on to suggest that categorising experiences purely through a trauma lens may limit more positive and hopeful framings of actions and feelings. In trauma-informed models of care, relationships are reduced to a clinical tool used to ‘overcome an individual’s perceived deficits’ [26] (p. 483) rather than being prized for their intrinsic human value.

We argue that any examination of everyday care in residential settings needs to take into account not only the models used, the nature of relationships, and the ways that past experience is approached; it also has to consider the multiple interacting relationships and systems within which everyday care is practiced in order to understand the processes by which that care has an impact on the recovery of children and young people—the ways in which it is ‘therapeutic’. It is to this exploration of ‘therapeutic’ care that the paper now turns.

1.3. The Residential Setting and Therapeutic Model

The residential setting ‘Kinbrae’, used as a case study in the project, was situated in a rural location in Scotland. It offered residential care for 15 children across three houses. Each house was staffed by 12–15 residential care staff, including house managers, on a shift rota. Kinbrae looked after children between the ages of 5 and 18 who had typically been referred by local authorities across Scotland. The children were described as having experienced neglect and/or physical, emotional, and/or sexual abuse while living with their birth families. These experiences had created a home environment that was regarded as unsafe for children, and the impact of these experiences had resulted in many of the children displaying behaviours that were portrayed as damaging to the self or others. Most of the children were described as not having had their social or educational needs met in mainstream school. Taken together, Kinbrae was tasked with providing a safe, nurturing school and home environment where children could be supported to make sense of their earlier experiences, rebuild (where possible) relationships with family, and make new relationships with caring adults. During fieldwork, the children were aged between 8 and 14.

The organisation also provided an education service staffed by teachers and education support workers, although not all children who lived in the care setting attended the school and vice versa. Other members of staff included the senior management team, cooks and catering staff, cleaners, administrative workers, and facilities staff who looked after the buildings and grounds. There were also specialist consultants (speech and language, play therapy, and psychology) who worked directly with children and staff members and contributed to training, practice discussions, and other development activities. The organisation was selected because it had introduced a whole team training and supervision programme for a well-defined therapeutic model called Dyadic Developmental Practice (DDP), aimed at providing relationship-based care to aid the recovery of children and young people from the types of experiences (i.e., neglect and abuse) described above (citation not disclosed—this is literature that was produced specifically for the residential setting, and it has, therefore, been withheld to maintain confidentiality). It is important to note that, while it was the main model in use, DDP was described by staff members as not the only theoretical influence on everyday practice.

Dyadic Developmental Practice [33] was developed from Dyadic Developmental Psychotherapy, a therapeutic model based on the work of Daniel Hughes. It is underpinned by attachment theory and incorporates learning from other fields, such as neuroscience, and psychological concepts, such as intersubjectivity [34]. This approach seeks to help residential childcare workers connect with young people by encouraging rich and emotionally engaged relationships between all staff and young people within the setting using a variety of techniques [35]. For example, staff are encouraged to self-reflect at the start of shifts, to focus on the 'emotional tone' of the setting at change-over meetings, to take time to connect with each young person, and to adopt a general attitude of PACE (playful connections, acceptance of the child's inner world, curiosity about the meaning underpinning behaviour, and empathy for the child's emotional state) [34,35]. According to this model, it is the relationships with staff members (who provide the parent function) that facilitate the crucible of healing for the children [36]. Because of this, staff training and support (e.g., through supervision and other processes) are seen as crucial to success.

At Kinbrae, the whole team approach to training and implementation of DDP commenced approximately 9 years before the research fieldwork was undertaken. All staff, regardless of role, were expected to undertake DDP level 1 training. Frontline care and education staff and managers were then required to undertake DDP level 2 training and engage in regular, ongoing consultancy/clinical supervision with the DDP consultant, a qualified psychologist. Training and supervision were provided to small teams of workers who worked together regularly in the same house on the care campus or in the same class at the school. The training and clinical supervision sessions sought to not only develop the knowledge and skills of frontline workers but also to be reflective spaces where adults could talk deeply about their own experiences in life and at work. Indeed, as will be discussed later, the shared reflective content of both the training and the clinical supervision was seen by staff as fundamental to their practice and their ability to develop and maintain genuine, caring relationships. Based on data gathered in the project, the implementation and maintenance of the DDP approach are depicted in Figure 1 below.

