The Lived Experience of Residential Home Care: An Interpretative Phenomenological Analysis study of the experiences of young adults who reside in therapeutic residential care in Denmark

Jacqueline Cameron-Mathiassen
BSc (Hons) Psychology, MSc Health Psychology

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy. The candidate has already achieved 180 credits for assessment of taught modules within the blended learning PhD programme.

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Faculty of Health and Medicine
Lancaster University

I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere.

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This work is dedicated to all the children and young people who cannot live with their families. Wherever you are, it is my hope that in some small way this thesis will be used to promote your well-being and happiness.

Abstract

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Residential care is, in many countries, a living arrangement for young people with behavioural problems who require a level of help which is beyond their own family's resources.

Research on residential care has, in recent years, focused on outcomes, intervention evaluation and economy including comparison with alternative care forms. Relatively little research has been conducted on how young people experience living in care. For example, the systematic review conducted as part of this thesis found from a systematic international search just 12 qualitative papers published between 1990 and 2020 which included residents' accounts in the findings.

This thesis' empirical study engaged interpretative phenomenological analysis as the methodology to investigate the lived experiences of eight young adults who lived in Danish therapeutic residential care. The participants engaged in two individual semi-structured interviews where their accounts of the experience of living in residential care as young people and young adults formed the study's data. Four group experiential themes are presented as the study's findings: (1) "They [carers] go up to the young people and talk to them": Navigating the challenge of staff-system-resident relationships. (2) "I am just more grown up": The experience of transitions towards adulthood and life beyond residential care. (3) "… actually, they wanted me back": The experience of having family and friends while living in care. (4) "I said yes, she told me that was good…": Making sense of receiving help and developing self-help.

As an original contribution to knowledge this study concludes with a discussion which highlights the resulting stress from moving both into care and during care, the importance the participants placed on feeling able to develop and ultimately leave care at a pace independent of legislative time frames, and how family, for five of the participants, was experienced as the most stable factor during their residency.

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List of abbreviations

CASP	Critical Appraisal Skills Programme
IPA	Interpretative Phenomenological Analysis
LOS	Landsorganisationen for sociale tilbud (National organisation for private social welfare institutions)
MTFC	Multi-Dimensional Therapeutic Foster Care
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Co-operation and Development
PRISMA	Preferred Reporting Items of Systematic reviews and Meta-Analyses
RM	Recovery Movement
TS	Thematic Synthesis
UK	United Kingdom
USA	United States of America

Chapter 1
Introduction

1.1 Introduction to the research

Residential care for children, youths and young adults is one of several living options for young people who are not able to live in a family environment. Residential care is concerned with child and youth welfare and development. It is a service aimed at improving the quality of life of the vulnerable young people it serves, enhancing the prospects for this marginalised group and easing their pathway into adulthood and independent living (Whittaker et al., 2015).

However, despite these laudable aims, residential care has a poor record; for example, Utting (1997), in a government report for England and Wales, argues that residential care for children and youths lies within a context of abuse and failed intentions. This is still emphasised over a decade later by Berridge et al. (2012) and in a review paper on the international status of out-of-home care (Petrowski et al., 2017). Indeed, Petrowski et al. (2017) investigated a large body of literature covering 142 countries and reported the adverse impact of institutional care on children's developmental outcomes and well-being. However, despite this negative backdrop, residential care continues to be a living arrangement which is perceived as a suitable service option within many countries' child and youth service programmes (Whittaker et al., 2015). Indeed, for some young people, it is still considered the best option (Canham, 1998; Holmes et al., 2018). In addition, efforts to replace residential care with alternative forms of care have had no recorded success. For example, in Australia during the 1990s a governmental reaction to the poor practices and outcomes in out-of-home care led to the closure of many residential care homes and foster placements. This led to high resource needing youth being served through homeless youth programmes. However, this change of direction led to negative consequences and outcomes for these young people and a reintroduction of residential and foster care for children and youths in Australia during the 2000s (Ainsworth & Hansen, 2005).

The continuous effort by those involved in the development of good practice in residential care has led to an increase in evidence-based research to define what works, for whom and in which circumstances (Whittaker et al., 2016). In 2016 a summit was held by The International Work Group for Therapeutic Residential Care to discuss ‘Pathways to Evidence-Based Practice’ (Whittaker et al., 2016). The report from this summit highlighted the need to identify structured, evidence-based models which could contribute to practice and the achievement of the desired outcomes. In addition, this summit drew upon the principles of ‘therapeutic residential care’ as a model for delivering optimal service.

Residential care has many forms dependent on the type of care and the country offering this service (Dozier et al., 2012). This study is conducted in Denmark, where the principles and practice of residential care homes are compatible with the description of therapeutic residential care offered by Whittaker et al. (2015):

> *“Therapeutic Residential Care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources.” (Whittaker, del Val and Holmes in Whittaker (2015) p. 24).*

Thus, the therapeutic residential care home is based on the principles of purpose, where the multi-dimensional living environment is a co-operation between child and youth specialists, family, and the community, to offer a framework for fulfilling the relevant goals for each young resident. In addition, the intended user of this offer is defined within the description as the child or youth with mental health or behavioural problems. This description of therapeutic residential care matches the profile of residential care homes for children and youth in Denmark (Socialstyrelsen, 2023) therefore this study will refer to the residential settings in which this study was conducted as ‘therapeutic residential care’.

Residential care in developed countries has, over the last century, moved forward in step with the general increase in both economy and living standards as well as a general societal interest in improving living conditions (Bessant et al., 2017). The placement of children and youths into residential institutions has a long history, from early sanctuaries often provided by religious orders followed by philanthropist reactions to the extreme poverty of early industrialisation (Holmes et al., 2018). With an increase in wealth in many countries during the mid-20th century, the traditions of residential care changed; children and youths were no longer placed in care because their families had no possibility of providing for them but rather because families did not have the emotional resources to help a challenging child or youth develop as well as they could (Thoburn, 2016). Thus, today, few children and youths are in residential care because they have no family to care for them. Instead, residential care has become a living arrangement for young people who have either mental or physical needs at a level where home care is perceived too difficult or where the burden of challenging behaviour, including a mental health diagnosis, requires a more specialist approach to help the young person develop as optimally as possible (Holmes et al., 2018; Thoburn, 2016). Modern residential care is a place where children, youths and, in some countries, young adults live together in a home with professional staff, working on a roster, to ensure that their physical and developmental needs are met (White et al., 2015). While the characteristics of residential care homes will vary from country to country, the principles for the placement are the same: The young person does not have a family situation which can encourage optimal development and the young person has challenges which suggest foster or kinship[1] care would be unable to meet the young person's individual needs.

1.2 Denmark as a setting for this research

Denmark is a small North European, Scandinavian country. It is the southernmost country in Scandinavia, lying south of Norway and south-west of Sweden (and is connected to the latter by a bridge). Denmark's southern border is with Germany. Today, Denmark has a population of approximately 5.8 million, with 24.3 % of the population living in the larger urban areas of Copenhagen on the island of Seeland, Aarhus in the Jutland

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[1] **Kinship care** is the care provided by relatives or a member of a child's social network when a child cannot live with their parents.

peninsula, and Odense on the island of Funen (Statistik, 2022). Denmark is a democracy with a monarchy and the Danish Kingdom includes Greenland and the Faroe Islands in the North Sea. It joined the European Union in 1973.

Denmark is an affluent country, ranking number 2 in world ratings for the standard of living (World Population Review, 2022) with a well-developed, tax-funded welfare state system. The Danish tax levies are both progressive and high; according to World Atlas (2019), Denmark is the third highest-taxed country in the world. Denmark's political orientation is a social democrat regime where the state is commissioned to promote employment opportunities for all citizens, pursuit of profit and generous welfare provision (Bessant et al., 2017).

1.3 Residential care in Denmark

The governmental department for social services [Socialstyrelsen] is responsible for all care facilities in Denmark, including residential care for children, youths and young adults. As a governmental organisation, the minister for social affairs has the ultimate responsibility for this department. While a degree of change of direction is evident when a new political party comes to power, the general political situation in Denmark, of coalition majorities, has given political stability for over a century (Folketinget, 2012). This in turn has enabled laws intent on improving residential child, youth and young adult services to continue over several government changes, offering sufficient stability in practice to enable the evaluation of outcomes (Iversen et al., 2021).

As a state-provided service, all forms of residential care and interventions pertaining to children, youth and young adults are provided under specific laws. The current formulation of the law which underpins residential care for children and youths is § 66 stk. 1, nr. 6 and 7:

> *"To take care of and ensure the well-being and development of the children and young people placed in care. Places of residence and residential*

> *institutions must work purposefully to support education, employment and prevention of crime for the children and young people placed in care."* [2]

The service law (LegalDesk, 2022)

Danish children and youth care facilities, including residential care homes, are provided either directly by the state or by non-profit foundations. In both cases, the care programme is fully state funded. Care homes provided by the state are referred to, in Denmark, as residential care homes, with those provided by private initiatives referred to as socio-pedagogical homes (Lausten, 2014). All homes, regardless of ownership, are subject to inspection at least twice a year. The local authority carries out the inspection which concerns itself with both practice and finances, with the results of each inspection available for public perusal on each home's website (Socialstyrelsen, 2022). In addition, to ensure the residence is acceptable to the young person each resident should have the offer of a private meeting with their case manager, who is engaged by the state for this purpose at least twice a year (Socialstyrelsen, 2022).

In 2021 one percent or 13,386 children and youths were in 'out-of-home' care in Denmark, of which 4,475 (33%) lived in either public or private residential care homes. The remaining 8,911 children and youths resided in either foster or kinship care. The age range for the residential care home residents was as follows: 100 aged 0-5 years, 605 aged 6-12 years, 2,716 aged 12-17 years, and 654 aged 18 years plus (DST, 2021).

1.3 Therapeutic residential care in Denmark

The Danish residential care system has, for more than two decades, provided residential care settings with a therapeutic approach in accordance with the Danish quality standards for residential care. These standards are set by the Danish Department of Social Services in a response to the laws pertaining to this service. One of the many tasks of this department is to list and control the approved therapeutic approaches which may be implemented into the residential care homes' practice; these are evidence-based and

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[2] Translated by the researcher.

evaluated for effect. Before the implementation of any social or therapeutic intervention, the phases of implementation, outlined in the publication Vidensdeklaration [Declaration of knowledge] (Socialstyrrelsen, 2022), are addressed to encourage the best possible practice and outcome. This publication also addresses the need for reporting on both the effect of an intervention and any difficulties the individual practitioner may have encountered. Examples of approved interventions can be specific courses such as Aggression Replacement Training. In this intervention participants' social skills, their capacity for self-control, including controlling outbursts of anger, as well as the ability to reason morally and empathetically, are developed (Socialstyrelsen, 2022). In addition, holistic approaches can be used such as Low Arousal, where staff are trained to evaluate episodes of extreme emotion and possibly affect and adjust the environment to encourage a more moderate reaction to possible stressors (McDonnell et al., 2018). Residential care homes may select other evidence-based approaches, however, these must be approved by the inspecting authorities prior to implementation. For example, one particular residential care home, ‘The environmental therapy home’ offers a specialist approach which includes mentalisation-based therapy (Daubney & Bateman, 2015). The mentalisation-based approach includes tools and models which visualise and clarify emotional reaction patterns for the young person. To underpin this process the carer is trained in techniques which, through their own mentalisation efforts, encourage the young person to be able to mentalise themselves, thus expanding their ability to understand and socialise with other people (Den Miljøterapeutiske Organisation (2022). This relatively uniform approach to the management of Danish residential care is also evident in other Scandinavian countries (Backe-Hansen et al., 2013).

Therapeutic residential care in Denmark can be observed as a system which aligns well with the consensus statement of the International Work Group on Therapeutic Residential Cares’ epistemological goal (Whittaker et al., 2016). This identified the importance of engaging evidence-based strategies or models within practice, ensuring the young resident’s right of contact to their family is both encouraged and, where possible, maintained (Socialstyrelsen, 2022). It also, through a transparent and consistent auditing process, upholds the requirement to provide a service which intends to do no harm. However, one of the expectations within the consensus statement, that of encouraging integration with the local community, is not as yet prioritised within the Danish governmental guidelines for good residency (Socialstyrelsen, 2019).

In addition, the consensus statement's goal of identifying evidence-based strategies and models which can be scaled and replicated in other sites is relevant to Denmark. The extended care programme which has existed for over 22 years is posited by the author as sufficiently described and tested to be a relevant scalable and transferable programme.

1.5 International perspective

The Danish residential care system does have some areas that are of relevance when compared to its counterparts in different countries.

1.5.1 The carers

Danish therapeutic residential care homes are expected, by society at large, to employ qualified staff. The inspecting authorities aim to approve homes where a minimum of 70% of the staff who work directly with children or youths hold a bachelor's degree in child and youth development. This Bachelor of Arts in Social Education offers specialisations within three different areas: nursery schooling, school and leisure education, and social and special pedagogy (University of Copenhagen, 2022). Those who hold this degree have the official title of pedagogue [pædagog]. Children and youths placed in care use the term pedagogue to describe their carers (as illustrated in chapter 4, Findings).

Other countries which promote this form of qualification are Germany, the Czech Republic and Slovakia (Knotová, 2014). This Nordic and central European focus on educating a workforce suited to working with troubled young people is slowly evolving in other locations. James et al. (2021), in a multiple case-study, investigated the similarities and differences between residential care, including how staffing is arranged, in five European countries. James et al. (2021) noted how the countries with a previous tradition for a low educational level within staff at care homes (Spain, Italy and Lithuania) were encouraging the employment of formally educated carers to ensure children and youths with complex needs received the best possible residency. Thus, the position within society of a carer is evolving into a person who is trained to a higher level than previously seen and renumerated according to their educational level and the professional service they supply. Finally, in the United Kingdom (UK) a pilot programme was conducted in 2009 whereby qualified pedagogues from Germany were invited to work in 18 English residential homes (Berridge et al., 2011). While the homes which had invited the pedagogues to join their workforce did not achieve better outcomes for the young residents in comparison to the control group, there were, within the results, suggestions from both managers and staff that the pedagogue's ability to reflect and focus on the young person's goals and maturation using a child centred approach was advantageous for the young resident. While this initiative did not change the educational pathway for those who work in care homes in the UK there is an established interest in establishing a professional workforce. The Social Pedagogy Professional Association was founded in the UK in 2017 to promote professional graduate qualifications in social pedagogy. Equally the United States (USA) has a professional organisation, the Social Pedagogy Association. This was established in 2016 by graduates of the social and cultural pedagogy Master's programme at the Arizona State University. The goal of this organisation is to encourage and track the growth of social pedagogy in the United States. However, there are no requirements within the UK or the USA to account for how many staff have this type of qualification.

1.5.2 Aftercare

In 2001, following a state enquiry into the situation of all children and youths in Denmark, the reform 'Children First' was introduced. This reform included a change in the laws concerning care leavers in Denmark. It was agreed that all young people who resided in a form of out-of-home care prior to their 18th birthday should have the chance of continuing in care for a period of up to four years (Andersen, 2019). Prior to this date, all young people in out-of-home care were able to remain in care until their 20th birthday. This extension of care, called aftercare, is offered to young people who have lived in a care situation, for example residential care, and are perceived capable of living an independent life following their placement in aftercare. The aftercare offer they receive is based on their previous living form. Thus, if the young person has lived in residential care they will continue to do so until they are perceived ready to move into a more independent form of living, while still under the care of the residential care home. Indeed, one of the major intentions of aftercare is to encourage a gradual move towards independent living (Socialstyrelsen, 2023).

Aftercare follows the laws and recommendations of section 46 of the Danish Service Act (LegalDesk, 2022). It has the purpose of providing support to young people with special needs so that they can receive the same opportunities of continuity in their upbringing, personal development, health, schooling, and preparation for independent adulthood as their non-care peers (Socialstyrelsen, 2023). Aftercare varies in its form depending on the young person's situation prior to the programme starting. For the young people who have resided in residential care, this will, as part of their aftercare plan, continue until the young person is perceived to have sufficient life skills to begin living away from the home. Usually, this transition is monitored by the residential care home during the last phase of aftercare (Socialstyrelsen, 2023).

While Denmark, along with its Nordic counterparts, has a comparatively long history of implementing extended care beyond the age of 18 years, other countries are beginning to effect laws to ensure out-of-home care youth obtain a more secure mode of care as they emerge into young adulthood. For example, in Australia the different states have either implemented an aftercare service or are in the process of implementing this service (McLean, 2018).

In England, young people in foster care are now able to engage in the Staying Put programme (Sweetman, 2015), which ensures young foster care leavers may continue to reside in foster care as young adult members of the household. For the young people in residential care a similar programme, the Staying Close programme, is currently under development. The Staying Close programme has been through a pilot programme, whereby 20 local authorities and three private providers between 2017 and 2023 participated in pilot trials. The next phase for the Staying Close programme is a random control trial during 2023-2025, where-by comparisons between the effect of programme participation versus "business as usual" will determine if young care leavers in the UK should receive this offer until their 21st birthday (GOV.UK, 2023).

In addition, in Wales, a pilot scheme has been launched which offers £19.000 per annum, for a two-year period, to care leavers following their 18th birthday (BBC, 2022). This pilot scheme is expected to be offered to 500 care leavers with the purpose of ensuring care leavers can establish themselves in affordable housing and focus on education and employment. The different forms of approach towards the needs of youth leaving care suggests a cultural disparity in how society perceives young people can best achieve a secure base from which to continue their development.

Despite the current tendency in most countries to discontinue residential care at 18 years of age, a growing concern suggests that this practice is contributing to the poorer outcomes and quality of life of young care leavers when compared to other young adult populations (van Breda et al., 2020). This concern has been voiced by Okpych and Courtney (2015). In 2007 a large-scale investigation into the outcomes of foster youth in the USA was conducted by Courtney et al. (2007). Okpych and Courtney (2015) investigated the findings from this study. They investigated the statistics on the immediate years after the transition out of care for youths who had moved from foster to residential care prior to their transition out of care. The study spanned eight years, with the respondents in their mid-20s during the final wave. The results revealed that the residential care leavers were positioned as a marginalised population with 31.7% disconnected from the workplace for at least 12 months, 56.2% in receipt of food-stamps, 31.5% homeless or ‘couch surfing’ and 36.4% with substance and/or alcohol problems.