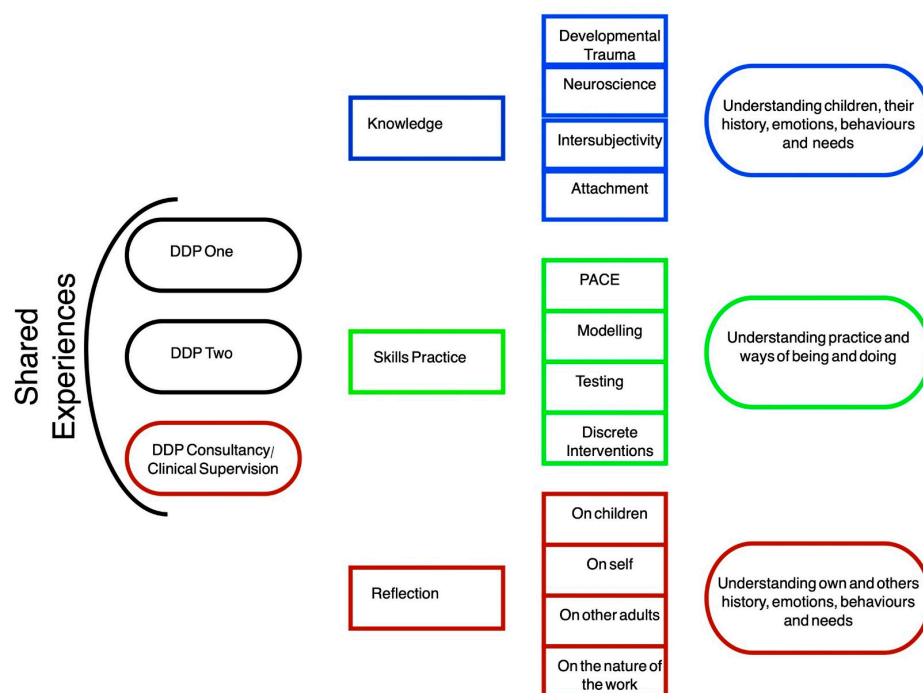


Figure 1. Diagram of DDP training and supervision model. Training levels and consultancy are depicted on the left as shared experiences that groups of staff undertook together. All of these included developing knowledge and skills and functioned as reflective spaces, with the consultancy being noted as especially reflective. Details of the types of knowledge, skills, and reflection are noted alongside the intended outcomes for understanding on the right. (Burns, 2021).

2. Methodology

In order to answer the central question posed by the research project ('what does therapeutic care look like in the everyday worlds of children and adults in a residential setting'), a range of ethnographic methods were employed. These had to be adjusted to accommodate social restrictions in place due to the COVID-19 pandemic, including collecting data in different phases, moving from initial, adapted, introductory online contact with all staff members, followed by online interviews, then in-person participant observation, and then concluding with semi-structured interviews. In phase one of the fieldwork, 30 min online 'orientation' interviews were held with 19 staff members between January and February 2021 in both small group and one-to-one formats. These adult participants volunteered to be interviewed following a meeting with the whole staff team. The interviews gathered initial data relating to how staff approached and understood their practice and what influenced it. Staff also shared views on the routines and rituals that marked everyday life at Kinbrae. Additionally, an hour-long, online, semi-structured interview was also held with a consultant specialist in Dyadic Developmental Practice. This interview was used to explore the background, development, and implementation of the model, including training and clinical supervision within the organisation.

In phase two (April 2021 to October 2021), 161 h of participant observation were completed. This dedicated time spent living as part of the group of children and staff allowed meaningful relationships to develop. Fieldwork primarily took place on the care campus across all three houses, and all staff and children (where parental consent was in place) were invited to participate. Alias et al. [37] (p. 9) suggest that '... the richest data typically hinges on the relationships created and maintained'. By allowing time to be given to getting to know the children and staff (and vice versa), we were able to set the fieldwork at the pace of participants and go some way to ensure depth to the data being collected. Details of activities, relationships, environments, and conversations were recorded in fieldnotes.

Between August and November 2021, 10 semi-structured interviews were conducted with key adults (frontline care and education staff, including managers and a senior manager) and two independent therapists (play therapy and speech and language). These individuals were selected because they represented a range of positions working at the organisation. The first author used the relationships that he had developed during participant observation to identify and recruit a range of adults who were willing to take part in interviews and then ensured a range of positions were represented in these. The interviews used an appreciative inquiry approach and Carter's [38] 4-D cycle: Discovery (appreciating the best of what is or what has been); Dreaming (exploring what might be); Design (co-constructing what the ideal should be); and Destiny (envisioning the future or what will be). The average length of the interview was 43 min. All interviews were transcribed verbatim for analysis.

Qualitative interviews (in the way they are described above) were not undertaken with children, but most (those who assented and had parental consent) took part in the participant observation. In both explicit and implicit ways, children declined to be interviewed in the traditional sense of answering a set of questions or discussing agreed topics. They were, however, open to wide-ranging conversations where they could influence and determine the topics for discussion and were particularly open to these when engaged in other activities. Such casual conversations, typically associated with ethnography and participant observation [39], were many and varied during fieldwork and were captured in fieldnotes. Activity-based methods of data collection were employed with some children. For example, an art-based activity was completed successfully with the support and collaboration of a staff member with specialist training in play-based activities. A total of 62 participants, 47 adults (mainly staff but also 2 social work students on placement and 3 independent consultants) and 15 children, took part. The children who took part were those for whom both parental consent and the assent of the child were confirmed.

As a method, participant observation does not follow the assumption of 'normal science' that one must detach oneself from the world to understand it. It is a key method in anthropology, a discipline that, more than any other in the human sciences, 'has the means and the determination to show how knowledge grows from the crucible of lives lived with others' [40] (p. 387). As such, the first author developed rapport and relationships with both children and adults in the setting. Geertz [41] argues that spending time in the field, getting to know participants, taking account of their social systems, and focusing on the everyday is a moral requirement, one that we would argue is even more pronounced when conducting research with children in this setting. While the first author used a reflexive diary and reflective discussions with the second author to consider his positionality and the ways in which this affected data collection and analysis, we also acknowledge the limitations of these tools as they are based on the assumption that both the self and the context are knowable and made transparent through their use [42].