Indeed, OECD (Organisation for Economic Co-operation and Development), following a survey of 30 countries, recommends that their members raise the age for leaving care to 21 (OECD, 2022). In addition to this global concern for the welfare and challenges this group face on turning 18 years of age, van Breda et al. (2020) raise concerns that the help offered to care leavers is often directed at those who already have the capacity to succeed in their housing and employment endeavours. This, then, increases the marginalisation of those who leave care with higher social and emotional burdens. In addition to these burdens the current norm in many countries for leaving the system of leaving care at 18 can enforce the experience of a compressed transition. The situation whereby a young person has both to leave home and accommodate the changes in their lifestyle as they transition to adulthood encourages a burdensome acceleration within these major transitions. Stein et al. (2011) argue that, in comparison to their non-care peers, this form of enforced transition encourages disadvantages in the main pathways to adulthood including education, employment, accommodation, health and well-being.

1.5.3 Research on aftercare

Comparatively little research has been conducted on aftercare in Denmark. However, in 2021 VIVE, the Danish centre for social science research, conducted a Rapid Evidence Assessment of studies aimed at investigating how aftercare can support young people who have lived in out-of-home care (Iversen et al., 2021). The assessment was based on 17 studies and reports from the Nordic countries, i.e. Norway, Sweden, Finland and Denmark, including one peer reviewed Danish study (Andersen, 2019), which investigated the outcomes for young adults who had received aftercare following foster care placement.

The remaining papers on aftercare in Denmark included the following:

- a post graduate report (Kjærsig & Damsgaard, 2015). This hermeneutic and social constructionist enquiry reported interviews with six young adults in aftercare and concluded the participants believed aftercare had improved their life opportunities.
- a Danish government requested report on the use of interventions targeted at the specific needs of those enrolled in aftercare and those who had recently transitioned out of aftercare. The interventions included safe housing, social competence and sustained employment. Eight different projects were included in this report. While all eight interventions were reported as achieving their target of improved outcomes for this group, the report explained the challenges of defining when a target was reached and in some instances the sustainability over time of the achieved target (Iversen et al., 2022).
- a report on the effect of aftercare (Mølholt et al., 2012) which concluded that aftercare promoted an improved outcome compared to non-aftercare peers.

The rapid assessment concluded that four areas within aftercare services and transitioning out of care should be further explored: early dialogue and involvement of young people;

duration of the aftercare effort; supportive relationships and networking; education, employment, housing and crime (Iversen et al., 2021).

While the individual reports suggest those in aftercare programmes have better outcomes than their non-aftercare peers, there are still many areas of concern. The Danish model, as with global counterparts, has not, as yet, created a situation where young people with a history of out-of-home care achieve the same normative milestones as their non-care peers (Andersen, 2019). While the rapid review does offer insight into areas of concern and opportunities for improvement, it is however important to note that the findings within the rapid evidence review and other material contained within VIVE's archives do not distinguish between outcomes in relation to the form of out-of-home care in which the young person was placed. Finally, it should be noted that none of the enquiries sourced within the literature in Denmark prioritise well-being or quality of life as a parameter for understanding the effect of out-of-home care in Denmark.

1.6 Research perspectives on child and youth residential care

Residential home care has had, in the last half century, a tendency of justifying why it is a suitable service when it is perceived as a last resort (Kendrick, 2008). However, within the last two decades the results of research into residential care have begun to challenge this narrative. Harder and Knorth (2015) conducted a meta-analysis of 110 international studies to assess evidence on effectiveness of residential youth care. The findings from this meta-analysis indicated that Multi-Dimensional Therapeutic Foster Care[3] (MTFC) (Fisher & Gilliam, 2012) appeared in some studies to initiate a higher level of behavioural progress in comparison with residential care. However, it was the authors' contention that residential placements may well be equally as effective if they used evidence-based treatments in residential care to the same extent as happens in MTFC. The second finding was a reported general improvement in psychosocial functioning following a period in residential care. It was, however, noted that this positive effect decreased over time. While this notation did not include information on the length of time or the degree of decrease,

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[3] MTFC an evidence-based training programme for challenged young people in foster care. The programme is delivered through training of foster-parents to deliver treatment in coordination with individual therapy, family therapy for both the child and the biological home. MTFC also encourages a co-operation with schools and, where relevant, justice departments to ensure a holistic case-management.

Harder and Knorth (2015) posited the gradual decrease in the positive effect of residential care could be curtailed if aftercare services and family liaison were prioritised when young people left care.

The combination of service providers' finite budgets, the societal interest in achieving productive members of society through residential care interventions and the need to reduce criminal behaviour have led to a larger research focus on these specific outcomes (Harder & Knorth, 2015). In addition, the current state of interest in researching the field of child and youth residential care demonstrates a move towards knowledge sharing through research and international cooperation (Whittaker et al., 2016). However, cross-national comparisons within the area of residential care can be difficult to perform, partially as this is an area where translation of definitions can be causal of unintended misrepresentation of the explored service and partially because each country tends to collect data in different ways (Whittaker et al., 2015). An example of this is the placement of young offenders as in the Scandinavian countries these young people form part of the statistics on residential care, however in, for example the UK, USA and Australia, they do not (Grietens et al., 2014). In addition, cultural beliefs regarding how best to serve the young people may differ, thus impacting on the type of service available. For example, Denmark has a relatively high percentage with 47% of those who live in an out-of-home placement residing in residential care. This level is similar to Germany (54%) and Italy (48%) whereas, for example, the UK and USA are lower at 14% and 15% respectively (Whittaker et al., 2015). The remaining out-of-home placements within these countries are foster care or kinship care. Despite these barriers, many important benefits can accrue from cross-national knowledge sharing, including the pooling of data to increase our knowledge on the factors which can contribute to better outcomes and economic models to encourage the best use of available resources (Whittaker et al., 2015).

In summary, research conducted on residential care has had a general focus on effectiveness and the evaluation of specific treatment programmes, with the ever-increasing availability of data leading to more reliable conclusions. The measurement of the effectiveness of residential care, based on indicators of improved behaviour, e.g., reduced antisocial behaviour etc., is important, particularly if certain interventions can be ascertained as superior in certain circumstances (Knorth et al., 2008). However, it is the researcher's belief that without knowledge on how residential care is experienced, the programmes under development may well lack the important dimensions of appealability, understandability and trustworthiness. Indeed, this research argues that understanding the resident's perspective and how they make sense of the experiences which impacted on the cooperative alliance between themselves and those providing the intervention or treatment-plan will enhance service delivery and successful outcomes.

1.7 Qualitative research and user perspectives

Research which includes first-hand experience of living in residential care is noted as particularly sparse, with most of the research on residential care services for children and youth focusing on effect, specific treatment plans and comparison between services. However, a recent systematic review (Cameron-Mathiassen et al., 2022) identified, within the last 30 years, the publication of 12 peer reviewed studies that had included residents' experiences of residential care. This review's findings pointed towards the residents' well-being being affected by authoritarian control, worries regarding an uncertain future, and how the individual residential care facility's approach to support affected some of the participants' well-being. Thus, this review has revealed areas which warrant further research and underlined the relevance of engaging residents of residential care as participants in research.

Qualitative research has been an acknowledged discipline since the mid-20th century and has since the 1980s become an established methodology when peoples' words, actions and reflections are key to achieving a greater understanding of a particular phenomenon. As research has progressed so has the ability of qualitative and quantitative research to the stage where the user of a service is now considered an important contributor to knowledge. Earlier, for example, dementia patients would not have been asked about how they experienced their lives with dementia (Bond & Corner, 2001). The prevailing narrative was that accounts would be unreliable, difficult to access and dependent upon 'validation', from a perceived reliable source such as a health professional or carer. In more recent times we have learnt that those who have first-hand experience of the phenomena, for example, Melrose (2002) who investigated the experiences of juvenile prostitutes in England and Wales, can offer a trustworthy account of what they experienced.

Edridge et al. (2018) posit patient involvement as a central tenet in the planning of mental health interventions; equally, patient-centred care was identified by the American Institute of Medicine as a key area for improvement in healthcare delivery (McGinty et al., 2012). Thus, research into service provision has become reliant on the willingness of service users to be participants in studies to gain a fuller understanding of their experiences. The findings from these enquiries have contributed to improved service delivery and a shift in the way research and researchers view how service provision can be understood (McGinty et al., 2012). Indeed, another example of a movement powered by patient perspectives is the recovery movement (RM) (Cromby et al., 2013) which has its origins in mental health user groups. It has, since its beginnings in the USA in the 1980s, created an alternative to the standard viewpoint of the mental health professional administering to the patient, with the recovery movement offering the framework for a collaborative approach between patient and professional (Cromby et al., 2013).

While RM has been promoted by its supporters to guide mental health in a new direction away from what they perceived as being an overly narrow biomedical model (Thornton & Lucas, 2011), it has evolved during the last three decades towards becoming an integral part of mainstream mental health services (Turner et al., 2011). Central governmental guidelines in Denmark encourage recovery as a therapeutic framework in adult residential care (Socialstyrelsen, 2019). Indeed, user involvement is increasing its presence within research to the extent that mental health users are now being invited to become involved in the analysis of user accounts (Locock et al., 2019). This involvement has encouraged the participating service users to argue for an adjustment in the values of research in mental health. These participants sought a lens which prioritised the values, preferences and practices of the service users when conducting analysis, thus the values and intent of the researcher within this form of research were adjusted to accommodate the participants' understanding of how findings could be analysed (Locock et al., 2019).

Research investigating user experience is minimal within the area of residential care. This is discussed in a publication aimed at encouraging cross-national evidence of best practice in therapeutic residential care (Whittaker et al., 2015):

> *"What is the lived experience of care for children and young people receiving TRC [therapeutic residential care]? This is not a question that traditionally has received a lot of attention in the field. Yet the lived experience of young people receiving care is an important source of evidence for regulators, researchers and those seeking to improve the theory and practice of TRC. Attention to the children's world in care settings is an essential way of protecting the interests and rights of the children involved, protecting them from the abuses of informal power by peers and of formal power by staff. Accessing the children's world is not a simple matter for adults, since it is in so many ways beneath the gaze of adults. But the first step to access is a strong commitment to the value of the child's perspective on the care experience". (Gilligan in Whittaker et al. (2015), p. 19).*

1.8 Rationale for this study

Children and adolescents within Denmark who display behaviours that offer severe disruption to their local environment or present a risk towards their own or others' safety can be placed in therapeutic residential care (Socialstyrelsen, 2022). The major markers for developing the need for out-of-home care are cited by the Danish Social Department as; neglect and abuse, parental incapacity due to drugs and alcohol, parental lack of capacity due to own mental health problems and the youth's inability to attend school (TrygFonden, 2013). Therapeutic residential care is positioned in Denmark as a necessary option when the level of developmental care, psychoeducation and behaviour regulation needed is considered beyond the capacity of assistance in their own home or a foster placement (Socialstyrelsen, 2022).

This study conducted research with young adults between the ages of 18 and 23 years who, at the time of the interview, were either living in a therapeutic residential care home or, if they were close to ageing out of their aftercare programme, in an apartment while still being under the care of their residential care home. This group has a lived experience of residential care for at least some of their formative years and will continue within the care system for, depending on their age at the interview, a period ahead. Thus, the interviews were able to acquire accounts spanning a length of residency where developmental change had the possibility of influencing the participant's experiences of care.

In addition to the advantage of investigating a longer residency period, the study was able to investigate accounts of receiving aftercare in a residential programme. While many countries offer assistance to care leavers as they turn 18 years of age, the extension of care into young adulthood is currently only available, as a normative service, in the Scandinavian countries and some parts of Australia (Mendes, 2021). Thus, this study is embedded in a context which facilitates the exploration of the experience of extended care.

This study directly contributes to the evidence base on life in residential care as a youth and as a young adult from a resident's perspective. In addition, this study has through the selected age group and their living situation, the objective of including accounts on the experiences of transitions in residential care. The transitions from child to teenager to young adult are perceived as critical phases in life whereby the physical, cognitive, emotional and social resources that are the basis for a healthy life become established (Patton et al., 2016). Thus, it has been possible to draw upon the experiences given within the accounts to gain knowledge on how these young residents have experienced transitions in care and their meaning-making of societal as well as residential restrictions on how they live their lives. The current tendency in many cultures towards a longer period of transition from teenager to adult, with, for example, longer periods within education, residing for longer within the family unit and an increase in pre-marital relationships, is less evident in formal care systems. Offers of care are, for most young people, limited to a certain age. Therefore, many care leavers lack the normative possibility of having an extended transition to independent living. However, the Danish care leaver can continue in care for a further four years, thus, this study has been able to explore the experiences and meaning making of participants who have resided in residential care during early adulthood.

1.9 Summary of the methodological choice

The methodology used in this study was interpretative phenomenological analysis (IPA) based on a critical realist ontological and epistemological approach. This choice enabled engagement with the individual's personal narrative of their lived experiences, thus relevant findings were gathered which could answer the research question. Therefore, this study is placed within the qualitative paradigm or world view (Silverman, 2013). The systematic review (chapter 2) used thematic synthesis (Thomas & Harden, 2008) to gain a full and effective line-by-line analysis of the included peer-reviewed papers.

1.9.1 Interpretative phenomenological analysis

IPA is a relevant choice when the research is focused on creating a deep and rich understanding of the meaning making of lived experiences. This approach demands attention to the individual experience, thus, as a methodology it required a direct engagement with residential care service users. The onus in IPA is on conducting an exploration of each participant's experiences, and how they made sense of these experiences (Larkin et al., 2021), followed by the merging of participants' accounts into group experiential themes. These group experiential themes then represent the salient experiences and concerns the participants have expressed within particular domains elicited by the research question.

One of the major tenets of IPA is idiography, which involves a focus on the individual lived experience (Smith et al., 2009). This is achieved through the exploration, analysis and attention to detail within each participant's account, ensuring that a comprehensive representation of their meaning making of their lived experiences can be formed. This close, deep and rich formulation of individual experiences was considered a prerequisite for answering the research question and therein providing a trustworthy account of the lived experience of individuals in Danish therapeutic residential care.

1.10 Theory

Theory can be applied at many stages of the research process and in different ways (Stewart & Klein, 2016). The deductive approach uses theory to drive the study's design and, is more common in quantitative studies where a theoretical position in a particular domain becomes a framework for hypothesis deduction. Moreover, following analysis a revision of the theory within the domain can occur (Bryman, 2016). The alternative to the deductive approach is the inductive approach which links the study's findings to theories within the domain, from which it is possible to increase the plausibility of the study's interpretations and conclusions as they are evaluated against what we already know within the domain (Bryman, 2016). In this thesis both the systematic review and the empirical study have an inductive approach to theory. Thus, during the phases of gathering the findings and conducting the analysis, theories connected to young people and their development were set aside. However, once the analysis had been conducted existing theories were drawn upon to inform further what the findings revealed and underpin how the findings contributed to current practise within the field of residential care.

1.11 The research question

This study from its earliest conception was guided and developed through a focus on three areas: (1) The belief that user experiences can contribute to knowledge; (2) this knowledge can add value when developing new practices in residential care; (3) qualitative research paradigms can give the best access to residents' experiences. The ensuing research encompassed these three areas to establish a conceptual framework for the research (Brearley, 2021). The conceptual framework united the original thoughts of the researcher regarding the phenomenon to be investigated with current knowledge. This knowledge was assimilated by the researcher through a systematic review of empirical research on the experiences of youths and young adults in residential care, an extensive search into empirical research in associated areas and a careful appraisal of relevant research methods. Thus, following the systematic review it was possible for the author to identify an empirical gap in the literature from which the research question was framed. This was considered a superior approach for this study as opposed to the alternative of working towards a theoretically informed research question.

From this process questions arose which encouraged a refinement of the researcher's existing thoughts. The systematic review (chapter 2) not only created a foundation for the interview protocol but also highlighted the differences in how young people experienced residential care, which, in turn, underpinned the importance of the original belief in the importance of user-informed evidence. Equally, the research into grey literature, including current trends towards therapeutic residential care and extended care, further informed the research's original aims and objectives. This process encouraged the development of a research project which linked the lived experience of residential care with policy and practice within residential care, youth and young adult related issues in contemporary society and theoretical perspectives on youth development.

This research aimed to investigate the lived experience of young adults living in Danish therapeutic residential care by engagement with young adult residents to answer the following research question:

How do young adults experience and understand life in Danish therapeutic residential care?

The aim and research questions were supported through the activation of the following objectives:

- To explore young adults' individual stories of their lived experience of therapeutic residential care in Denmark.
- To examine young adults' perspectives on the current system of therapeutic residential care in Denmark.

1.12 Concluding comments

In conclusion, it is the researcher's contention that while an increase in interest in this area is evident from both the research community and those involved in policy and practice (Whittaker et al., 2015), there is a marked deficit in the number of papers which have gathered data from a resident perspective (Cameron-Mathiassen et al., 2022). In addition, little research has been conducted into existing aftercare services (van Breda et al., 2020). Moreover, Denmark, despite being one of the first countries to offer aftercare, has not, yet, published any peer-reviewed research within this area. Finally, there has been no evidence of IPA as a methodological choice for researchers investigating the experience of living in residential care.

1.13 Researcher positionality

Larkin et al. (2006) posits that IPA has two complementary commitments: the phenomenological requirement of understanding the participant's experiences and concerns, from which the researcher is committed to giving voice to these concerns and the interpretative requirement of making sense of these concerns from a psychological perspective. These commitments required a full and enduring focus on how I, as a researcher, recruiter, interviewer, analyst and reporter, understood my role and my influence on the conducted research.

I was also aware of the complexities of 'inter-subjectivity', how the interactions between the researcher and participant are in constant flux and may well affect the meaning making between participant and researcher, as well as affecting the cognitions of each participant and myself as each interview developed. Duranti (2010) relates that Husserl, who wrote on intersubjectivity, suggested it related to a shared or mutual understanding and coming closer to the place where the other person was situated. Thus, as the interviewer and analyst, I was in a situation which required a deliberate effort of maintaining focus on the interviewees' own meaning-making of their situation to gain the necessary closeness to their interpretations of the experiences they were recalling.