Analysis was ongoing throughout the project, including initial analysis of events and activities as they were recorded in fieldnotes. Following well-established traditions in the analysis of ethnographic data [43], both authors regularly reviewed the data (fieldnotes and transcripts), discussed potential codes and emerging themes, and brought these initial ideas to advisory group members. The first author then returned to the field for further periods of data collection. Further thematic analysis began towards the end of data collection and was undertaken as described by Braun and Clarke [44] by familiarising ourselves with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and then producing a report. In reviewing the themes, we checked these against the original data to ensure fidelity.

Ethical Considerations

Ethical guidance from both The British Sociological Association and the Association of Social Anthropologists of the U.K. (ASA) informed each stage of the project. Ethical approval was granted by the (anonymised for peer review) General Ethics Committee.

Processes were developed to ensure ongoing, informed consent from both children and adults. Written leaflets were developed specifically for children, parents, and staff, respectively, which made clear the voluntary nature of participation. All discussions with participants prior to and during fieldwork reinforced this, and the first author returned to the subject of consent where any uncertainty or ambiguity arose. We remained open to the diverse ways children communicate, including verbal and non-verbal assent or dissent [45]. All participants were made aware of their right to withdraw consent at any point without having to provide a reason or explanation and the limits of confidentiality, including recognising each other's stories despite pseudonymisation and the requirement for the researcher to discuss any concerns for welfare or safety with a senior manager in the organisation were regularly shared. Because of the long-term nature of this research, some participants (especially the children) chose to opt in and opt out at different stages or during different activities, and the first author had to react and adapt accordingly.

Exiting the field can be a complex and ethically challenging process for anthropologists and the people with whom they work [46] and required even more careful consideration in this project, given that the children involved had varied and sometimes difficult endings to relationships in their lives. The first author provided a clear explanation of the time-limited nature of this project at the outset and returned to the issue of endings at appropriate times throughout. He worked with children and staff in the final stages of fieldwork to make appropriate plans for the end of fieldwork, including return visits to present and explain the findings.

3. Findings

While the study on which this paper is based took a broad look at the experiences of children and adults in this setting, we focus here on one key finding that emerged from the data relating to the perspective of adults on the processes of implementing and embedding a 'therapeutic' model and how these were translated by practitioners into what they regarded as 'therapeutic' care. Through analyses, what became apparent was that it was staff members' response to therapeutic approaches within these processes, as applied to themselves, which appeared to free them up to make sense of and support children and enable them to provide conditions for everyday childhood experiences.

3.1. Creating Caring Relationships

From data gathered in interviews as well as through observation, it appeared that, in many ways, the care provided in the everyday environment did not look specifically 'therapeutic' but rather very familiar and familial. Care happened within and rested upon genuine caring relationships. On the surface, it seemed that 'therapeutic' care at Kinbrae looked like 'good', everyday care, although this belies the complex sets of processes, environments, and cultures within which this can happen in a residential childcare setting.

The data showed that everyday care had many faces; it was not one thing but rather a range of different elements that were used in varied combinations depending on the individuals involved and the contexts and situations in which the care took place. To highlight this, during the analysis, we identified 22 sub-codes under the main theme of 'everyday care' where we attempted to specify exactly what types of care were evident in the everyday worlds of children in the setting. These included practical care, domestic activity, protection, boundary-setting, anticipation, facilitation, managing transitions, and relationships. Indeed, this last code relationship was the most densely populated, highlighting the centrality of relationships in the provision of everyday care. This is in line with the organisational ethos and the aims of DDP: that the adult-child relationship is the vehicle through which everyday care *can be rendered therapeutic* for children. Relationships were key in every aspect of care, as can be seen in the interactions in the following situation:

I position myself in the kitchen where staff and children and busily coming and going between there and other parts of the house. I watch as each child, in turn, arrives and tries to get access to the cupboard (a locked cupboard where a range of sweets, crisps

and juice are held). Each child comes up against a patient Thelma who enforces a rule of 'healthy snack' first (fruit or a yoghurt) and, by my assessment, only one child (Brian) successfully negotiates his way through the healthy option to be offered something from the cupboard. Thelma seems so in control—funny, sweet, encouraging with the children, but also unmoveable on her rules as clearly stated. This is not the first or last time today that I will feel like I'm in a big family home. (Fieldnote, 8 June 2021)

There are many ways to view this practice: as protective of the children's health and as mindful of their socialisation to rules and to food or as a display of adult power in an institutional setting with locked cupboards, for example. However, it is important to acknowledge the established relationships between Thelma and the children. What was evident in this scenario was how well Thelma knew each of the children and how well they knew her. There were in-jokes, laughter, feigned outrage, and blatant attempts at emotional blackmail. It felt familial because of the *nature of the relationships* that were evident. During fieldwork, these types of interactions were commonplace.

From the data, it was clear that the simple but effective power of these relationships and their impact on the children could not be taken for granted. Relationships were viewed as messy and complicated at the best of times, but particular challenges were faced by children and adults in this setting.