My background is in special needs education. As a headmistress and teacher of history and English as a foreign language I have taught, listened to, and helped many troubled young people, including those who live in out-of-home placements. I have at times been affected by governmental rulings that have appeared unjust or negligent towards the individual. Equally, I have been joyful over the success stories I have witnessed and to which, at times, I believed I have contributed. To ensure transparency in the reporting of this research, it was important that I acknowledged my life history and, as it is a part of me and how I make sense of the world, it may well have affected my judgements during the interviews, while analysing the transcripts and when drawing conclusions from the findings of the study. Thus, I, as with any other qualitative researcher, have accepted that the interview, analysis and findings will have been shaped at some level by my involvement (Palaganas et al., 2017).

1.14 Thesis structure

The following chapter presents a systematic review of peer-reviewed empirical papers relating to the experience of living in residential care. Chapter 3 describes the methodological approach, data collection and analysis for the empirical research study. chapter 4 sets out the research findings, chapter 5, discusses the findings and the final chapter, chapter 6, presents the conclusions, strengths and limitations of the study and suggestions for further research as well as considerations for improvement in policy and service provision.

Chapter 2

Literature Review

2.1 Background

This chapter is a presentation of a systematic synthesis of peer-reviewed literature on the experiences of young people in the age group of 12 to 25 years who live in residential care. This review was published in Children and Youth Services Review in July 2022 (Cameron-Mathiassen et al., 2022).

2.2 Underpinning the empirical study

This thesis has two enquiries: the systematic review of literature, presented here as chapter 2, and the empirical study investigating the experience of living in Danish therapeutic residential care, which is presented in chapters 3, 4 and 5. This review is a part of a whole, thus, the predicate of an intent to serve the empirical study with valuable knowledge on what is known about the experiences of residential care has been an essential underpinning of this review. To encourage coherence between the review and the empirical study, this review, as with the empirical study, was embedded within the qualitative paradigm (Bunniss & Kelly, 2010).

2.2.1 Age group

It was appropriate when designing this review to consider how the intended participant age group of the empirical study could be best served. The empirical study's participants had an expected age range from 18 to 22 years at the time of the interview, with an, at the time of the review, unknown age for the time they entered residential care. Therefore, it was concluded that this systematic review should focus on the experiences of young people in the age group of 12 to 25 years who lived in residential care. This age-span is consistent with Heath et al. (2009)'s contention that the age group "youth" has two life stages; the stage between childhood and youth and between youth and adulthood. The term young people will be used throughout this chapter when referring to the identified age group.

2.3 The evaluation of methodology for the literature review

An essential parameter, prior to the conduct of any form of scientific enquiry, is to investigate the current knowledge in the area of interest and from this knowledge ascertain what new knowledge could be of value (Gough et al., 2017). Thus, it was necessary, prior to finalising all decisions pertaining to the empirical study, to investigate the available literature on the area of interest. This investigation was committed to uncovering what is already known about the subject, in which context this knowledge has been defined, and how reliable this knowledge is (Gough et al., 2017). Indeed, Chalmers (2001) reports of the importance of using reliable information when intervening in people's lives.

Literature reviews have over time evolved with the intention of enhancement of quality, trustworthiness and rigour. Thus, in recent times, different forms of review have evolved, each review type being targeted at a particular need (Booth et al., 2016). Booth et al. (2016) list 13 different forms of review, including for example, the integrative review which enables the reviewer to combine knowledge from a variety of sources including peer-reviewed articles and grey literature. Literature reviews have previously been criticised for creating a large amount of data in which there is little clarity in the organisation, integration or evaluation of the reviews approach or results (Bem, 1995). However, recent developments of how a review can be conducted has led towards, at first within the medical sphere and later to other areas, the recognition of a systematic approach to conducting a review of the literature. Booth et al. (2016) argue that decisions based on evidence should be made from the best available evidence. They also argue that the research synthesis is the most useful research tool for defining what works and what does not work within a given area, as well as being a strong tool for highlighting areas of inconsistency and areas which need further development.

The clear and rigorous guidelines pertaining to the conduct of a systematic review, including the systematic search and reporting process (Booth et al., 2016; Petticrew & Roberts, 2008), were considered, for this enquiry, superior to the alternative, the traditional literature review. The traditional literature review is not informed by this approach as it lacks a clear auditable trail of the literature search. The selection of a systematic review methodology ensured a rigorous, transparent, and repeatable search for studies which fulfilled the predefined inclusion criteria (Booth et al., 2016). In addition, the quality assurance phase of the systematic review encourages rigour in the quality of the data from which the findings were drawn (Gough et al., 2017).

2.4 Residential Care

The development and purpose of residential care, as discussed in chapter 1, is an important part of the foundation for this systematic review. Residential home care can be characterised by continuous evolvement as it strives to meet the needs of modern children and youth and the society which it serves. Within this development the term therapeutic residential care as discussed in chapter 1, is synonymous with the current form of residential care in Denmark, a form of residential care which aims through purposeful planning to create an environment specifically designed to support and protect children and youth with behavioural and mental health needs (Whittaker et al., 2015). While the author has proposed therapeutic residential care as an appropriate title for residential care in Denmark, this review has, however, drawn its findings from international peer-reviewed literature. Therefore, it was necessary from the outset of the review chapter to define residential care in a global context. While residential care has many definitions and names, according to the geographical location, there are certain modal features that encompass this form of service (Dozier et al., 2012). This review chapter has selected Galik's (2013) definition of residential care as an appropriate description of the service to be explored: A congregate living space with professional staff who are continuously on-site providing an environment which can meet the functional, medical, personal, social, and housing needs of individuals who have physical, mental, and/or developmental disabilities. This definition confirms residential care's aim to provide a social service, as opposed to placements within the criminal justice system, which would also entail strict limitations on freedom of choice, movement etc. The approaches of the individual residential care facility practice will vary according to the needs of the residents it serves and the culture in which the home is situated which, in turn, is influenced by political and historical forces.

The decision to place young people in residential care is often made by governmental health and social services. These decisions are drawn from the relevant professional's observations and reports which demonstrate the relevant markers were exhibited and, from which, residential home care was deemed the best placement.

The current literature suggests the prospect of a successful residency varies, with some of the young residents attaining enhancement in their developmental trajectory as well as improvement in their well-being and a well-balanced mental health as adulthood approaches (Holmes et al., 2018). For other residents, however, extreme behavioural patterns are exhibited during their time in care including self-harm, adverse risk-taking, anti-social behaviour and isolation (Campos et al., 2019; Cordell & Snowden, 2015). These behaviour patterns indicate lower levels of well-being and contribute to a higher level of mental health diagnoses when compared to other youth groups (Cordell & Snowden, 2015). Indeed, it is suggested by Macdonald et al. (2012) that the young person's mental health burden, if not adequately addressed, can be both one of the determinants for placement in residential care, and one of the determinants for an unsatisfactory placement in residential care.

Vinnerljung and Sallnäs (2008) in their longitudinal study on outcomes in residential care in Sweden point to almost 33 % of residential care residents being hospitalised for mental health concerns at 20–24 years of age compared with 1.2 % in the general population. In an English study (Berridge et al., 2012) reported almost 66 % of the young people who resided in residential care had clinically significant mental health difficulties and 75 % had, in the previous six months, exhibited violent or aggressive behaviours.

2.5 Aims, objectives and research question

Petticrew and Roberts (2008) contend that systematic reviews not only provide a source of evidence-based information but also allow for the identification of gaps in knowledge. Thus, this review had the purpose of identifying peer-reviewed studies where residents' own experiences of residential care had formed the findings. The findings from this chapter are discussed in their own right within the chapter and further discussed in the discussion section in chapter 5, as they offer a platform of comparison between the findings from the author's own empirical study conducted in Denmark and the findings derived from the 12 studies in this review.

The review had the following objectives:

(1) identifying qualitative research articles which explored experiences of residential care by young people who resided in residential care from a first-person perspective.

(2) implementing a high-level approach to synthesis aimed at extracting interpretations beyond those offered in the original papers.

(3) discussing how the findings offer insight on the potential impact on young people's well-being.

(4) identifying gaps in our current knowledge.

With these aims and objectives, the review had the following research question:

What is known about the experiences of youths and young adults who live in residential care and how do these experiences impact on their well-being?

2.6 Methodology

This systematic review followed the Preferred Reporting Items of Systematic reviews and Meta-Analyses (PRISMA) (Moher et al., 2009) guidelines which provided an auditable approach of clearly defined and transparent methods for each stage of the review (Jesson et al., 2011).

2.7 Methods

2.7.1 Provisional search

A provisional search (Jesson et al., 2011) was conducted to get a general sense of the literature in the area and to enable a working assessment of the volume of available qualitative data, the type of data and the disparity of the data. The provisional search contributed towards the development of the final systematic search strategy (Booth et al., 2016). The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) search strategy tool was engaged (Cooke et al., 2012) to ensure both the sensitivity and the specificity of the search.

2.7.2 Search Strategy

The search strategy was originally developed in the SocINDEX electronic database and adapted to ensure a comprehensive search (Booth et al., 2016) of five databases: PsycINFO, SCIE, SocINDEX, Child Development & Adolescent Studies, and MEDLINE Complete. In addition to the database searches, citation searching (Booth et al., 2016) uncovered one additional paper. The sourced studies were imported into Endnote. Titles and abstracts were screened to remove duplicates and papers that did not fulfil the inclusion criteria. The search was conducted in January 2020. The following search terms were used: (youths or adolescents or "young people" or teens* or "young adults" or juvenile*) AND (experiences or perceptions or attitude or views or effects or impact or coping) AND ("residential care" or "care homes" or institutions or "looked after" or "out of home care" or "congregate care") AND ("qualitative research" or "mixed methods research") AND (behavi* or problems or "mental illness" or "mental health" or "mental disorder"). (Appendix I).

2.7.3 The inclusion and exclusion criteria

The inclusion criteria for the systematic review were defined through the systematic review's research questions, aims and objectives and the identified constructs from the SPIDER framework (see Table 1).

Table 1. The review's inclusion criteria:

	Inclusion criteria	**Exclusion criteria**
Sample	Young people aged 12 to 25 years, resident in a care home, where residency is perceived to be of a period stretching from months to years. Young people whose residency is not related to physical or learning disabilities.	All other ages, as their experiences were not relevant to the research question. Placements with an interventional intent, whereby weeks rather than months were defined as length of residency as these experiences were not relevant to the research question. Young people whose residency was connected to physical or learning disabilities as these groups would have had a residency with specific focus on these disabilities.

Phenomenon of interest	Studies which explored the first-person experiences, perceptions, feelings, effects, impact, or coping related to living in residential care.	Studies which did not engage in an exploration of the experience of residential care from a resident's viewpoint.
Design	Studies which engaged in first-person experiences of mental health, mental illness, mental disorder, or mental well-being related to being a young person living in residential care.	Studies which did not engage in an exploration of at least one of these constructs from a resident's viewpoint.
Evaluation	Qualitative research, where data had been gathered through direct contact with the residents of residential care and where direct quotes from the participants support the findings. Mixed methods were included if it was possible to isolate the qualitative findings.	Quantitative research. Research that did not engage directly with the residents of residential care. Research which did not use direct quotes from residents to support the findings. Mixed methods where it was not possible to separate the qualitative findings from the quantitative findings.
Research type	Explorative, peer-reviewed research.	Research which did not have an explorative intent within its design. Grey literature and non-peer-reviewed work.
	Published after 1989.	All research published prior to 1990.

To capture fully the experiences of residential care the participants in the targeted original research were defined as: children, youths and young adults within the age range 12 to 25 years, living in residential institutional care of a continuous or ongoing nature. Consequently, papers relating to short interventions whereby the young person was envisaged to be resident for weeks or a few months were not perceived as able to offer insight into the experience of longer-term residential care. Papers reporting on an age range that extended beyond these ages were only included if the findings could clearly be attributed to the systematic review's selected age range. Equally, if staff had been a part of the original studies' sample, only papers where these findings could be desegregated from the young people's findings were included.

In addition, decisions regarding the publication type and publication date of the primary papers were made. The earliest inclusion date for relevant literature was 1990. Earlier journal articles were considered of low relevance as the experiences of residential care prior to this date would not correspond to the experiences young people have more recently (Rew et al., 2000). Only evidence from peer-reviewed journal articles was selected to ensure a clear pathway between the primary research's question and the reported experiences. The research question was explorative and focused on the individual person's experiences, thus the search was focused on papers embedded in the qualitative paradigm (Silverman, 2013).

2.7.4 Quality appraisal

Quality appraisal of the papers was conducted using the Critical Appraisal Skills Programme (CASP, 2018) check-list for qualitative research. CASP facilitated a systematic assessment of the trustworthiness, relevance and results of the published papers. The CASP guidelines use a series of 10 questions to appraise aspects of each paper. The 10 questions are placed in three sections: section A has six questions concerning the validity of the paper: Was there a clear statement of the aims of the research? Is a qualitative methodology appropriate? Was the research design appropriate to address the aims of the research? Was the recruitment strategy appropriate to the aims of the research? Was the data collected in a way that addressed the research issue? Has the relationship between the researcher and participants been adequately considered? Section B is concerned with the results: Have ethical issues been taken into consideration? Was the data analysis sufficiently rigorous? Is there a clear statement of findings? Section C is concerned with the ability of the papers results being of benefit: How valuable is the research?

The questions have a response format of: yes, can't tell or no. Comments were placed on the appraisal sheet for each study. While the quality appraisal did note some weak elements within the selected studies, in particular regarding the reporting of ethical considerations (Barter, 2003; Bundle, 2002; Jansen, 2010; Kelly et al., 2019; Schofield et al., 2017), all studies were considered acceptable for this review (Appendix II). Therefore, the generation of themes within the synthesis was based on the findings of all the papers across the quality range.

2.7.5 Data extraction

Data were defined as all elements of the findings and discussion of each primary paper because thematic synthesis facilitates the synthesis of data from studies with disparate theoretical and methodological foundations (Thomas & Harden, 2008). The data from the 12 papers were extracted through the adoption of an existing data extraction sheet available through the British Psychological Society (Appendix III). Simultaneous with the data extraction, the study characteristics of the primary papers were collated to enhance the understanding of the context in which the studies were positioned.

2.7.6 Thematic synthesis

Thematic synthesis (Thomas & Harden, 2008) was selected as an appropriate method for the analysis of the included papers. Thematic synthesis is a well-tested method for synthesising qualitative studies Thematic synthesis has much in common with thematic analysis (Braun & Clarke, 2014) which is a common method for analysing qualitative data. Thematic synthesis is a method for identifying, analysing, organising, describing, and reporting themes found within a qualitative data set (Nowell et al., 2017). Booth et al. (2016) have listed 12 different approaches, with each approach developed to accommodate particular needs according to the research question, the area of research and the epistemological position the research is embedded in. However, thematic synthesis was considered the best fit for this study partially as it is not bound to a particular ontological or epistemological position (Nowell et al., 2017) and partially because the clear guidelines on how to engage this method were considered advantageous both in terms of time and clarity during the synthesis. An example of an alternative approach was meta-ethnography (Atkins et al., 2008). As with thematic synthesis, meta-ethnography is interpretative in its approach, however meta-ethnography has a focus on theory generation and ‘same practice hypothesis’ which is grounded on the principle that what one group of participants would do in a particular situation could be representative of another group in the same situation (Soundy & Heneghan, 2022). This approach was rejected in favour of a thematic synthesis which allowed the researcher to approach the synthesis of the studies without specific comparisons between sub-groups, as it was contended that the studies were too diverse to engage this form of analysis.

2.7.7. Conducting the synthesis

The findings and discussion from each primary paper were imported into Atlas.ti a qualitative data analysis program (Woolf & Silver, 2017). Thematic synthesis (TS) followed the three phases suggested by Thomas and Harden (2008): phase one was a line-by-line coding of the primary studies' findings and discussion, with the coding conducted individually on each paper. The coding was conducted in alphabetical order according to the study's first author and each paper added new codes to the synthesis as the paper's particular focus brought new information to the study. Each code had an explanation of what the code included and what the code excluded. For example, the code "trust" included: the young person's perception of trust and reference to trust between themselves as resident and others, for example carer, peer, institution, authority, and family. Excluded: Non-residents' perceptions of and reference to trust, all references to issues not pertaining to trust. In phase two the phase one codes were placed into related groups to construct descriptive themes. Phase three facilitated the evolvement of 'theory-driven' analytical themes, thus this review, as suggested by Thomas and Harden (2008), went beyond the 'data-driven' descriptive themes within phase two. Thus, the review question offered a structure within which it became possible to develop analytical themes as detailed in Figure 1, which shows the coding process.