Similar to the findings of Brown et al. [16], adult participants identified the added complications that came from issues such as the political and public discourse around residential care, regulation and oversight of practice, and the complexity of relationships that extend into and out of the everyday care environment. All these factors contributed to a context in which, at times, adults felt worried about both the nature of their work and their relationships with children. Some of these complexities were evident in Mary's description of an incident in a public park where she and another worker had to prevent one of the children from hurting another:

I took the opportunity to chat to Mary about her experience last week and commented on the bruising that was visible on her arms. She went into some detail about the incident and talked about how stressful it was because it was in a public place and she and [another worker] Christopher had to 'safe hold' [one of the children] Daniel while some of the local teenagers and members of the public commented or filmed them saying things like 'that's child abuse'. Understandably, this makes her feel really bad and she is 'wary of wearing a lanyard or saying 'we're his carers' because a lot of the children don't like to be labelled/stigmatised in relation to their care situation'. (Fieldnote, 7 June 2021)

Here, public discourse around childcare was experienced first-hand by those working at Kinbrae. It highlights the complexities that surrounded staff members' relationships with children, including the potential for stigmatisation arising from the very nature of the relationship itself and how it was viewed by the 'outside world'. These complexities extended beyond members of the public to the messages received by staff members from friends and family. In the example provided above, Mary was quite badly injured and had to receive a tetanus inoculation following a bite wound to her leg. She talked about how much she loved her job despite having to work hard to reassure her partner and other family members that she was safe at work and that the incident was not Daniel's 'fault'.

At Kinbrae, the data showed that much time and thought were given to relationships and the ways in which these could be genuine and meaningful for both children and adults, as well as the type of practice, culture, and support required to enable this. Quin, a senior manager, discussed the intensity of relationships and the concomitant emotions:

What I witness is, people invest a lot of themselves. Absolutely. And I think that does make it a lot more difficult, because I think there's not a switch off in the same way. Yeah, because I think it goes both ways. I think because of the intensity of time spent with the children, it can be really loving, beautiful relationships, or it can be incredibly challenging. So pushing you to your absolute limit [in] relationships in the same way that, you know, a parent who's got a child who's not coping particularly well and going through a lot,

you know, when it affects them to the core [. . .] I think that's why the whole concept of love within residential care was one that always feels quite comfortable with me, because how can you spend so much time with people without developing some type of love for them, and developing genuine relationships with them? And if you develop genuine relationships, all these other emotions happen as a result of that. (Individual Interview, Quin, 13 September 2021)

It appeared that, while not named explicitly, there was acceptance of the impact of having genuine relationships on the staff members and how this resulted in a sense of vulnerability. Quin went on to discuss the various support systems, or 'layers' as he put it, that were in place for staff, including one-to-one and group supervision, support from on-site consultants, and the training and clinical supervision provided to small staff teams by the DDP consultant (discussed further later). During participant observation and in the interviews with staff, these support mechanisms were characterised as fundamental to 'good' practice. What might be regarded as therapeutic mechanisms and systems helped to create a practice culture and environment where adults felt safe to create, develop, and maintain genuine, caring relationships with children. In effect, therapeutic relationships between adults were used to create a safe and secure environment for the children.

3.2. Creating Safe Spaces

Kinbrae had, over a number of years, invested heavily in DDP as a core therapeutic intervention. What was striking in our data were the ways in which DDP was understood and used by those who were trained in it. There were significant differences in how staff members discussed DDP, including fundamental disparities in its orientation; some staff members viewed DDP as a disposition (a way of being), while others regarded it as a discrete intervention (a way of doing):

TANYA: I think it's . . . it's not something that we do, it's something that we are [. . .] Yeah, so we don't say 'right, we're going to do DDP just now' we just do that all the time. (Group Interview, Education Team 2, 16 February 2021)

And it works really well. Not all the time. Yeah, not all the time. But I think it works well. And everybody knows that you're away to do DDP, and some of them will stay in the background. (Individual Interview, Duncan, 31 August 2021)

While DDP is described as an approach that seeks to achieve a team-wide attitudinal change [35], the contrasting views noted above show how the same programme of training and supervision can be understood and practiced in diverse ways within the same team.

Interestingly, in conversations and interviews, staff talked about the changes in process and practice culture that had resulted from the implementation of DDP rather than the specifics of the model itself. They identified the distinctive skills and abilities of the DDP consultant in the training and clinical supervision sessions, which were seen as creating a safe space for staff to open up and reflect honestly on their experiences:

And I think without [the consultant], yeah, [the consultant] is so important and what we're doing and, and not just the initial training or the level two training, but the sessions that we have with that as well. I think any gripes or anything always come out in there and don't get me wrong, it can be a really difficult session. Like sometimes I've left feeling upset before [. . .] and upset, but ready to start afresh almost. And that can just give you a better perspective on, I suppose it gives you a safe space to have things out. And so [the consultant] is a massive part in, I suppose helping us be in a place to support the children and recovery. (Individual Interview, Philippa, 20 September 2021)

Philippa's account was representative of how most of the staff members discussed their experiences of training and clinical supervision. They regarded the DDP consultant as creating spaces where they felt safe to reflect honestly, to try out different ways of being and doing, and where they felt seen and valued. In many ways, what they described could be regarded as representing Roger's core therapeutic conditions [47]. These safe spaces and

the kind of thinking, reflection, and acceptance that the consultant facilitated influenced other aspects of the working environment for the adults. This included the support and understanding that staff members offered to each other and a general recognition that, because of the complexity of the work, mistakes in practice were inevitable and that these could be acknowledged, learned from, and repaired without attributing blame:

I sort of think the training is part of it, but I think there also needs to be the right, the right culture to help people develop, and it not being, a, that sort of blame culture when something goes wrong. People make mistakes, people's buttons get pushed, you're in high intensity situations with the kids, sometimes. And they, things can go wrong, I suppose. But it's no, it's having that supportive environment and culture, I suppose. And openness with each other. (Individual Interview, Ronnie, 22 September 2021)

Having the space to 'fail' and then to discuss and reflect on this in a supportive environment can facilitate transformations in learning and in practice [48]. Ronnie's example begins to demonstrate how some of the ways of thinking and being within the training and clinical supervision shaped the general ethos and practice culture. In turn, the 'everyday' permissive space and protective culture empowered staff and enabled them to trust the wider, more traditional processes of supervision and training. Most importantly, together, these elements appeared to contribute to an environment where adults felt safe developing deep relationships with children and were willing to try different approaches and ways of working with them.

3.3. Getting It Right?

Many of the staff discussed gaining confidence from the training and clinical supervision because they felt their practice was recognised and valued. Often this was through a process of affirmation, where training and supervision confirmed to them that they were doing the job 'right'. Having space to reflect on and consider not only what was being done to support children but also why staff members were responding in the ways that they did appeared to further enhance a sense of confidence and a view of themselves as skilled and knowledgeable practitioners. Staff were keen to have a clear sense that they were getting it 'right'. This was consolidated through a range of other supports, including formal and informal supervision and verbal and non-verbal feedback from the children in terms of their approach.

LEXI: I think that's what I took out of it. Do you know what, after all, we must be doing an ok job?

TANYA: Yeah.

LEXI: and, yeah, there were bits you could take and go 'alright, ok, we could work with that' but, you know, it was more, you know, realising that you're actually doing ok

(Group Interview, Education Team 2, 16 February 2021)

The opportunity to continue to reflect and discuss practice in the clinical supervision sessions was seen as a way of continuing to feel confident in practice:

ANNIE: yeah, I think it was confirming, it's what we were already doing. But having, you know, [the consultant] then always keeping on top, and having these talks with [the consultant] you know, just reminds you and keeps you—'yeah, I am doing the right thing'—and it makes a big difference that you've got somebody that's, although, putting into words what you were doing before, we were doing all this but there's not a . . . a name for it. You know? And it's always nice to have that refreshing talk of why we're doing it, you know the reasons, and I like having the DDP [clinical supervision], you know, getting that every so often. It's good. (Group Interview, Education Team 3, 17 June 2021)

This theme of ‘rightness’ was prevalent across conversations with staff, including opinions about ‘being the right kind of person to do this work’, ‘doing the right thing’, ‘knowing the right thing to do’, and ‘feeling right when at work’. This concern for ‘rightness’ extended across practice and was not always related specifically to the DDP therapeutic model. Indeed, the ‘right’ practice was embodied in what could be regarded as traditional pedagogical approaches to residential childcare: head, hearts, and hands or knowing, being, and doing [49]. Pru and Florence, in their discussion below, highlight this idea of ‘rightness’ when thinking about who would first take Simone (child) in the car after a short car ban had been in place:

Pru was asking Florence if she should take her and noted that she wanted to and she ‘felt like it was the right thing’ because it would be her doing the run with her again since it was her and Simone the last time when there was an issue—that this would ‘get that over with’. She asked Florence ‘it feels like the right thing, but is it the right thing’? This was an interesting discussion where they were trying to work out together what would be the best approach and why. (Fieldnote, 30 August 2021)

These types of discussions were frequent during fieldwork and highlighted the everyday ways in which staff reflected together on the best course of action and then followed this up by trying the approaches that they thought would work. When these were seen as successful or unsuccessful, further discussions and reflection would be used to try and determine why so that they could get it ‘right’ in the future.

Overall, then, it appeared that the processes that were instigated as a part of introducing and embedding DDP, such as creating safe spaces for honest reflection, opportunities to test out new ways of being and doing and recognising and valuing the work of adults, were important to staff and discussed by them more often than the specific knowledge elements of the DDP model, which is a point we take up in the discussion.

4. Discussion

Relationships are key to promoting the healthy development of children and aiding their recovery when they have experienced neglect and abuse [30–32], as highlighted by the data generated in our study. In the course of this paper, we have suggested that residential care is not simply focused on trauma and recovery but rather is a place where childhoods (and the play, friendships, talents, interests, and experiences) are also played out; it is a complex field where adults, as well as children, can be vulnerable [3,16]. Therefore, the provision of suitable, everyday care via genuine, caring relationships in this context is fraught with potential difficulties and barriers.