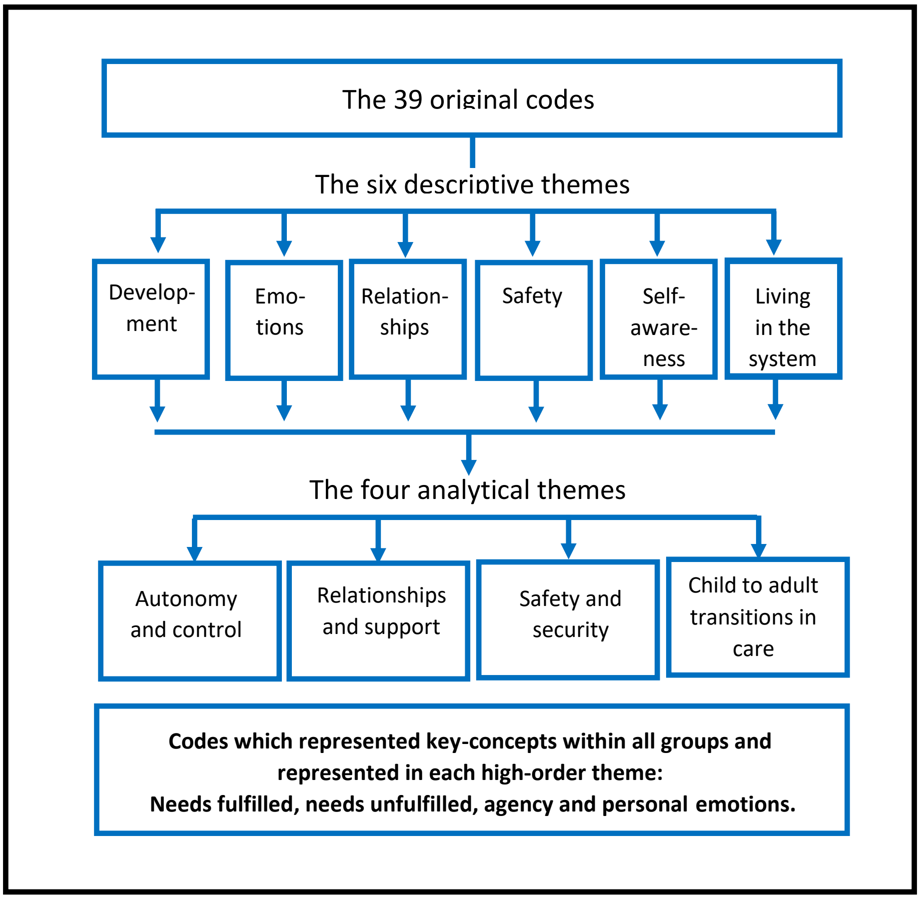

Figure 1. The sequence of steps within the synthesis illustrating how the 39 original codes were collated through patterns to groups, to analytical themes and, finally, to key-concepts with the transcending codes applying to all high-order themes.

The synthesis involved continuous reflection on the context of the original studies (Thomas & Harden, 2008), while maintaining the purpose of synthesising original findings to create findings fundamentally different from those within the individual primary papers (Thorne et al., 2004). The nature of the primary studies, while all engaged with the experience of residential care, offered varying contexts for the elicitation of the primary findings, within methodology, demographics and the research question. Thus, it was necessary to revisit the original findings to ensure a clear representation of the original participant's viewpoint was maintained as analysis developed. To encourage rigour in the maintenance of context for each of the original studies, a reflexive diary was maintained by the researcher during the synthesis phase (Booth et al., 2016).

2.8 Findings

2.8.1 Results of the search strategy

The search strategy located 1726 papers from which, after the removal of duplicates and screening for meeting the inclusion criteria, 12 papers were included for the thematic synthesis (see Figure 2).

PRISMA Flow Diagram

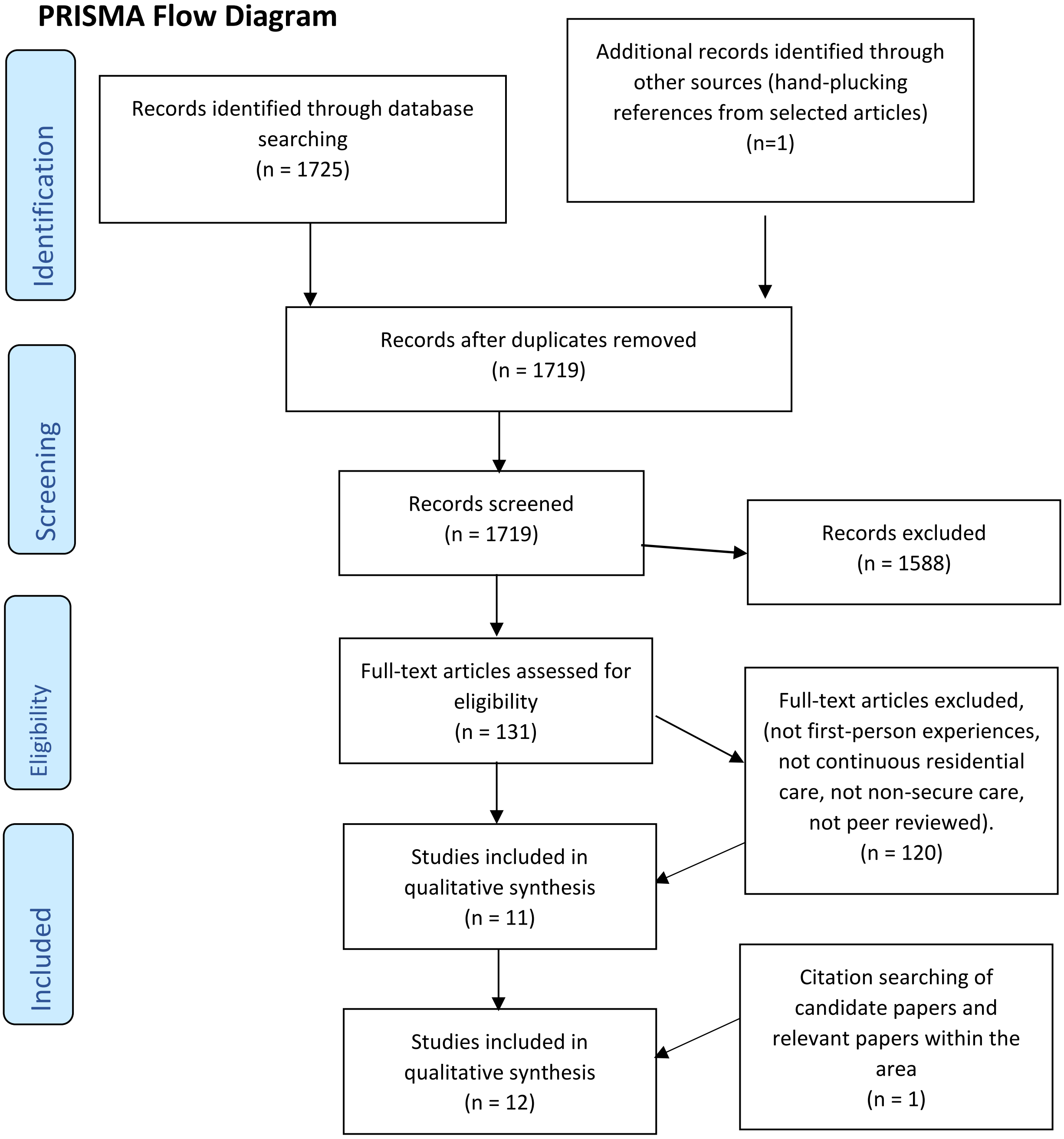

Figure 2. The sequence of steps in the search strategy resulting in the 12 included studies.

2.8.2 Study characteristics

The twelve studies had the following geographical locations: England (3), Scotland (2), Sweden (2), Ireland (1), Norway (1), USA (1), Australia (1) and South Africa (1). The demographic and methodological characteristics of the included studies (Table 3) highlighted the geographical limitations of the included papers as only one paper from a country with a lower economic status, South Africa (Nurcombe-Thorne et al., 2018), could be located. Two papers were mixed methods (Bundle, 2002; Stevens, 2006) from which only the qualitative findings were brought into the synthesis. Equally, the two papers (Barter, 2003; McCarthy, 2016) where both staff and young people's experiences were investigated, only have the findings pertaining to the young people within the synthesis.

Table 2. Demographic and methodological characteristics of the studies included in the synthesis.

Authors	**Number of participants**	**Participant age range**	**Participant gender variation**	**Location**	**Research area**	**Methodological approach**	**Data collection**
Barter (2003)	71	8 – 17* Staff ***	Male: 45 Female: 27	England 14 homes	Exploration of the meaning and context in which young people experienced peer violence.	Qualitative, combining personal experiences with abstract discussions.	Semi-structured interviews. Use of vignettes.
Bundle (2002)	22	13-16	Male: 12 Female: 10	England one home	Clarification of what a specific group of teenagers in residential care see as important in the area of health information.	Mixed methods. Results given both as a narrative and as a tabular count of the different points raised.	Semi-structured interviews and questionnaires. (Only the qualitative section was represented in the synthesis).
Emond (2003)	13	12-17	Mixed gender	Scotland two homes	Exploration of the ways in which young people in residential care offer one another support.	Ethnography	Fieldwork (researcher resident, observatory).
Henriksen et al. (2008)	46	14-20	Male: 23 Female: 23	Sweden 13 homes	Exploration of obstacles and opportunities for establishing a therapeutic alliance between residents and key staff members.	Qualitative research underpinned by psychoanalytical theory.	Semi-structured interviews, with follow-up interview one year later.
Jansen (2010)	12	14-18	Male: 3 Female: 9	Norway four homes	Investigated how youths in residential care understand and are positioned regarding child protection and development.	Qualitative, analysis conducted from a process of subjectivation model.	Repeated (3) interviews over 15 months. First interview life mode.

Johansson and Andersson (2006)	6	15-17	Male: 3 Female: 3	Sweden one home	Exploration of adolescents' experiences of living in residential care.	Qualitative case study. Idiographic approach.	Semi-structured interviews. Retrospective, Interviews.
Kelly et al. (2019)	20	12 -17	Male: 11 Female: 9	USA Group homes and shelter placements	Exploration of youths' own conceptualisation of conceptualize their social emotional well-being.	Qualitative, incorporating use of the developmental systems lens.	Semi-structured interviews.
McCarthy (2016)	6	12-18 *Staff* ***	Not stated	Ireland, one organisation with four addresses	Young people's experience of participation in decision-making processes.	Case study, qualitative.	Semi-structured interviews of both residents and staff.
Moore et al. (2017)	27	10-21*	Male: 18 Female: 9	Australia, three jurisdictions.	To understand how young people, perceive and experience safety in residential care.	Qualitative nested study, utilizing constant comparison.	Semi-structured interviews.
Nurcombe-Thorne et al. (2018)	6	19-21	Male: 2 Female: 4	South Africa, number of homes unaccounted for.	Exploration of participants' perceptions of their experience of residential care.	Qualitative exploratory approach	Retrospective. Semi-structured interviews.
Schofield et al. (2017)	20	20-26**	Male: 13 Female: 7	England, residential care homes run by one organisation.	Investigation of young peoples' experiences of the transition to adulthood from children's homes run by a voluntary sector organization.	Qualitative using narrative analysis	Individual narrative interviews.
Stevens (2006)	24	15-19	Male: 16 Female: 8	Scotland,	The aims of this study 1) develop and pilot a	Mixed methods	Focus group, repeat sessions

				multiple residential care homes	methodology to encourage participation and focus of care environments. 2) Generate information to inform on the monitoring and inspection process.	(only the qualitative section was represented in the synthesis).	and questionnaire

*Only quotations from young people aged >12 were included in this study, conclusions drawn from the youngest participants were not represented in the synthesis.

**Quotations and direct reference to the young people of 26 years of age were not represented in the synthesis.

Staff*** Quotations and findings related to staff interviews were not represented in the synthesis.

2.9 Theory

The use of theory within the included papers varied. The papers by Barter (2003), Bundle (2002), Johansson and Andersson (2006), McCarthy (2016), Moore et al. (2017) and Stevens (2006) were without reference to the studies' theoretical approach. In addition, these studies did not explore their findings in relation to existing theories. A number of theoretical approaches had been used to either inform the papers (Emond, 2003; Kelly et al., 2019; Nurcombe-Thorne et al., 2018) or as a reflection within the findings (Henriksen et al., 2008; Jansen, 2010; Schofield et al., 2017). The theories which were drawn upon included sociological theories; for example, Rogers' person-centred approach (Rogers, 1979) was used in Nurcombe-Thorne et al. (2018); Bourdieu's theories on the pursuit of power and how this influences habitus[4] and practices (Bourdieu, 1989) in Emond (2003). In relation to psychological theories, attachment theory (Holmes, 2014) was used in Henriksen et al. (2008), the Development Systems Theory (Bronfenbrenner, 1977) in Kelly et al. (2019) and theories of resilience (Gilligan, 1999) in Schofield et al. (2017). Finally, Jansen (2010) drew upon discourse theories, in particular Foucault (Kiesling, 2006).

2.10 Thematic synthesis

The analysis identified four analytical themes: *Autonomy and control*: *Relationships and support; Safety and security;* and *Child to adult transitions in care.*

Autonomy and control

This theme examined issues related to the young people's perspectives on the values attached to living in an institution. The findings in this analytical theme were primarily sourced from the papers: Bundle (2002); Henriksen et al. (2008); Jansen (2010); Kelly et al. (2019); McCarthy (2016), and Nurcombe-Thorne et al. (2018).

Some of the young people held the belief that they lived in an environment with excessive and unnecessary control with limited freedom of movement and few opportunities for shared

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[4] Habitus is a term proposed by Bourdieu to describe an integral part of behaviour which is observed as a 'way of being': including ways of seeing, moving, talking, etc.

decision making. However, some of the young people experienced the opposite, an environment where co-operation with carers facilitated a perspective of prospering while in care.

While none of the papers highlighted material needs such as clothing, food or shelter. Within this theme the unmet needs were conceptualised by the young people as being rooted in institutional and authoritarian control. Across the papers were examples that, within residential care, shared decision-making was not experienced as normative. A participant from McCarthy's (2016) stated:

> … I've never been in a situation where a social worker makes a decision and you say "Well, I'm not really happy about that." I've never heard them say "well, maybe we can negotiate". It's "well, that's the decision, that's it". (McCarthy, 2016, p. 375).

As this quotation suggests, control was reported by some young people as problematic and the lack of freedom of movement with the constant expectation of following a timetable was experienced as constricting. The participants in the studies also offered insight into the additional control placed upon them by external authorities, who were not present in their daily life within care, but had the capacity to exert influence on the young people as they monitored and judged progress; as explained by this young person in Kelly et al. (2019):

> My case manager comes all the time and talks to me and checks on how I'm doing. She then tells the Judge if I'm doing good or not. The Judge then decides when I get to go home. If she tells the Judge I'm doing good then I may get to go home (Kelly et al., 2019, p. 260).

Equally, control of freedom of movement was reported as problematic for some of the young people, as explained by this young person in Nurcombe-Thorne et al. (2018):

> The thing is, I have always loved my independence … and [the CYCC: child and youth care centre], I'm going to describe it very clearly; it's like a mini jail …

> and those walls are like prison walls and you cannot get out unless the warden comes, puts you in the car, and takes you out … or a friend comes and fills in a hundred forms and then only can take you out." (Nurcombe-Thorne et al. p. 643).

Additionally, for this young person in Kelly et al. (2019) limitations on freedom of movement were coupled with a general feeling of being apart from wider society and usual activities such as shopping and connecting to others via a cell phone: "It would be nice if I could have friends over to the house like other kids or go to the mall. I can't even have a cell phone." (Kelly et al., 2019, p. 260).

In addition to experiences of control from carers and authorities the young people perceived control over where they were placed as stressful which in turn impacted on the young person's well-being. For example, participants in Nurcombe-Thorne et al. (2018) perceived a direct link between the care home's control of where they lived and the experience of not belonging, as explained by this young person:

> Changing house-parents all the time … was difficult. And most of the time it was because of your age. And then [in] that [new] house you [are] going to be the newest or youngest again. Um … to move from house to house, I have to say, was not so nice. Mmm … you don't feel like you belong anywhere. (Nurcombe-Thorne et al., 2018).

However, the young people who related the experience of joint cooperation with their voice being heard offered a more positive experience, as explained by a young person in Henriksen et al. (2008):

> My KSM (key staff member) designs my treatment plan and then we talk about it together. He is helping me to plan for the future, and he got me a spot in a practical vocational training programme. My KSM really cares about me (Henriksen et al., 2008, p. 154).

While this theme includes examples of constructive cooperation between young people and residential care, which were related as a positive aspect of residential care, it also identified the experience of reduced well-being through limited freedom, unexplained decisions, and concerns regarding the outcome of decisions about the young people over which they had no influence.

Relationships and support

This theme examined issues related to the young people's relationships and how the young people experienced support as they integrated with those around them. The findings in this analytical theme were primarily sourced from the papers: Bundle (2002); Emond (2003); Henriksen et al. (2008); Jansen (2010); Johansson and Andersson (2006); Kelly et al. (2019); Moore et al. (2017); Schofield et al. (2017). Relationships with peers were perceived for some as one of the benefits of residential care and for others burdensome. Equally relationships with staff were recalled with variation, some of the young people experienced a supportive relationship with staff while others found this relationship challenging. Two further relationships are discussed in this theme: family relationships and non-care peer relationships. In both instances these relationships appeared to be of less importance to the residents than those they encountered with staff and peers.

The shared peer situation was experienced by many as a positive aspect of residential care, giving a sense of community, as well as a safety net in adverse times, as explained by a resident in Emond (2003):

> You're never by yourself, you can always find someone that understands you, there's always someone you can trust, you know like one of the residents so that's nae (not) so bad (Emond, 2003, p. 328).

While examples such as the one above were well represented in the papers, not all peer relationships were positioned as positive. In the papers investigating safety, peer relationships were sometimes experienced as a source of fear and insecurity.

Within this theme loneliness and exclusion emerged as negative parameters of residential care. For example, loneliness was connected by this young person to feeling different from other residents: ‘‘I’ve experienced things that I can’t share with others, feel like an outsider. I can control my distress better and keep a lot of things inside myself’’ (Johansson & Andersson, 2006, p. 314). For some of the young people loneliness was connected to the experience of not being close to the staff in a familiar and family-orientated fashion, as stated by this young person: “Nobody feels like family, and I feel like I am something that could be thrown away. I just need to know that I matter ya know? The staff always cook dinner, but what about how I'm feeling?” (Kelly et al., 2019, p. 260). Thus, the lack of family life was perceived as uncaring and alienating.

Relationships with carers were varied. Experiences of carers being supportive and understanding were evident in the findings, as portrayed by this participant in (Schofield et al., 2017):

> They help you realise that you can do things and you might act like a spoiled brat and you might not want to go to school, you might get kicked out of school but they.... sort of try and tell you, “You can do that” –they don’t give up on you (Schofield et al., 2017, p. 786).

However, the establishment of a positive relationship with carers was not always straightforward for the young people. Moore et al. (2017) reported how the young people felt that building a rapport with staff was difficult - there was always the risk of getting moved or rejected. Equally, just as young people could get moved from home to home, so could carers. Moore et al. (2017) suggested the young people offered the experience of continual rejection and abandonment as a rational for avoiding further relational commitments. In addition, the findings include the identification of an additional group of young people who, while they accepted their time in care, did not perceive a need for relationships with the carers they met. This is exemplified by a quote from a participant in Henriksen et al. (2008): “I could manage without them also” (Henriksen et al. 2008 p. 153).

Relationships with the biological family were also perceived as complex, with the need to maintain contact, visit and interact with family expressed as being important for some of the young people. However, few direct references to the biological family were given. Most references to close family were connected to support concerning social services, legalities and evaluations of family and residential care communication.

Friendships outside of residential care were rarely mentioned, with the findings suggesting a general avoidance of relationships outside their immediate context and family. A suggestion of collective isolation from family and the wider society was represented across the papers. The only exception to this were some of the participants in Kelly et al. (2019) who reported a commitment to mainstream education, which appeared to facilitate a more integrative approach to society outside of residential care.

Different effects of being placed in residential care on relationships, where peers were lived with as pseudo-family members, were experienced. For some of the young people there was a strong fellowship through being in the same situation. For others these contacts were hard to find, and loneliness became a part of the experience.

Safety and security

This theme summarised young people’s perspectives of how safe they felt in their care home and what was perceived to impact their perceptions. The findings in this analytical theme were primarily sourced from the papers: Barter (2003); Moore et al. (2017) and Stevens (2006). Within this theme the recall of experiencing violence is discussed as well as the recall of living in a residential care home with a culture which encouraged the sense of feeling safe and secure.

This theme was well represented across all papers. While two papers were dedicated to investigating aspects of safety in care, the remaining papers had findings which positioned safety as an important factor for young people in residential care. While none of the papers reported any incident of physical abuse by staff, physical and psychological violence from peers appeared common.

For the young people who lived in homes where violence was habitual, violence was positioned as both a norm and a necessity. To be perceived as strong enough to avoid being a victim was explained by this participant: “I think that if you stay in resi [residential care] long enough you either become a bully or a victim. It's just how it is. You do it so you don't get bullied yourself” (Moore et al., 2017, p. 215). However, while peer violence was reported as a norm it was not considered a natural aspect of peer relationships generally; for example, the young people in Barter (2003) expressed the belief that this was unique to living in care. They also believed that residential care should be safer than home, and in this respect felt underserved by residential care.

Violence was experienced psychologically as well as physically. Abusive language, personal verbal attacks and witnessing violence on others suggested trauma from these events had impacted upon well-being, as stated by this young person in Barter (2003):

> I think having names called to you is worse… because it hurts you more and it’s, like if you had a fight and you cut yourself, the pain goes and it heals, but having, being called whatever is always at the back of your head. (Barter, 2003, p. 43).

Moore et al. (2017) suggested that the older participants in their study believed that the impact of witnessing violence limited a sense of safety and reported that some participants felt anger when peers were not protected as well as experiencing re-traumatisation when witnessing self-destructive or painful behaviours from peers. This was explained by this participant in Moore et al (2017):

> Actually, one of the worst things that ever happened in our … unit at … was when … one of the younger boys that was there, he had problems, but the workers knew that that day was going to be a hard day for him, but they didn't keep an eye on him. We walked in, threw our bags in our room, we got into the toilets to a suicide scene … thankfully he survived, but not the safest or best thing to walk in on … We weren't offered counselling, but I ended up seeking out counselling when I was 19 for that and other issues … they could have dealt with it better. (Moore et al. 2017, p. 215).

In addition to reports of violence from peers, the young people also reported experiences of staff utilising hierarchies to exert control within residential care and, equally, reports of staff waiting before intervening when peer fights occurred. Such experiences were positioned as stressful and causal of a continuous anxiety.

However, there were also reports of homes where residents and staff were united in building a home where violence, bullying and oppression did not happen. Equally the young people acknowledged the importance of both privacy and contact as necessary parameters for safety, as this young person from Stevens explained: “I feel safe because I’ve got a lock on my door….The staff come and speak to you and that makes you feel safe and secure. It’s good in there.” (Stevens, 2006, p. 63). This quote suggests well-being is established through the establishment of a safe space where staff were positioned as trusted, respectful of boundaries and welcome.

Child to adult transitions in care

This theme examined the young people’s experiences of maturing through late childhood, adolescence and early adulthood within the context of residential care. The findings in this analytical theme were primarily sourced from the papers: Schofield et al. (2017); Henriksen et al. (2008); Kelly et al. (2019); Nurcombe-Thorne et al. (2018) and (Schofield et al., 2017). This theme revealed how some of the young people who reported satisfaction with their development in care also reported a positive attitude to transitioning out of care. For some of the other young people their belief in their ability to cope with transitioning out of care was perceived as unrelated to the efforts of their care home. The last part of this theme concerns the young people who accounted for this phase in their lives as burdensome, as they did not believe they had the necessary resources to achieve a comfortable transition to life beyond care.

The findings within this theme generally came from the older participants who offered a well-considered evaluation of their maturing and the transitions they navigated. The findings suggested the young people who were satisfied with residential care offered positive narratives of maturing and an evolving capacity to make decisions they believed would enhance their future prospects. Schofield et al. (2017) noted a link between the establishment of a trusting relationship between the young person and carer and the gaining of an appropriate sense of agency whereby positive transformation became possible. In addition, the findings revealed that the young people who had achieved scholastic success reported how effort and agency gave progress towards their goals, as told by this young person in Schofield et al. (2017): “At the time I had no intention of going to university, but she (worker) said, “Well why don’t we put it in your Pathway Plan?” (Schofield et al., 2017, p. 785). This young person related how goal setting could be a cooperative process where carers could encourage a continued focus on progression and achievement.

However, for the young people who felt poorly placed in residential care, the opposite appeared to be in action. In addition to the perception of being placed in the wrong home not being where they wanted to be in their developmental trajectory, they had an uncertainty towards their future situation. This compounded the experience to being one of both being left behind and lacking the desired help. This, in turn, as suggested by this young person in Kelly et al. (2019), gave rise to a sense of hopelessness towards the future: “I guess I just don't know where I'll be when I turn 18 though or what I need to go do. I'm not like the other kids in school who know what they're doing. I need more help.” (Kelly et al.; 2019, p. 259).

Not all the young people who felt they had gained maturity and development in terms of educational success felt this had been facilitated by their experience in residential care. Some participants believed that the maturing they had achieved was simply a part of the ageing process, as suggested by this young person in Henriksen et al. (2008): “It just happened by itself, I think, it’s not due to them, it is because one matures, gets older” (Henriksen et al., 2008, p. 153). Growth was not only measured by the young people as achieving instrumental success but also the experience of being able to regulate emotions and behaviour, suggesting that as the young person matured, they identified growth in their social skills.

Transitions in residential care also encompassed the transition out of care. In Schofield et al. (2017) the experience of leaving care emphasised the importance of a continuing care presence after residential care. The explicit gratitude for this service suggested that transitioning out of care was a long process where help was needed. In Nurcombe-Thorne et al. (2018), the young people were aware of the lack of help in this transition and gave voice to their concerns.

The findings in this theme demonstrate the young people’s ability to reflect on their life course. Some identified the benefit of a good relationship with staff, while others identified burdensome worries and a perceived future, they did not have the resources to survive.

2.11 Discussion

The presented themes demonstrated considerable variation within the young people’s experiences from gratitude towards the help they received in care, to the experience of frustration regarding the expectation of fitting in and being cooperative in an environment where they experienced cooperation as challenging. These varied findings were noted across all papers and superseded setting, primary research area and age. Thus, it could be suggested that successful residency and outcomes in residential care are connected to the ability of the care home to engage with the young person in a way where it becomes attractive for the young person to engage positively with residential care. This is an important factor when investigating residential care as it raises questions towards the ability of the individual residential care setting to adjust expectations and methods to accommodate the individual needs of each young person.

The findings revealed a group of young people who were at homes where they, quite possibly due to the actions of their care facility, had developed an understanding of being responsible for their own behaviour. This group also signalled an ability, within the context of their residential care home, to engage with the help offered and continue this positive development. This group were in a position and context to practise agency (Thoits, 2006). They demonstrated an experience of congruency between their perceived needs, development and the opportunities provided by a residential care placement that could support their development of agency. The young people who spoke of scholastic achievement and finding jobs offered an additional insight into their accounts of adjusting their mindset to accommodate the actions needed to support their goals. The second major group within the findings were the young people who experienced the help provided as inadequate. When this occurred, an alternative outcome of reduced well-being and exclusion was identified. These young people experienced a situation where they struggled to mature and appeared to be in a context where help was limited and the opportunity to develop the skills to be purposeful and agentic as they matured was perceived as inaccessible.

The core properties of agency (the belief we have control over our own life) are complex and acquired through maturing from childhood to adulthood (Bolin, 2015). Thoits (2006) argues for a relationship between good mental health, problem-solving and the ability to exercise agency. Consequently, a finding from this review is that this group, who are young and therefore lack experience in problem-solving and have a lower sense of well-being, possibly with mental health problems, will have greater difficulty in being agentic in decision-making. Thus, the findings suggested that some of the young people lacked the necessary help in situations where agency was expected with a follow-up experience of a negative cycle of struggling with agentic application to events which resulted in disappointment and an increased belief of not being well-placed in care.

Positive well-being was reported as a result of a close supportive relationship between the young person and their carers, when good peer relationships were established and when success could be measured through meeting normative milestones such as good school grades. Positive behaviour, including emotional control, was also perceived as enhancing well-being as this achievement was perceived as enabling stability and social inclusion.

However, the predominant tone within the findings was towards negative emotional states such as fear, anger and sadness which were either directly represented in the findings or represented in the discussion sections within the papers. These were explained by the young people partially as an inevitable part of residential care and the life course of living outside a family unit but also, for some, as a direct result of violence from peers, perceived indifference from the authorities and lack of interest and understanding from carers. The arguably over-representation of these emotions within the young people’s experiences was connected both to instrumental actions such as control and decision-making by others and towards internal cognitions and emotions expressed as worry, loneliness and self-doubt.

For the young people who had an over-representation of negative psychological states, the outlook for a stable adulthood was reduced (Westermair et al., 2018). This group can arguably be positioned as under-served by the system of care. For this group residential care did not increase their emotional stability (Stikkelbroek et al., 2016) and, simultaneously with this, residential care appeared to increase negative associations within the realms of trust and safety.

Friendships were considered a major benefit of residential care, offering solace in often difficult situations. Friendship was positioned as giving a sense of belonging, beyond what the relational social capital (the quality of a positive relationship [Read & Laschinger, 2015]), between the young person and the carers could offer. The benefit of peer relations was however marred by experiences related to both peer violence and traumatic events occurring in residential care. Violence in care, as well as trauma connected to pre-care situations and the sequence of events connected to the transitions in and out of care, led to an aura of insecurity and fear for some of the young people. Trauma in childhood can have severe consequences for adult life (Callaghan et al., 2019), including the sense of a foreshortened future, whereby the individual holds a perception of a future bereft of positive meaningful events (Ratcliffe et al., 2014). In addition Callaghan et al. (2019) argue that children who have experienced violence have anxieties towards a future where violence is feared to be continuously repeated.

This discussion raises issues relating to how young people in residential care are either progressing or failing to thrive. However, in-between these two groups, a third group was identified; this group gave the appearance of non-engagement with the care home in which they resided. While the findings are comparatively scarce from those within this profile, Henriksen et al. (2008) identified some young people who established an exchange between compliance with residential care and material gain. Whether the lack of information from this group is connected to their reticence to participate in research or because it was only the more extreme views of residential care that were asked about and therein presented in the primary papers is not known from the available information.

Finally, only participants in one paper, Nurcombe-Thorne et al. (2018) mention therapy with a psychologist. Whether this is omitted because the young people did not receive this offer, the study they engaged in did not ask about this form of help, or they did not wish to discuss this part of their life is information unavailable to this review.

2.12 Limitations

The papers were generally located in countries with western values; thus, the findings of this systematic review do not reflect all cultures. This review has only included qualitative studies, findings from other methodologies are therefore not represented in the findings. Young people in residential care are a vulnerable population, choosing to share experiences may be unattractive (Liamputtong, 2007) and therefore it is doubtful that all the experiences the young people have lived through in residential care will have been revealed in the primary studies, which in turn may have affected the conclusions drawn in this systematic review. In addition, by synthesising other researchers' papers a secondary analysis has been conducted, thus, though the interpretation of other authors' interpretations, limitations on the representation and understanding of the original participant's actual views and beliefs could have occurred (Sandelowski, 2008). Finally, the decision to include studies where the participant age span was 12 – 25 years of age has meant that this review is only able to offer a broad insight into the experiences of residential care rather than a precise insight into age-related development groups within the care system.

2.13 Conclusion

Each of the four high-order themes described specific benefits and burdens when living in residential care. In summary the main findings of this review suggest that while experiences in residential care are varied, with positive experiences related, policy and practice makers need to investigate further: the impact on the young people when measures are enacted to ensure safety in care are perceived as controlling and impact on the young people's well-being; how to limit further the experience of being subjected to or witnessing violence within residential care; and, lastly, the at times, uncertain transition out of care needs further consideration by policy makers to ensure that the young people are suitably supported during this phase of their lives.

This review has stimulated a discussion on how the young person's agentic capacity (Bolin, 2015), as well as their general mental state, can be affected by the young person's residential care facility's approach to support. This concern allies with the report from The International Work Group for Therapeutic Residential Care (Whittaker et al., 2016), which has highlighted the need for high-intensity treatment services for the most challenged children and youth within the care system.

The concluding comments on the findings from the review and how they align with current research have offered valuable insight into the current situation within residential care for youths. The findings on the perception of control and how this has impacted on well-being in residential care and on witnessing or being involved in acts of violence in residential care have been integrated into the interview schedule for the empirical study. Furthermore, the raised concerns from the participants in the review on transitioning out of care at the age of 18 have offered a relevant lens to further explore, in the empirical study, how transitioning out of care has been experienced when extended care beyond the age of 18 years has been experienced.

Chapter 3

Methodology, methods and recruitment

3.1 Introduction

This chapter aims to explore the choices made during the selection and implementation of the research approach used to answer the research question:

How do young adults experience and understand life in Danish therapeutic residential care?

When conducting high-quality social science research, the selected methodology provides a framework from which the type of knowledge which is needed to answer the research question can be accessed. Mackenzie and Knipe (2006) suggest that the term methodology encompasses the overall research approach which is linked to the paradigm or theoretical framework in which the study is embedded. In addition, Mackenzie and Knipe (2006) argue that this should not be confused with the term "methods" which refers to the actual tools used to gather and analyse the study's findings.

Bourgeault et al. (2010) discuss the relevance of exploring the philosophies and theories that underpin a methodological tradition to ensure compatibility between the research question and the chosen methodology. Thus, decisions concerning the methodological approach of this study have involved a detailed exploration into which philosophies and theories could procure an appropriate methodological approach. The selection of the methodological approach will lead the researcher towards choices regarding a compatible method or choice of tools from which the sought knowledge can be attained (Mackenzie & Knipe, 2006). Therefore, it was necessary from the onset of this study, to consider the existing knowledge within this domain, including concepts and theories (Bryman, 2016) and the type of knowledge that would be required to answer the research question.

In addition to these considerations, it was important to consider the paradigm or shared belief system (Morgan, 2007) which permeates the selected research methodology. Within research, there are a variety of paradigms, each offering a particular combination of ontological and epistemological position (Bunniss & Kelly, 2010). Ontology is the study of the reality of existence, exploring what exists independently of our existence and what exists through our existence (Marsh & Furlong, 2002). Epistemology is the study of knowledge, working with questions to define what knowledge is, where it can come from and what can inhibit new knowledge from being attained (Ashcroft, 2004). The ontological and epistemological position of the researcher should inform the research's methodological choices (Bunniss & Kelly, 2010).

This study has sought to find knowledge by enquiring into the lived experiences of a group of people who received professional help in a particular setting. Thus, this study required a methodological position founded on a philosophical viewpoint that posits that through engagement with the individual's personal account of their lived experiences, relevant findings can be gathered which can answer the research question. The qualitative, non-numerical approach fits with this position (Remler & Van Ryzin, 2014). The alternative quantitative approach was, at this stage, rejected as this approach seeks to measure and quantify data through numbers (Bunniss & Kelly, 2010). While a quantitative enquiry could reveal relevant information in terms of testing hypotheses, or studying statistical predictors of well-being, it would not lead us towards understanding the lived experience of residing in therapeutic residential care. Thus, this study is placed within the qualitative paradigm or world view (Silverman, 2013).

While qualitative research does not have a single definition (Aspers & Corte, 2019), qualitative research contends, within its shared belief system, that it is possible through the act of asking people what they think and feel about the meaning attached to an experience, the phenomenon or social situation can be better understood (Bowling, 2014). In addition, Bowling (2014) argues that qualitative research accepts that lived lives can be complex and unstructured. Thus, when the research focuses on exploring the experience of living in care, the complex interwoven series of events and experiences which form our memories, beliefs and actions can be examined as they are understood by those who have experienced the phenomenon.

3.2 Critical realism

The ontological and epistemological claims inherent within critical realism are presented here as the paradigm most suited to the aims and objectives of this study. Critical realism (CR) was developed by Roy Bhaskar, in collaboration with a number of British social theorists during the 1980's (Gorski, 2013). CR has its origins in philosophic questions towards ontology and the nature of the natural and social world (McEvoy & Richards, 2003). Bunniss and Kelly (2010) suggest that CR can be used as a paradigm to envision how things could change for the better; this position fits with the study area where existing research points towards poorer outcomes for the users of residential care in comparison with their peers (Vinnerljung & Sallnäs, 2008). In addition, Bunniss and Kelly (2010) suggest that CR offers a worldview that is applicable to studies intent on the representation of diverse and under-represented views. This also fits well with the findings from the undertaken systematic review which found relatively few studies conducted within the last 30 years. Finally, the results of the review suggested a variation in the young people's experiences.