This complexity makes determining what is therapeutic (or not) about everyday residential care especially difficult as there are differences between and within residential settings, regardless of any model or approach that is employed [50]. For example, the values of care, comfort, and safety may be readily agreed upon by those working across this sector; however, Jakobsen [51] argues that values such as these are ‘rationalised myths’, which provide no insight into the everyday lives of children and young people (p. 225). Jakobsen [51] highlights differences in how such value conceptualisations are interpreted both across and within different settings, including those where staff are highly trained in particular theoretical models of childcare. Jakobsen’s arguments are useful for beginning to think through how everyday care is likely to vary within and between residential settings. This creates a challenge to designing and implementing controlled trials in this field.

Another aspect of the complexity in residential settings arises from a context of different, interacting, and multi-level relationships. For example, Brown et al. [16] discuss how macro factors (such as the portrayals of historical abuse in the media or the individualisation of blame in childcare discourses) interact with micro factors (individual workers’ conceptualisations of role and identity) to generate fear for residential childcare workers who are using relationship-based practice models and how this can impact on the everyday care that they provide. This vulnerability of adults and its impact on practice is further discussed by Kor et al. [17], while Steckley [48] highlights the difficulties that practitioners can

have with both learning and negotiating personal and professional boundaries. At times, in line with Brown et al. [16], vulnerability appeared to occur as a result of outside pressures. This included being able to cope when children were very distressed or dysregulated and was acute when in a public space where the child and the adult were seen to be judged and not well understood. Staff members were also made vulnerable by the words and actions of their own family and friends, who they felt did not always understand the context of the work and who worried for their safety and wellbeing. Perhaps most profound was the vulnerability experienced through having genuine and deep relationships with children in the knowledge that the relationship could end or be disrupted at any point and where, despite a model of 'relationship-based practice' being employed, such relationships had to be navigated through the complex terrain of the personal and professional, the adult as a person and the adult as a staff member.

Arguably, the ways in which vulnerability is experienced and managed are determined by the ethos and practice culture of the residential setting. At Kinbrae, the organisation used DDP to change the practice culture and environment over a nine-year period. They were keen to develop an overarching model to help guide and shape their support of children and their vision for the service. While all staff spoke positively about the DDP model and training, the vast majority focused on the reflective spaces and support processes involved rather than the specific theories or skills promoted within DDP. The reflective elements of the training, such as when staff reflected on their own childhood experiences and relationships, as well as the safe spaces that were created in the clinical supervision sessions, were central to why they thought the DDP model was working well. Beyond this, they stressed the value of having opportunities to try out different ways of being and doing with children, both in training and in actual practice, and for their work to be seen and valued. Crucial to this was the need to feel like they were doing it 'right'.

These findings generate some critical questions about whether it was the DDP model per se or whether there were some underlying processes that can offer wider learning for the residential childcare sector, regardless of which specific model or models are being implemented. What was evident during this research was that close, genuine, meaningful relationships were permitted and encouraged to be formed between adults and children; time and thought were given to how these relationships developed; safety appeared to be created around these relationships in the full understanding of their complexity, knowing that difficult situations would arise and mistakes would be made; and adults were supported with the range of feelings that arose from these complex relationships.

Importantly, it was *how* this was performed that seemed to impact the everyday experiences of the adults and children. DDP offered a way to think more broadly about the place that staff wanted to work in and how they thought children would be best cared for. DDP appeared to provide a framework around which a set of training and supervision processes were implemented. However, the knowledge content of the training (attachment theory, neuroscience, intersubjectivity, and developmental trauma) could arguably be covered by other models, combinations of models, or through bespoke or ad hoc programmes developed locally. Rather, it was the development of safe, ongoing opportunities to think deeply about self and others and practice ways of being and doing and being seen and valued that appeared to create the conditions in which adults felt safe developing and maintaining genuine, caring relationships with children in this setting. Most importantly, it was these relationships and the everyday care that was provided in and through them that appeared to make a meaningful difference to children and young people. In this regard, the model and the practice that resulted were not directly therapeutic. Indeed, it appeared that the therapeutic elements of being seen, accepted, contained, and supported in a consistent and safe way were directed at and experienced *by the adults*, not the children. However, what this allowed was an environment full of adults who could offer everyday, family-like care in the most empathic and connected way despite the often rejecting and confusing protective responses from the children. The children were being

‘super parented’ by consistent and emotionally available adults. They appeared to be able to do so through the containing structures in place.

5. Conclusions

This paper has suggested that, in many ways, the specific therapeutic model employed by residential childcare is secondary to the facilitation of safe, ongoing opportunities for staff to (a) think deeply about themselves and others (children and staff), (b) practice ways of being and doing, and (c) be seen and valued. Arguably, these could be viewed as therapeutic conditions. These opportunities and processes can contribute to a practice culture and context in which adults feel safe and able to create genuine, caring relationships with children.