Critical realism has a realist ontology; this implies that at least some parts of reality exists independently of the human mind and therefore can operate independently of our awareness (McEvoy & Richards, 2003). However, we are never in a situation where there is only one defined truth or where one aspect of reality can be applicable to everyone. This ontological understanding has also been argued to be compatible with a relativist epistemology (McEvoy & Richards, 2003). This is an important distinction as it is often suggested that a relativist epistemology is more compatible with a non-realist ontology (Goldman, 2010). A relativist epistemology implies that our understanding of events is relative to how much information is available to us, within which there is the caveat that we can never know the whole truth and that available knowledge is continuously stratified within social systems (Fletcher, 2017). Within this approach the empirical (what is observable), the real (the unobservable qualities of structure or power) and the actual (which is concerned with examining what may happen should the real be activated) (Edgley et al., 2016) are all under observation to explore how they interact with each other. Fryer (2022) argues that CR offers an explanatory mode of investigation, in that we should look for causal explanations within our research. CR is concerned with the engagement of three concepts of reality when recalling past experiences; experiences, events, and causal mechanisms (Fryer, 2022). For example, when a young person must move to a new home; the empirical, the observable, is the actual move. The real, the unobservable, is the power and structure the authorities have on the decisions regarding the move, and the actual is the young person's experiences of how the move felt to them, such as experiencing relief (Fryer, 2022). Thus, critical realism offered a lens where reality could be understood through a series of layers, and through which the meaning making of the experiences of living in residential care could be further explored. The ontological and epistemological position of this study posits, therefore, that the natural world functions as a multi-dimensional open system, whereby temporality, environment and social situations all contribute to how people understand and experience the events in their lives (Benton & Craib, 2010).

In summary this study is embedded in the critical realist approach which contends that knowledge is fallible, as the real can be observed and experienced from different viewpoints and at different levels and that subjective evaluation is unavoidably embedded in the information that is available to use.

3.3 Interpretative phenomenological analysis

The study's ontological and epistemological position is also compatible with and complementary to the study's methodological choice of interpretative phenomenological analysis (IPA) (Tuohy et al., 2013). IPA is a methodological approach committed to understanding the experiential within qualitative research (Smith et al., 2009). In addition, IPA's origins were in psychological research with the earliest work done in health psychology. Smith et al. (2022) argue for the use of IPA within applied psychology or 'psychology in the real world' (Smith et al., 2022, p. 4). IPA has three key areas, all of which have a focus on the individual's lived experience of a particular phenomenon:

- Phenomenology: the philosophical approach to the study of experience, a scientific approach which seeks to explore and understand what the experience of being human is like within the lived world of the individual (Smith et al., 2009).
- Hermeneutics: the theory of interpretation, herein the double hermeneutic that occurs when the participant interprets their feelings/memories/physical reactions/thoughts on the given phenomena and the researcher's ability to understand as closely as possible the participant's meaning making as they relate their experiences (Smith et al., 2009).
- Idiography: this is the focus on the particular, which is an alternative to most quantitative nomothetic approaches which make claims towards populations or groups when establishing general laws of human behaviour (Smith et al., 2009). In idiography the onus is on exploring, analysing and representing the individual's experience of life. This commitment to the individual is operated on two levels: the sense of detail and therein the depth of analysis and how particular experiential phenomena have been understood from the perspective of a particular person in a particular context (Smith et al., 2009).

Alternative approaches to analysis aligned with the theoretical position of this study could have been thematic analysis (Braun & Clarke, 2012) and narrative analysis (Bourgeault et al., 2010). Thematic analysis engages in the identification, analysis and interpretation of patterns or themes within chunks of text, including interview transcripts (Braun & Clarke, 2012). Narrative analysis uses the narrative or story of the individual as the data from which a careful analysis of how the life story is structured is undertaken. This methodology places emphasises on the use of language to explore and understand the meaning within each narrative. Both these methodologies are widely used within qualitative research and on evaluation of their merits were considered to have certain methodological strengths which could make them relevant contenders for this study. They were, however, rejected in favour of IPA. IPA would encourage a fuller understanding of each participant's experiences when compared to other methodologies and encourage the development of themes which could illuminate areas of common experience and areas of disparity within the participants accounts (Smith et al., 2022).

3.4 Ethics

This study received ethical approval from Lancaster University's ethics committee on the 23rd of July 2020 (see appendix IV and V). The principles of research ethics are guided by moral principles to ensure, at all times, from the inception of the research endeavour through to completion, as little harm or even inconvenience to anyone or thing occurs within the research's context (British Psychological Society, 2021).

The methodological framework of this study required close cooperation and interaction with vulnerable young adults. In addition, the recruitment phase of this study required a close cooperation with the residential care homes. The residential care homes' staff could be drawn into conversations if the young people were curious about the poster (Appendix VIII), and what participating in a study might entail. To ensure that the prospective participant was able to practise autonomy in their decision making, the researcher talked to the relevant line-managers regarding limiting the risk of coercion; support workers may believe they are acting in a particular person's interest by either leading them towards participation or away from it (Aluwihare-Samaranayake, 2012). While it was not possible to avoid all influence from other people towards choices made regarding participation, it is believed that through clear and transparent communication throughout the recruitment process, the young people felt empowered to make their own decision on whether to contact the researcher or not.

Following initial contact with the researcher, onus was placed on ensuring that any prospective participant was sufficiently informed about this study and their rights. A pre-interview meeting was individually conducted with each prospective participant. Emphasis was placed during the pre-interview meeting on any consent to participate occurring through genuine choice. The right to withdraw was explained again both before and after each interview to ensure participants felt they could withdraw, in the knowledge that they were exercising their rights and, in effect, looking after themselves.

The often-perceived difference in power between researcher and participant (British Psychological Society, 2018) was inevitably a part of the interview process. While the prospective participants were, due to their age and living arrangement, in receipt of directions from carers as well as authoritarian figures, they were perceived to be ready to exercise their autonomy. They were in this sense a non-captive audience as opposed to for example offenders residing in criminal justice systems (Quinlan et al., 2022). It is the researcher's belief that attempts were made to mitigate the evident power imbalance. The participants were experienced as capable and interested in telling their stories. They appeared to understand their rights; indeed, these rights were used as one participant comfortably avoided answering a question during the interview and one participant asked at the end of the interview if we could redo the interview, which was accommodated. Finally, one possible participant changed his mind following the pre-interview meeting and withdrew from the study. All the participants had the opportunity to have a carer with them during the interview if they wished. Only one participant requested this[5], and the researcher believes that this did not affect the interview process, or the quality of the data gathered during the interview.

Following the completion of the interviews, the researcher became more aware of the potential benefits of this form of engagement. All participants described satisfaction through having a chance to be heard and some expressed a belief that talking about their time in care had helped them understand the events they had experienced which, at the time, had been more difficult.

3.5 Methods

One of the advantages of engaging IPA as the methodological approach for a research study is that it has a series of well-established guidelines for the planning and execution of IPA research (Smith et al., 2009). This well-considered framework underpins IPA's intent on finding the individual lived experience of the phenomenon. A framework is established to facilitate a deep exploration into the participants' accounts of their experiences, thus, revealing the essence of the individual idiographic accounts of the experience.

IPA does not have a rigid approach to data collection, however the concern of IPA, the detailed examination of personal lived experience (Eatough & Smith, 2017), required an in-depth approach to data collection whereby the intent to elicit richly detailed first person

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[5] The carer was a social pedagogue working for the company in which the participant resided. The carer was not involved in the conversation. However, on two occasions the carer helped the participant remember the order of events as the account unfolded. This prompting has been removed from the clean transcript.

accounts of experiences and phenomenon could be achieved. IPA studies have included various forms of data collection including diaries (Morrell-Scott, 2018), focus groups (Tomkins & Eatough, 2010) and chat dialogues (Hughes, 2009). However, it was decided, due to the vulnerability of the study's population and the possible divulgence of stressful memories, that the most common, and therein well-tested form of data collection, the individual semi-structured interview, would offer the best opportunity to gather rich narratives of the experience of residential care.

3.5.1 The semi-structured interview

The semi-structured interviews allowed the researcher and the participant to engage in real-time dialogue (Eatough & Smith, 2017). They offered a flexibility which gave room for original and unexpected issues to arise within the dialogue which, in turn, enabled the researcher to deepen the enquiry with additional questions and dialogue. One of the aims of the enquiry was to gain entrance to the participant's lifeworld by listening to their experiences of the events which were important to them and their experience of their reactions to these events. Smith et al. (2022) refer to the term in-depth interviews, whereby the interviewee is encouraged to tell their own stories with their priorities and concerns central to the discussion. The interviews were guided by a schedule or guide (Appendix VI).

The interview guide was formed with the intent of encouraging a relaxed discourse on a very personal and possibly stressful account. The questions were chronological whereby the first question was regarding the first encounter with residential care, followed by questions regarding living in care, transitioning to adulthood and at the end reflecting on the experienced journey through care. However, during the interviews the spontaneous interaction between the interviewee and the questions meant that in some instances questions were omitted and then returned to when the opportunity arose. The conducted systematic review had given valuable information towards concerns on autonomy, carers, violence and peer relationships. These were integrated into the interview guide. While it can be argued that a guide may limit the interviewee's choice of direction within an interview, a guide which is well-planned and tested should facilitate a conversation with a purpose (Smith et al., 2022). Indeed, it was the purpose of the protocol to encourage a breadth of discussion which could facilitate, where possible, the participant's revelation of their unique experiences. Additionally, while it is difficult for any researcher to anticipate exactly how an interview will unfold (Alase, 2017), the interview schedule contributed to the quality of the interviews as it enabled the interviewer to have a continuous overview of which areas had been covered and which still needed to be explored. Finally, as it was anticipated that during the interviews there may occur elements with sensitive revelations, the interview guide became a tool which could help the interviewer adjust the direction of the interview thus avoiding unnecessary participant stress or irrelevant disclosures in relation to the study's aims and objectives.

3.5.2 The pilot study

Following the integration of the results of the systematic review, the interview guide was piloted with a young person in the aftercare programme. The young person considered the interview guide appropriate in terms of clarity and what was asked. The young person helped the study's advancement by making important suggestions towards transparency and ethics. The young person explained the importance of seeing how the recording was made and uploaded onto Lancaster University's secure site. In addition, the pilot participant conveyed the importance of not conducting an interview over too long a time. The 35 minutes the pilot interview lasted was considered by the participant to be quite long. The pilot participant offered a strong opinion on the importance of the research and asked if it was possible to participate in the actual study. This request was in accordance with the ethical approval of the study and the participant's inclusion as an interviewee facilitated.

3.5.3 Repeat interviews

The format of a single interview was evaluated and the possibility of including a second interview was carefully considered. Repeat interviews have the disadvantage of being time-consuming for both interviewee and interviewer, however they can offer advantages towards achieving a deeper understanding of the entity in hand; this in turn can offer a more rigorous approach (Vincent, 2013). The negative factors of taking time from both the participant and the researcher were weighed against the perceived benefits of expanding the opportunity to decrease any misunderstandings between the researcher and the participant and to strengthen the participant's voice as they were able to revisit and build upon the first interview's transcript. Following a thorough reflection on the advantages and disadvantages of repeat interviews, the researcher decided the advantages were of significant weight and integrated a second interview into the method of data collection.

The second interview was conducted approximately 14 days after the first interview. This gave sufficient time for the participant and the researcher to reflect upon what had been asked and discussed during the first interview. In addition, the participant received an additional opportunity to be heard and feel understood. Moreover, the researcher gained a further opportunity to achieve an understanding of the participant's "objects of concern" and "experiential claims" (Smith et al., 2009). IPA has a focus on the specifics (Larkin et al., 2006), therefore the findings from the first interview could be further investigated to attain the level of intensity and detail which was sought for the in-depth analysis of the individual accounts. This approach encouraged the participants, within the second interview, to either elaborate on areas they may have felt were under-emphasised and reduce the emphasis on areas they considered of low importance. Finally, if the participant wished to remove content from the first interview's transcript, they could do so by crossing out on the printed transcript content they wanted deleted. The process of revisiting the explanations the participant revealed during the first interview exposed an opportunity for the researcher to come closer to the reported lived experience (Elliott, 2005), which in turn enhanced the interpretation of the data and sensitivity to context (Yardley, 2000). While second interviews are not that common in qualitative research, Hollway and Jefferson (1997) have published a detailed account of their experience of using a second interview to investigate fear of crime in a British city. In addition, Vincent (2013) published a paper promoting the advantages of repeat interviews following a study on pregnant schoolgirls. Finally, repeat interviews have been used in IPA studies, for example, an investigation into the experiences of family caregivers of people with amyotrophic lateral sclerosis (Lisiecka et al., 2020).

3.6 Recruitment

3.6.1 Sample and recruitment strategy

IPA is committed to the detailed examination of the particular case (Smith et al., 2009). Thus, in accordance with the principles of IPA, a relatively homogeneous group of participants who had similar characteristics in terms of the research area were recruited as shown in Table 3:

Table 3. The study's eligibility criteria:

Inclusion criteria	Exclusion criteria
Age 18 to 23 years.	All other ages, as they would not be engaged in the aftercare programme.
Currently connected to the Danish aftercare programme.	Young adults on alternative programmes for example within the justice system or programmes for young people with severe physical handicap, as these groups could have had additional experiences outside of care or from a closed care facility.
Minimum of twelve months of residential care prior to their eighteenth birthday.	Less than twelve months in residential care prior to their eighteenth birthday as this would limit the experience of the therapeutic interventions.
Able to converse in either Danish or English	Any other languages.

Due to the study's intention on gathering in-depth, personal experiences, where rich data were attained through close engagement between the researcher and interviewee, a small sample size was considered appropriate. Therefore, it was planned to recruit between eight and ten participants (Smith et al., 2022). Purposeful sampling (Bowling, 2014), was selected as the best fit. It allowed the researcher to facilitate the recruitment of a homogeneous population (Tuckett, 2004). An alternative to this approach could have been a public call, possibly via social media, asking for interest from any young person in the aftercare programme. This approach would have accessed a larger potential participant pool. However, this approach was not possible as residential homes in Denmark do not encourage researcher access to the homes where the young adults live without prior screening of the research purpose and methods.

3.6.2 Recruiting participants

The recruitment strategy has been underpinned by two main factors; firstly the need within IPA to have a homogeneous participant group, whereby only residents connected to the aftercare programme were approached; secondly, the ethical concern of ensuring, as far as possible, that the participants who choose to participate did so without any form of coercion (Dugosh et al., 2010). The process of contacting the homes where the young people lived and the follow-up conversation(s) with the homes kept these two factors in the forefront.

All those who demonstrated interest in participating in the study received at the first interview a thank-you voucher, worth approximately £20, to the Danish chain Matas. This chain sells health and beauty goods. The prospective participants were informed during the pre-interview meeting that this voucher was a token of appreciation for the time they had used and was theirs regardless of whether they chose to withdraw from the study or not.

The recruitment strategy had the following steps:

1. Creating awareness of the study's existence:
   This was done through an endorsement by the organisation, *Landsorganisationen for sociale tilbud* (LOS), the leading private network for child, youth, and adult residential care homes in Denmark. This endorsement included an article on their Facebook site which was available to all LOS members from September 2020. In addition, the study was promoted through the researcher's network within special needs teaching.

2. All the homes which offered aftercare were contacted via e-mail, with an introduction to the study (see Appendix VII). The e-mail included a poster (see Appendix VIII) which the homes were encouraged to print and place where the young people could read it and, if they were interested, respond.

3. In the event of a response from a young person wishing to hear more about the study, the researcher contacted the home to ensure that they were aware of the young person's interest in the study and aware that the researcher would make arrangements

with the young person to visit them at their home for the pre-interview meeting. Time was taken to discuss this issue with the homes and reiterate the importance of autonomous decision-making by the young people. In addition, the conversation allowed the researcher to answer any questions the home may have and give assurances towards the validity of the researcher, Lancaster University and the study.

4. The researcher then contacted the young person and arranged a time to meet with the researcher to discuss the study and to check if they wished for a carer from their home to be present or not.

5. Following this, the researcher met the young person and introduced the study via an information sheet (Appendix IX) in the pre-interview meeting, where the following points were discussed: the purpose of the study; the form of the interviews; how the recording would be done; and how the data would be stored. Emphasis was placed on the importance of understanding withdrawal rights and the possible limitations towards anonymity. Only when this phase was completed, and the researcher truly believed that the young person was comfortable with the arrangements was the young person asked if they were ready to sign the consent form (Appendix X).

The recruitment process was affected by the COVID-19 pandemic, with this study being directly affected by the second wave of the COVID-19 pandemic in the autumn and winter of 2020/21. The planned contact to residential care homes throughout Denmark was suspended until March 2021. Despite this setback it was possible through the pilot study recruitment initiative to recruit three candidates prior to the national lockdown in Denmark in December 2020. Following the opening of Denmark post COVID-19 lockdown in winter 2020-21 the original recruitment plan was re-engaged, with a fourth participant being interviewed in April and the remaining four participants being recruited during late summer and early autumn 2021.

3.7 Data collection

Data were collected from two, face-to-face, in-depth individual interviews, whereby each participant was offered participation in a second interview approximately 14 days later.

3.7.1 The interviews

The interviews were conducted either in participants' residential care home, or, if they were living in an apartment connected to their residential care home, their apartment. The interviews varied in length with the shortest being 23 minutes and the longest being 98 minutes. The mean time for the first interview was 61 minutes, and the second interview 32 minutes. Two participants did not participate in the second interview; Bee's absence was due to COVID-19 restrictions limiting access to her residential care home for over three months and her decision, that a second interview was not relevant. Jene who gave no reason for not wanting a second interview. However, both participants expressed they would like the first interview to be used if the researcher found their interview relevant. Both participants' interviews have been analysed and used in the study's findings.

The youngest participant was 18 and the oldest was 23. The mean age was 20.3 years. The interview process followed the ethics committee approved sequence of events (see Appendix IV and V). The consent form, on being signed by the participant, was photographed by the researcher, using an iPhone 12, and sequentially uploaded onto Lancaster University's safe site. The participant kept the original consent form along with a copy of the information sheet. The recording of the interview was done on an iPhone 12, which was also, on completion of the interview, uploaded to Lancaster University's safe site. This process was carefully monitored by each participant. On completion of the first interview, the interviewer and the participant went through the debriefing sheet for the first interview (Appendix XI) and the participant received their thank-you gift voucher.