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References

1. Johnson, D.; Steckley, L. Residential Care for Children and Youth in Scotland: Keeping the Promise? In *Revitalizing Residential Care for Children and Youth: Cross-National Trends and Challenges*; Whittaker, J., Holmes, L., del Valle, J.C.F., James, S., Eds.; Oxford University Press: Oxford, UK, 2023.
2. Sabate-Tomas, A.; Sala-Roca, J.; Arnau, L. Treatment progress of foster care adolescents with severe behavioural problems: Factors conditioning their performance in the residential treatment centres. *Child Fam. Soc. Work.* **2020**, *26*, 203–213. [[CrossRef](#)]
3. Brend, M.; Sprang, G. Trauma-informed Care in Child Welfare: An Imperative for Residential Childcare Workers. *Int. J. Child Adolesc. Resil.* **2020**, *7*, 154–165. [[CrossRef](#)]
4. The Scottish Child Abuse Inquiry. 2023. Available online: <https://www.childabuseinquiry.scot> (accessed on 11 August 2023).
5. Funnivall, J. Exploring the Meaning and Impact of the Suicides of Young Care Leavers from the Perspectives of Those Who Worked and Lived Alongside Them in Residential Care. Unpublished Ph.D. Thesis, University of Stirling, Stirling, UK, 2023.
6. Smith, M. *Rethinking Residential Child Care*; Policy: Bristol, UK, 2009.
7. Milligan, I.; Furnivall, J. The Scottish Children’s Home: An Evolving Model of Residential Provision for Vulnerable Children. *Child. Aust.* **2012**, *36*, 66–73. [[CrossRef](#)]
8. Fisher, M. British Agencies for Adoption and Fostering. In *And Out of Care: The Experiences of Children, Parents and Social Workers*; Batsford in Association with British Agencies for Adoption and Fostering: London, UK, 1986.
9. Souverein, F.; Dekkers, T.; Bulanovaitė, E.; Doreleijers, T.; Hales, H.; Kaltiala-Heino, R.; Oddo, A.; Popma, A.; Raschle, N.; Schmeck, K.; et al. Overview of European forensic youth care: Towards an integrative mission for prevention and intervention strategies for juvenile offenders. *Child Adolesc. Psychiatry Ment. Health* **2013**, *13*, 6. [[CrossRef](#)] [[PubMed](#)]
10. Strijbosch, E.L.L.; Huijs, J.A.M.; Stams, G.J.J.M.; Wissink, I.B.; Van Der Helm, G.H.P.; De Swart, J.J.W.; Van Der Veen, Z. The outcome of institutional youth care compared to non-institutional youth care for children of primary school age and early adolescence: A multi-level meta-analysis. *Child. Youth Serv. Rev.* **2015**, *58*, 208–218. [[CrossRef](#)]
11. Li, D.; Chng, G.S.; Chu, C.M. Comparing Long-Term Placement Outcomes of Residential and Family Foster Care: A Meta-Analysis. *Trauma Violence Abus.* **2019**, *20*, 653–664. [[CrossRef](#)]
12. Steckley, L.; Smith, M. Care Ethics in Residential Child Care: A Different Voice. *Ethics Soc. Welf.* **2011**, *5*, 181–195. [[CrossRef](#)]
13. Frost, N.; Mills, S. *Understanding Residential Child Care*; Routledge: Oxford, UK, 2019.
14. Marshall, G.; Winter, K.; Turney, D. Honneth and positive identity formation in residential care. *Child Fam. Soc. Work.* **2020**, *25*, 733–741. [[CrossRef](#)]