The second interview began with a short introduction to the purpose of the second interview and a reminder of the participant's withdrawal rights (Appendix XI). At the commencement of the second interview the young people either read the transcript from the first interview or, if they wished, listened to it being read out by the interviewer. Following this, the young person was asked if they had any comments, with these comments providing a relaxed pathway to reconnecting the interviewee and the researcher. The researcher had, before the second interview, noted on her transcript areas that raised interest for further discussion. It was noted that while the second interviews often took less time than the first interviews the conversations were focused and rewarding with further depth being added to the data.

Table 4. Participant overview.

Name (pseudonym)	Age at interview	Current living situation	Age on entering residential care	Number of moves during care	Situation prior to residential care
Sacha	22	Apartment with visits from the residential care home	13	0	Foster care
Bee	18	Living in a specialist residential care home*	17	0	Biological home
Kris	22	Living in a specialist residential care home*	13	4	Biological home
Marcus	22	Apartment with visits from the residential care home	14	4	Foster care
Caroline	18	Individual house with live in carers	9	6	Biological home
Ben	23	Living in a residential care home	16	3	Biological home
Jene	18	Living in a residential care home	16	2	Biological home
Miker	19	Living in an apartment on a residential care home site	13	3	Biological home

- The residential care home specialised in autism.

3.8 Analysis

The analysis was conducted with a detailed case-by-case approach following the guidelines of (Murray & Wilde, 2020). As with other IPA analysis guidelines, for example Smith et al. (2009), the onus was on encapsulating the individual story of lived experiences and meaning-making by the participant. The decision to follow the guidelines of (Murray & Wilde, 2020) was made following an exploration of the guidelines of Smith et al. (2009) and then undertaking a compare and contrast analysis with the guidelines of Murray and Wilde (2020)The author concluded that both formats contained clear and justified explanations of each stage of the analysis. However, IPA is a methodological tool in constant development, as the theoretical underpinnings of IPA are continuously developed through use, and retrospective analysis of its application (Larkin et al., 2006). Therefore, it was considered advantageous to follow the more recently published guidelines of Murray and Wilde (2020).

The analysis was conducted one transcript at a time. The analysis was conducted in the order of the interviews. Smith et al. (2009) argue that it is acceptable to begin analysis before all data are collected. This argument is justified through one of the principles of IPA, namely, the ability to bracket off all other research activities when focusing on the analysis. A determined effort by the researcher ensured that every attempt was made to see each transcript with fresh eyes. The researcher focused on the voice of the participant when transcribing and the associated ideas that emerged while listening, transcribing, and translating were noted down and then analysed for possible preconceptions and biases the researcher might unwittingly infuse into the analysis. The process of working through each participant's interview as individual case studies with an idiographic focus allowed for analysis to commence after the third interview.

3.8.1 Terminology

The formative planning of this study started in October 2019, whereby the terminology of individual accounts, and the ensuing themes elicited through the analysis followed the terms of that time (Smith et al., 2009). However, in 2022 Smith et al. published a second edition of their seminal book 'Interpretative Phenomenological Analysis Theory, Method and Research'. This publication has encouraged new terminology within the practice and reporting of IPA, which this study has chosen to follow. Therefore, the previous term ‘emergent theme’ is replaced by the term ‘experiential statement’, a cluster of experiential themes are now referred to as Personal Experiential Themes (PETS) and the previously termed ‘superordinate themes’ are now referred to as ‘Group Experiential Themes’ (GETS) (Smith et al., 2022). The purpose of these changes was to, following the guidelines of Smith et al. (2022), further encourage the researcher to remain grounded in the participants’ experiential accounts and meaning making of these experiences during analysis (Smith et al., 2022).

3.8.2 The phases of the analysis

The analysis followed the following five steps:

1. **Transcription and translation**

   The first interview was transcribed in Danish and presented at the second interview. When data from the second interviews were collected and transcribed, the first and second interview were merged into one text file. Following the first transcription and analysis the author decided, after consultation with the supervisor team, to translate directly to English and perform the analysis in English. While Van Nes et al. (2010) recommend remaining in the original language to ensure the most accurate representation of the participant’s narrative, the researcher noted in her research diary how when working and thinking in Danish, her skills from her job came forward and encouraged thoughts and speculations which were perceived by the author as conclusive, and therein detrimental to the purpose of the analysis. As this form of analytical thought process was averse to the purpose of the analysis and compromised the need to bracket off any preconceptions and non-relevant thoughts, it was decided to approach the analysis in English. The researcher, when working and thinking in English, noted how reminders towards a commitment to the idiographic and existential while seeking to maintain a neutral lens from which to work were more readily available. Moreover, as the entire analytical phase was iterative with a continuous reflection on the original interviews and recording, the cultural aspects of language use (Larkin et al., 2007) were respected and accommodated through the researcher’s long residency in Denmark.

There are a variety of approaches to transcription, for example within discourse analysis the transcription will include timing of pauses between utterances etc. as this is an important part of the discourse approach (Goodman, 2017). However, this study focused on the spoken content with some indication, where applicable, of emotional outbursts such as laughing and pauses between words which were construed as the participant's effortful thinking about the experience and their meaning making of their recollections. This approach was consistent with IPA's content based methodological approach.

The process of transcription and translation contributed towards the researcher becoming very familiar with the data (Appendix XIII). The repeated listening, typing, rewinding, and checking together with reading the transcript first in Danish and then in English while listening to the recording encouraged familiarisation between the interview, the data and the researcher. At this point the researcher paused in the work and noted down in the research diary the thoughts the text provoked. This was an important phase. While every effort was made to bracket off thoughts which might lead to preconceived conclusions, it was considered important to accept their existence, take note of them, and through this action of active address remove them from the immediate process of familiarisation.

2. The formation of notations

The transcribed and translated text from the interview was placed in a two-column word document with the transcribed text placed in the first column (Appendix XIV). It was printed out with the research question placed as a running header on the top of each page. The research question was the lens through which the data were seen and acted as a reminder towards the purpose of the analysis. In the other column a summary phrase which encapsulated the perceived experience in relation to the research question was noted down. Throughout this phase, the focus was placed on attempting to be as close as possible to the experiential sense-making the participant had disclosed. The number of notations for each participant ranged between 77 and 150 notations.

This phase served the function of distilling the research-related experiences to create a more succinct account of the participant's narrative, to create phrases or codes which functioned as signposts to the original manuscript and serve as core elements for the next phase in the analytical process.

3. Working towards thematic threads

The notations from the transcript were typed up in the second column and printed out. They were then cut into individual strips which were placed into small, related groups (Appendix XV). Having physical copies facilitated ease in moving the phrases around. At all times the essence of the experience was reflected upon to ensure quality in the choices made. To ensure that the original interview and manuscript were fresh in the researcher's mind this phase was done consecutively in a period of two to three days for each transcript. The grouping of the notations facilitated the formation of thematic threads. The thematic threads were a succinct articulation of the dimensions of particular experiences within each participant's transcript.

The process was iterative and time-consuming, with many moves being conducted before the final clusters were considered representative of the essence of each notation. The researcher was aware that the point was not to create many different groupings but to ensure that the clusters related to a discrete but emerging theme within the participant's reflections and experiential meaning-making.

4. Summarising each theme

Each cluster of phrases was then entered into a new word document with three columns; in the first column the phrases were listed; in the second column a narrative summary was conducted; the third column contained relevant quotes from the original transcript (Appendix XVI). This summary explained what the theme related to, what it encompassed, and how sense-making by the participant was represented within the theme. The summary was interpretative, whereby the researcher accepted the responsibility of interpreting the narrative of the participant's interpretation of their experiences. Seeking the advice of an experienced researcher during the analysis phase in IPA is considered relevant for those who are relatively new to IPA (Murray & Wilde, 2020). Therefore, the researcher presented the transcript, the formation of notations, thematic threads and summary of each theme for the fourth participant (Marcus) to the project's supervisor. This process encouraged maintaining the focus on the participants' sense making of the events they had encountered during the analysis, as opposed to trying to ensure the objective 'accuracy' of the account. Furthermore, this process heightened the quality of the researcher's interpretations of the participant's interpretations, thus encouraging an analysis grounded in the original transcripts.

The interpretations included psychological implications of the participant's meaning making (Murray & Wilde, 2020). To ensure that the researcher's interpretations continued to be grounded in the original interview, quotations from the transcript were placed in the third column. On completion of this phase, the different summaries were titled.

5. Theme titles

The theme titles had the purpose of providing a succinct explanatory encapsulation of the summary of each theme within the individual transcript analyses. The theme titles from the eight idiographic studies amounted to 40 theme titles. The titles were then set up in a tabular format where areas of convergence and divergence were assessed.

Table 5. Matrix over cluster titles.

	NAVIGATING THE PARADIGM OF STAFF-SYSTEM-RESIDENT RELATIONSHIPS			EVOLVING IN CARE		THE PEOPLE IN MY LIFE		HELP SHOULD BE THERE FOR ME	
	Experiencing the reality of having carers guiding me through life.	**How it felt to live within the phenomena of a care home.**	**The system of care and how I perceived it impacted on my life and well-being.**	**The journey from child to adult within the realm of residential care**	**Becoming me**	**The impact, of finding new relationships within and without the care home.**	**Families are close for some residents and a long way away for others.**	**Help-seeking can create problem-solving, but it can be hard to enact when help feels a long way away.**	**When everything is just too difficult deviant solutions can become the chosen route.**
Sacha	A game of consequences.			Connecting to the outside world	Self-determination and taking control	Connecting to the outside world.		Help that was tangible, useful and received.	
Bee		Experiencing a good fit between own needs and care home.		Acknowledging and overcoming barriers	Self-discovery in a new home				
Kris		Residential care as a social opportunity.		What will the future bring?	Becoming seen heard and influential.	Residential care as a social opportunity.		From isolation to confident help-seeking.	
Marcus	Relationships are built on lies and rejection.			Transitions in life, getting educated and moving forward.		I need to keep a distance, living alone keeps me away from everything I don't like.	My family was never there for me, and I was never there for anyone else.	Self-help is the best help.	Addiction and drugs.
Caroline	I like the carers who were open towards me. being who I am	Living in the system for better or worse.	Living in the system for better or worse.	They are my transitions – I chose to stay - for as long as I like.	I want what I need – try and understand me.	It is simpler to live alone than with peers in care.	My mom is always there for me.	Alone in care – where is the help?	When I couldn't stand it, I ran away to places and took drugs.

Ben	I only interact with people I know well, the careers who take the time to talk to me fill this position.	It's all OK, I live on the periphery – no great expectations and no great disappointments.		It's a slow process, I still want help.		I am shy and I like things just so – but peppered with fun!	My family and I are always connected.	It's a slow process I still want help.	
Jene		My care home has a family feeling to it.	The custodial sentence was hard days for me, today, in care I am almost free.	I am maturing slowly, commitment takes time.			I live two lives one at home and one in care.		Why do I do the things I do? Self-understanding and self-medication.
Miker	I was unhappy and they did their best to help me.		I was never sure when or where I would be moved to next.	From special needs schoolboy to a young man at trade school.		Always the youngest means building barriers and keeping the good guys close.	I was taken away and I still do not know why.	I was unhappy and they did their best to help me.	

3.9 Merging the analysis across the transcripts

The themes were then analysed to explore where similarities and differences occurred across the dataset. The exploration of the convergences and divergences enabled a deeper and more complete understanding of the phenomenon. As the participant's experiential accounts were pooled it was possible to understand more about both the individual experiences and the group's experiences.

All the themes for each participant were printed and cut out ready to be moved about on a large table. The titles gave instant recall to the researcher of the theme content. The titles were grouped as similar issues became identified, for example feeling confident/not confident with help-seeking, each group had several themes from the different cases.

On completion there were nine theme titles, these were then further collated into groups and the final four group experiential themes (Smith et al., 2022) were identified. A synthesised account of each theme was written to ensure that the selection process was logical and representative of the findings from the original case studies. Each theme was then titled. These four themes are presented as the findings of this study.

3.10 Quality

The quality of research is dependent on the quality and appropriateness of the methods used (Mays & Pope, 2000). This study engaged IPA as its methodology and followed closely the guidelines of Murray and Wilde (2020) for the framework of the methods used in this study.

Throughout the planning and execution of each phase of this study, ensuring quality has been paramount. Smith (2011) has previously investigated the quality of peer reviewed articles to identify the benchmark of a good IPA paper. For a paper to be judged of high quality, Smith (2011) advocates the paper has: a clear focus on a particular aspect; strong data through the conduct of good interviews; rigour, through the clear representation of the transcripts from each participant in the analysis; sufficient space to elaborate on each theme; an analysis which goes beyond the descriptive and offers justified interpretations of the participants' sense making of their experiences; the analysis should point to both convergence and divergence; and, finally, the paper must be written well and with care.

These six targets for quality were at the forefront during both the planning and the execution of this study. To complement these six markers for high quality IPA and to ensure a high level of quality assurance, the researcher additionally used the four qualities of good IPA (Nizza et al., 2021) as a benchmark for assessing this study following the completion of the analysis and discussion:

1. Close analytic reading of participants' words. The researcher throughout the process of gathering data, transcribing data and analysing the transcripts held a clear focus on each participant's words and meaning making of their lived experience. As IPA is inherently interpretive the researcher has sought to ensure the reporting of the interpretative process as transparent, grounded in the data and therein trustworthy. It is the author's intent, as suggested by Nizza et al. (2021) p.23, that:

   "... the reader is thus invited to join the hermeneutic circle and make sense of the participant's and researcher's sense making endeavours".

2. Develop a vigorous experiential account. This study has been intent on exploring each participant's subjective lived experience. This has included an examination of the experiences the participant has presented as important to them. Thus, the author has delved beyond what was said and interpreted how the recalled accounts of previous experiences have impacted on the participant's well-being.

3. Construct a compelling, unfolding narrative. The study has sought to combine the close interpretation of each participant's perspective and the merging of the individual case studies analysis to achieve an interpretation of these participants' experience of living in therapeutic residential care as a whole.

4. Attending to convergence and divergence. Within IPA, the whole is structured around individual experiences. Thus, prevalence as well as convergence and divergence have become important aspects of the presented findings. IPA seeks to understand how participants can share similar experiences and meaning making of

> these experiences while diverging in some aspects of their experience. The idiographic details within the accounts have offered richness to this study and enabled a deeper understanding of the lived experience of living in therapeutic residential care.

It is the researcher's belief that the close attention to detail during the analysis of each of the participant's accounts has ensured a full representation of the meaning making of their lived experience of residential care. The findings presented in this study are grounded in the conducted interviews and, through the researcher's interpretations, reflect, as closely as possible, the experiences and lifeworld of the participants.

3.11 Methodological critique

IPA as an approach is not without criticism, it is time consuming both to learn and to implement (Miller et al., 2018). The researcher's ability to extend beyond the descriptive and into the interpretative, can be difficult to perform and difficult for the reader to identify, thus IPA can be criticised for a lack of transparency and trustworthiness (Pringle et al., 2011). To ensure quality assessment within this study, the four qualities of good IPA (Nizza et al., 2021) have been integrated as a benchmark for assessing the quality of this study (see Chapter 6).

IPA is a detailed approach and as such requires expertise and practice. The researcher is relatively new to this approach and has therefore lacked a reference framework to refer to during times of indecision. Thus, some interviews may have failed to capture fully the essence of the participants' experiences. Equally, during the analysis the researcher may have, due to lack of experience, placed either too little or too much emphasis on certain events or experiences. The level of detail, depth and richness of the data in IPA resulted in a vast amount of data. The process of refining this to four themes involved choices which prioritised certain elements within the findings above others.

3.12 Positionality

Positionality describes an individual's position and world-view in relation to the task in hand, in this instance research (Holmes, 2020). The researcher's world view includes their ontological and epistemological assumptions and those about how the researcher interacts and relates in the environment (Holmes, 2020). To ensure trustworthiness within social research, it is important that the researcher's knowledge of their own position is transparently communicated within the research.

As I, the researcher, read and took notes from the books, articles and websites which offered advice, insight and understanding towards researching in the qualitative paradigm and specifically using IPA, it was accepted that, as I worked through the study, my understanding of my personal lived experience would expand. This deeper understanding of how my world-view could influence my assumptions created an opportunity to utilise a reflexive process to openly acknowledge and engage with how my positionality may have influenced the gathering of data and analysis.

3.13 Reflexivity

As the first analysis developed, I realised that I had unwittingly brought preconceptions into the analysis. I accepted that I was, at that time, unable to fully bracket off (Chan et al., 2013) thoughts arising from my professional position as a head mistress within special needs education, and this conclusion brought new thinking to my work. I choose, following the first failed attempt of conducting the analysis in Danish, to translate the interviews from Danish to English, prior to analysis. While this deviates from usual practice, I believed the introduction of a language I do not use in my daily work was of value. My thoughts were, in the English language, attuned to the role of a researcher. To further assist my quest for avoidance of pre-conceptions, biases, and any form of conclusive thought I, on the completion of each interview, wrote down my immediate thoughts. These notes became valuable markers, as they reminded me to address any preconceptions that may have affected my clarity of observation and thought both during the analysis and when writing chapter 5, the Discussion. Indeed, it was my intention to understand as closely as possible the participant's meaning making as they related their experiences (Smith et al., 2009). Without doubt, as I immersed myself in the process, my abilities improved. However, I needed to redo the first two analyses I had conducted.

During the transcription phase I kept my diary close at hand. If I had any thoughts regarding previous participants, work situations, or even previous knowledge which might infringe on embracing each participant's particular account and meaning making I wrote these thoughts down. This procedure encouraged me to focus on what was happening in the current transcription. As I engaged myself in the process of conducting interviews, transcribing, and analysing the accounts, I noticed an improvement in this ability to separate out each participant's account. The accounts were unique insights into the experiences of the individual. While I, as the researcher, cannot ensure that no preconception or bias has affected the outcome of this study, I believe that every effort has been made to represent each participant's experiences as they understood them to be. In addition, while the analysis was conducted by myself, I sought advice from my tutor, who, as an experienced IPA researcher, was able to consider the approach I had taken and helped me focus my thoughts on the participants' accounts and how they, through their accounts, offered explanations, thoughts and sense making on the events and experiences they encountered during their time in care.