15. Holden, M.; Sellers, E. An Evidence-Based Program Model for Facilitating Therapeutic Responses to Pain Based Behavior in Residential Care. *Int. J. Child Youth Fam. Stud.* **2019**, *19*, 63–80. [CrossRef]
16. Brown, T.; Winter, K.; Carr, N. Residential child care workers: Relationship based practice in a culture of fear. *Child Fam. Soc. Work.* **2018**, *23*, 657–665. [CrossRef]
17. Kor, K.; Fernandez, E.; Spangaro, J. Relationship-Based Practice in Therapeutic Residential Care: A Double-Edged Sword. *Br. J. Soc. Work* **2022**, *52*, 663–681. [CrossRef]
18. Berridge, D.; Biehal, N.; Lutman, E.; Henry, L.; Palomares, M. *Raising the Bar? Evaluation of the Social Pedagogy Pilot Programme in Residential Children's Homes*; Department for Education: London, UK, 2011.
19. Clarke, A. Three Therapeutic Residential Care Models, the Sanctuary Model, Positive Peer Culture and Dyadic Developmental Psychotherapy and Their Application to the Theory of Congruence. *Child. Aust.* **2011**, *36*, 81–87. [CrossRef]
20. James, S. What works in group care?—A structured review of treatment models for group homes and residential care. *Child. Youth Serv. Rev.* **2011**, *33*, 308–321. [CrossRef] [PubMed]
21. Redl, F.; Wineman, D. *The Aggressive Child*; The Free Press: New York, NY, USA, 1957.
22. James, A.B. ROOTS: The Life Space Pioneers. *Reclaiming Child. Youth* **2008**, *17*, 4–10.
23. Social Care Institute for Excellence (SCIE). Report 58: Therapeutic Approaches to Social Work in Residential Care [Online]. 2012. Available online: <https://www.scie.org.uk/publications/reports/report58/summary.asp> (accessed on 4 August 2023).
24. Izzo, C.V.; Smith, E.G.; Sellers, D.E.; Holden, M.J.; Nunno, M.A. Promoting a relational approach to residential care through an organizational program model: Impacts of CARE implementation on staff outcomes. *Child. Youth Serv. Rev.* **2022**, *132*, 106330. [CrossRef]
25. Whittaker, J.K.; Holmes, L.; del Valle, J.F.; Ainsworth, F.; Andreassen, T.; Anglin, J.; Bellonci, C.; Berridge, D.; Bravo, A.; Canali, C.; et al. Therapeutic residential care for children and youth: A consensus statement of the international work group on therapeutic residential care. *Resid. Treat. Child. Youth* **2016**, *33*, 89–106. [CrossRef]
26. Smith, M.; Monteux, S.; Cameron, C. Trauma: An Ideology in Search of Evidence and its Implications for the Social in Social Welfare. *Scott. Aff.* **2021**, *30*, 472–492. [CrossRef]
27. James, S. Implementing Evidence-Based Practice in Residential Care—How Far Have We Come? *Resid. Treat. Child. Youth* **2017**, *34*, 155–175. [CrossRef] [PubMed]
28. Macdonald, G.; Millen, S. *Therapeutic Approaches to Social Work in Residential Child Care Settings: Literature Review*; SCIE: London, UK, 2012.
29. Aldgate, J.; Jones, D.; Rose, W.; Jeffery, C. *The Developing World of the Child*; Jessica Kingsley: London, UK, 2006.
30. Emond, R.; Steckley, L.; Roesch-Marsh, A. *A Guide to Therapeutic Child care: What You Need to Know to Create a Healing Home*; Jessica Kingsley: London, UK, 2016.
31. Saracho, O.N. Theories of Child Development and Their Impact on Early Childhood Education and Care. *Early Child. Educ. J.* **2023**, *51*, 15–30. [CrossRef]
32. Howe, D. *Child Abuse and Neglect: Attachment, Development and Intervention*; Palgrave MacMillan: London, UK, 2005.
33. Casswell, G.; Golding, K.S.; Grant, E.; Hudson, J.; Tower, P. Dyadic Developmental Practice (DDP): A framework for therapeutic intervention and parenting. *Child Fam. Clin. Psychol. Rev.* **2014**, *2*, 19–27. [CrossRef]
34. Hughes, D.; Golding, K.S.; Hudson, J. Dyadic Developmental Psychotherapy (DDP): The development of the theory, practice and research base. *Adopt. Foster.* **2015**, *39*, 356–365. [CrossRef]
35. Golding, K.S. *What is DDP? An Introduction (Staff Booklet)*; Sage: Malvern, UK, 2015.
36. Hughes, D. *Attachment Focused Family Therapy*; W.W. Norton: New York, NY, USA, 2007.
37. Alias, A.; Nasri, N.M.; Awang, M.M. A Tracer Study on Child Participation in Child Councillor Programmes Aimed towards Development of the Child Friendly Cities Initiative. *Children* **2023**, *10*, 732. [CrossRef] [PubMed]
38. Carter, B. 'One expertise among many'—Working appreciatively to make miracles instead of finding problems. *J. Res. Nurs.* **2006**, *11*, 48–63. [CrossRef]
39. Association of Social Anthropologists of the UK (ASA). Ethical Guidelines 2021 for Good Research Practice. 2021. Available online: https://www.theasa.org/downloads/ethics/asa_ethicsgl_2021.pdf (accessed on 11 August 2023).
40. Ingold, T. That's enough about ethnography! *J. Ethnogr. Theory* **2014**, *4*, 383–395. [CrossRef]
41. Geertz, C. Deep Hanging Out. *N. Y. Rev. Books* **1998**, *45*, 69.
42. Rose, G. Situating knowledges: Positionality, reflexivity and other tactics. *Prog. Hum. Geogr.* **1997**, *21*, 305–320. [CrossRef]
43. Becker, H.S. *Tricks of the Trade: How to Think about Your Research While You're Doing It*; University of Chicago Press: Chicago, IL, USA, 2008.
44. Braun, V.; Clarke, V. Using thematic analysis in psychology. *Qual. Res. Psychol.* **2006**, *3*, 77–101. [CrossRef]
45. Kirby, P. 'It's never ok to say no to teachers': Children's research consent and dissent in conforming schools contexts. *Br. Educ. Res. J.* **2020**, *46*, 811–828. [CrossRef]
46. Coleman, S.; Collins, P. Introduction: 'Being . . . Where?' Performing Fields on Shifting Grounds. In *Locating the Field: Space, Place and Context in Anthropology*; Coleman, S., Collins, P., Eds.; Berg: Oxford, UK, 2006.
47. Rogers, C.R. A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In *Psychology: A Study of a Science. Vol. 3: Formulations of the Person and the Social Context*; Koch, S., Ed.; McGraw-Hill: New York, NY, USA, 1959; pp. 184–256.

48. Steckley, L. Threshold concepts in residential childcare: Part 2, relational practice as threshold. *Child. Youth Serv. Rev.* **2020**, *112*, 1–9.
49. Cameron, C. With Heart, Head and Hands. Community Care. 2005. Available online: <https://www.communitycare.co.uk/2005/08/16/with-heart-head-and-hands/> (accessed on 11 August 2023).
50. Emond, R.; Grant, M. *Safer Places: Implementing Policy Change in Physical Restraint Practice, unpublished research report*; Aberlour Child Care Trust: Edinburgh, UK, 2021.
51. Jakobsen, T.B. What Troubled Children Need? Constructions of Everyday Life in Residential Care. *Child. Soc.* **2010**, *24*, 215–226. [[CrossRef](#)]

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