Engaging in such a close and deep analysis triggered many thoughts and at times I was confronted with accounts which were both sad and distressing. I have during the period of interviewing and analysis ensured my well-being through contact with my supervisor at Lancaster University and through the supervision I receive at my place of work.

Chapter 4
Findings

4.1 The group experiential themes

The analysis produced four group experiential themes: (1) “They [carers] go up to the young people and talk to them”: Navigating the challenge of staff-system-resident relationships. (2) “I am just more grown up”: The experience of transitions towards adulthood and life beyond residential care. (3) “… actually, they wanted me back”: The experience of having family and friends while living in care. (4) “I said yes, she told me that was good…”: Making sense of receiving help and developing self-help.

“They [carers] go up to the young people and talk to them”: Navigating the challenge of staff-system-resident relationships.

This group experiential theme is concerned with the participants’ experiences and meaning making of their relationship with staff and the authorities involved in their placement. This theme explores how personal interest from staff affected the participants’ experience of care, how the participants navigated their experiences of power imbalance and the rules and norms of residential care, the participants’ perceptions on residential care as a family-like home or an institutional system and the role their case managers held during their residency.

The interaction between the participants and those who were employed to take care of them during their time in care was portrayed by all participants as having a profound impact on their experiences. Two specific areas, the level of engagement in the carer-youth relationship and the young person’s ability to cooperate with the rules and norms of residential care, were cornerstones of how the young person experienced their residency.

Carers who demonstrated a personal interest in young people’s well-being and took time to listen were categorised by the participants as being “a good carer”. Being in contact with a “good carer” was considered integral to feeling comfortable in the residential care home.

Moreover, recalling being together with a carer who had these qualities was common within the accounts. Indeed, all the participants, with the exception of Marcus recalled carers who had made a positive impact during their time in residential care. As recalled by Caroline:

> Caroline: … there was one contact person called Catrina. Catrina was very good; she could get me to follow the rules and way of being there without pressurising me… (43-45).

The participants who recalled a carer choosing to engage in their needs was interpreted as creating a platform from which a trust between themselves and the carer could emerge. This in turn allowed the carer-resident relationship to contribute to the participant's belief of self-worth and potential. In addition, the ability to talk with adults was interpreted as a benchmark for some of the young people as being met as an adult, as related by Ben: "ERR I think more over things and talk with a carer and so well yes, I am OK grown up." While helpful and caring carers were frequently reported in the participants' accounts so were problematic carers. Some of the participants revealed the experience of being ignored and misunderstood and for one, feeling victimised by the carers. These experiences contributed to beliefs that their placement could be harmful to them, as explained by Marcus:

> Marcus: No, [I have not been treated justly] and in general people aren't just, until I moved in here [the apartment] there was always some professional, somewhere, who saw me as a lesser person because they had the position they had. Err, the difference. (216-218).

The balance of power between the young people and the professional carers was, for Marcus, Caroline, Sacha and at times Miker, distressful. The concept that people with whom they had no family connection, who could dictate what they should do and when, was experienced by these participants, as difficult. In addition, Marcus' experience of being stigmatised contributed to his perception of not feeling wanted by the carers in the homes in which he lived, which in turn contributed to a reduction in his perception of self-worth.

Jene's account offered a different perspective of how he experienced benefits in residential care. He found the experience reminiscent of family life, where a recalled sense of unity amongst the residents and carers helped him to feel safe and comfortable in his situation:

> Jene: Yes, it is because we are here in this house to do, erm, it is not just a residential care home. We are a family together, err, we are all together in our home, there is a lot of respect between us, we all respect each other, it is like a family yes, a place. (54-56).

The need to experience the comfort and security of a family home was important to all the participants. For some of the participants, this was a reminder of what they had lost when they moved into care and for others, it was what they believed they should have had before care. However, not all participants experienced a family-like environment in care. For some, the experience that they were placed in care homes with people who did not want to care for them was also evident:

> Miker: Because the carers, they promised so many things, and said they will see to so many things, and nothing ever really happened. Err, you got collected by someone who drove you to school, and yes, there was someone from the school who came and woke us every morning and made breakfast and then we were driven to school and afterwards, home again, and then you were just in your room. (72-75).

> Sacha: Yes, but there were just some [carers], where I could feel that they wanted the best for me, so I was like more willing to be nice to them.
> Interviewer: What about the staff you said that made it harder?
> Sacha: Mnn, it was just that there were some, and you could just feel, well that was it, you couldn't feel that they felt it was good to be there, and then if they felt like that I didn't want to be there either. (22-26).

When the participants experienced indifference from the carers, they formed not only the belief that they, as individuals, were of little value and not deserving of attention, but also that the care system was of low value. Some participants reacted to this stigmatising situation with avoidance, which could create a barrier to development and decreased their perception of self-worth.

While most of the young people believed that the carers wanted to help them, Caroline, Sacha, Marcus and Miker did not perceive the system of care as beneficial. Only one participant, Bee, who recalled being depressed prior to care, experienced a continuous improvement in her well-being from the time she went into care. The other participants' experiences were described as more complex, with areas of pleasure and satisfaction on the one hand and challenge, disappointment, and unhappiness on the other. For these young people, an internal conflict became a part of the care experience; while they believed there was no other alternative than care, they also believed that they could have been better placed elsewhere, as explained here by Caroline:

> Caroline: No, I should have been in foster care, on a farm where I could have walked around the fields if I was cross and screamed and yelled away from everyone. (502-503).

Caroline, as with all the participants, accepted that the help she needed was beyond her family. While Caroline had no actual experience of foster care, her experience of residential care as a repressive environment was interpreted as contributing to her belief that foster care would have been a better placement. Equally, Marcus and Sacha, who had both left foster care for residential care, believed that while foster care had helped them, residential care had caused them harm. Accounts which promoted foster care as superior to residential care implied that these participants found reasons to stigmatise residential care.

Following rules was not easy for the young people; undoubtedly, some participants had come from homes where their disruptive behaviour, or that of others, was present before starting care. However, memories of carers who were recalled as actively helping them navigate the rules and norms of the home were common. The participants believed this help encouraged them to cope with their situation and promoted their well-being. Ben, in this excerpt, described what the carers in one of his homes did to help the young people:

> Ben: They go up to the young people and talk to them, go for a walk and talk, make contact as much as possible with the young people. (137-138).

Indeed, the rules and norms the participants encountered in care caused, at times, anger and unhappiness. In particular, rules on disclosing their whereabouts, as well as those which directly limited their freedom of movement, were perceived as being unfair. This was highlighted by the perceived difference between themselves and their acquaintances outside of residential care, who lived with their families and had the freedom to go out and visit friends when it suited them. Visiting friends on impulse, prior to her 18th birthday, was, as explained here by Sacha, not permitted:

> Sacha: Yes, well it wasn't much fun, uhm, sometimes I did what I wanted anyway, went to see my friends, went to the activities I liked. Yes, just did what I wanted to do. Yes, but when I got home there were consequences. (113-115).

The participants had varied attitudes towards their case managers; Sacha received useful help when she considered her care home had overstepped its rights in connection with the removal of her mobile phone, yet Miker reported that his case manager had lied to his parents, which had a negative effect on how often he could visit his family. However, for most of the young people, contact with the case manager was infrequent. Consequently, the young people's understanding of how the care system operated and how their daily life in care was constructed was connected to the carers they met and the homes they had lived in, and not the professionals who had placed them in care and had monitored their progress. Despite this distance from the authorities behind their placement, nearly all the young people offered beliefs that residential care homes should be checked more often by these same authorities. Equally, they believed the carers should have more education so that they were in a better position to understand the young people's individual needs, as suggested by Caroline:

> Caroline: For example, at Little Fields, I know that a lot of the pedagogues[6] were not educated. They did not have any background for looking after young people. (386-387).

The young people expected the professionals who looked after them to have the necessary training to perform their job well. When the young people felt their carers lacked appropriate skills, they all suggested this was not the individual's failing, but the statutory authority's for not providing the homes with well-educated and trained staff. Thus, the participants revealed a bias towards blaming the system behind care for the difficulties they had with their carers.

This theme has revealed how each of the participants experienced their relationship with carers, case managers and the rules and norms of living in residential care. Carers, and their engagement with the participants, were perceived to be the most important factor for a positive residential experience. The strength of this personal interaction created a feeling of safety and value. When this level of personal interaction was achieved the young person experienced motivation towards cooperation with their care home. However, even for the participants who were actively cooperative, strict rules were experienced negatively and indictive of a lack of value.

"I am just more grown up": The experience of transitions towards adulthood and life beyond residential care.

This group experiential theme draws on the participants' experiences of maturing into young adulthood and initiating the phase of preparing to leave residential care. The theme includes the experiences and meaning making of the transition to adulthood at 18 years of age, the participants' beliefs on their own ability to mature and the barriers they encountered in this process, and how they, as independent adults, have chosen how to continue their alliance with their residential care home.

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[6] Paedagog: The generic name young people in residential care call their carers in Denmark. See introduction page 8.

Each of the young people's residencies had its own starting place and had concluded at a place in time where the young people were either preparing for, or aware that preparations would soon begin, for a more independent mode of living. Two specific transitions, the transition to adulthood at 18 years of age, and the forthcoming transition out of residential care, were affected by emotional and cognitive barriers. Bee, Caroline, Marcus, Ben and Miker all reported a lack of proactive coping styles, during these periods of transition, which in turn affected their abilities to engage in their own progression:

> Bee: No, I never could think about what I will do in my life, I don't know yet what I want to be. Even if that sounds weird. (166-167).

Bee's account suggests awareness of the normality of preparing for a life within a profession, while being unable to participate in this age-related activity. Becoming an adult at 18 was perceived by the participants as a milestone which had given them both the freedom to make their own decisions and the burden of responsibility. Most participants described not feeling prepared for this change in their lives. However, this lack of preparation was, they suggested, caused by their own lack of engagement in the offered help, as explained here by Marcus:

> Interviewer: Yes, so neither your earlier foster family nor the residential care homes have taken time to teach you about taxes, budgets that sort of thing?
> Marcus: Uhm, not well, the other places have tried but I didn't want to cooperate. I was so impulsive and dependent on my impulsive shopping, so well, I wasn't listening. (87-90).

While the aftercare programme was designed to encourage a gradual increase in responsibilities in preparation for independent living, the findings suggested that new or increased responsibilities were difficult for the participants. This lack of engagement, as illustrated by Marcus' account, was interpreted as being connected to the participant's lack of belief in their own ability to manage responsibilities, a lack of role models where successful transitions had been observed or connected to a life-style culture where the opportunity to explore life outside of the home had been limited. This last possibility was evident in Miker's recall of when he became18:

> Miker: …My life has changed completely; I have lots of new friends, something I never had before when I lived in the home before I was 18. But now I have got so old I can, my youth has been wasted, I haven’t had a life like other young people. Most young people when they are 15 can go out and drink and have fun, but that is closed for all of us in care, because it is not allowed. So, before I was 18, I had never experienced that kind of life. (212-216).

Without the opportunity to interact with people from different backgrounds, it was difficult for the participants to understand the opportunities and risks the world around them offered. This in turn became a barrier towards progression.

The use of comparison to understand the changes young adulthood brought to the participants was common within the accounts, as exemplified by Kris:

> Interviewer: Do you feel you are treated with respect?
> Kris: Yes, especially compared to the others [carers in previous homes] some years ago, now I am treated much better. (214-215).

The findings suggested that the use of comparison to establish their level of their progression could become a burden if they did not identify sufficient progress within their accounts. Sacha, Kris, Marcus, Ben, Jene and Miker all expressed the need to compare how, at the time of the interview, they were better at living in their current placement in comparison to placements earlier in their lives. Being successful at living in care was perceived, by some of the participants, as a milestone which should be achieved prior to engagement in the activities needed to move on to a more independent form of living.

> Ben: Err I think it is OK that I have control of my life and that sort of thing. Things are quiet and I am going to school and that sort of thing. I need to have things in place. (205-206).

All the participants noticed, as they matured, that the relationship between themselves and their carers adjusted to a more mature and cooperative alliance. Following their 18th birthday, the participants lived in residential care by choice and were treated as young adults by the carers. In addition, while they may not have had any real alternative to accepting aftercare, they had been involved in the decision. This involvement together with the knowledge that they might, if they found an alternative place to live, leave at any time appeared to encourage a belief in the need to invest in themselves in their last placement as explained by Miker:

> Interviewer: Are you pleased they can help you?
> Miker: Yes, I am because I admit that that is why I haven't moved out yet, because I still need to learn some things. (334-336).

The change of status from child to adult appeared to encourage a mature mode of thought and reflection in the participants, including a belief that cooperation and help-seeking would improve their prospects. There was pride in their voices when they explained how they had gained the ability to make well-considered and mature choices regarding their lives. This maturing was evident within the accounts, as exemplified by Miker:

> Miker: Yes, the message has really landed, you just don't get anything out of behaving badly. You can tell people what you think but you don't get anything out of screaming and yelling or destroying things. (282-283).

While the participants expressed pride when they achieved milestones, they also revealed how progression could be risk-laden. They worried that sufficient progression could be interpreted by the authorities as a sign that they were ready to live more independently, even if they did not feel ready to do so.

While some of the participants; Marcus, Sacha and Miker looked forward to an independent life away from care, they did express worries about the future. Few of the participants appeared to have a clear vision of how they would continue to develop beyond care; some, such as Marcus, had faith in education as their way forward whereas others had families whom they believed would support them during their transition out of care. Ben, Bee and Kris held the belief that life after residential care was still far in the future. Ben, 23 years old at the time of the interview, appeared uninterested in a more independent lifestyle:

> Ben: I will at some point in time [move], I would like my own apartment. But it is not something I need here and now. (267).

The normative desire for a more independent lifestyle appeared to be pushed well into the future by Ben. Ben, from this perspective, can be argued to have become institutionalised with a lifeworld[7] that does not see the future as a secure place with opportunities; instead, he sought to hold onto the security of a lifestyle he knew and trusted.

All the participants recalled experiences of uncertainty and worry when they moved to care and for some the amplification of distress through multiple moves. For example, Marcus, who had moved five times, explained how his many placements had affected him:

> Marcus: Well, actually, it [longest stay] is where I am now, otherwise, well, the other places have been under a year. You know, it started well with a positive development and then the same pattern appears, and it just goes downhill.
> Interviewer: How did it feel when there was a positive development?
> Marcus: It created confusion in my head, I have been rejected so many times, until today where I hold onto the fact that my development is my responsibility. (61-66).

Some of the participants revealed a difficulty in coping with positive responses to their progression. Marcus' recall of confusion and insecurity suggested there was a lack of support towards understanding emotional responses when successful, as well as guiding in how to share progression with others.

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[7] "*Lifeworld refers to a person's subjective construction of reality, which he or she forms under the condition of his or her life circumstances*" Kraus, B. (2015). The life we live and the life we experience: Introducing the epistemological difference between "lifeworld"(Lebenswelt) and "life conditions"(Lebenslage). *Social Work & Society*, *13*(2).

Caroline, as with Miker and Marcus, recalled several of her moves as traumatic, with stress recalled from being unable to find stability within the new placements. This had created a need in Caroline to control future moves in her life:

> Caroline: … because I need to do things at my speed, and if I must move, I need to know well in advance. (368-369).

Caroline was one of the participants who had experienced multiple moves, which in turn was interpreted as affecting her meaning making of what moving entailed, including her belief that by exercising some control on the communication process of moving the move would be less traumatic for her. While control of the transition out of care was perceived by all the young people as important, the findings revealed that the young people who had experienced several moves, for example, were directly affected by the perceived anxiety another move could cause.

However, not all the participants had experienced anxiety when moving and this influenced their views on future moves. Kris experienced an improvement each time she had a new placement.

> Kris: Well, the place before this one was also good, actually, I would say I have gone from bad to better and better. (100-101).

Kris in her account suggests a progression and a belief that through moving she is acquiring useful skills. However, both Sacha and Marcus had different perceptions; theirs was embedded in a history of feeling underserved by the home(s) in which they resided and a belief that they were not helped as they should have been. Both participants reported they were ready to reduce the amount of help the home should provide:

> Sacha: It was great, so lovely to come out of the house [care home], and right now my aftercare is nearly over, so well, as soon as I do not want it any more it can stop. They don’t come running to me every day anymore. But if I need help, I can ask for it. (222-224).

> Marcus: … Starting college, you name it, all of that I have now control over and I have a very specific explanation. I should not receive help; I should take control myself. (131-132).

Progression to the stage of feeling capable of living a life without any support from the care home system contributed to a positive belief in the ability to progress towards independence.

Throughout all the participants' lives in residential care, change and transitions followed them. This theme uncovered how each participant had experienced growth in care as they matured and gained enough experience to make decisions for themselves. However, the findings also informed of a general unwillingness to be prepared for adulthood. This reluctance was amplified by some of the young people when they reflected on their next major transition, moving out from aftercare. However, two participants, Sacha and Marcus, offered a very different account, revealing a belief that they were severely underserved by the care system. Thus, they had a lifeworld which suggested that further involvement by the care system would be detrimental to their wellbeing. Both these participants were actively seeking a lifestyle where they could be the major decision maker in their lives.

"… actually, they wanted me back": The experience of having family and friends when living in residential care.

This group experiential theme is concerned with the participants' experiences of continuing their relationships with family, including foster families and friends from home, while in care. In addition, it draws upon the participant's meaning making of new relationships from both within and outside of the residential care home, including accounts of new social lives, the transitive nature of relationships in care, bullying, poor behaviour with peers and loneliness.

Loving and feeling closely connected to their family was, for Sacha, Caroline, Ben, Jene and Miker an important part of life in residential care. It was from this family base that these participants had moved into residential care. This change in circumstances - they were unable to be with their parents when they wanted to be - was considered by these participants as detrimental to their well-being, as explained here by Miker:

> Miker: Mnnn, yes, the first day was the weirdest day in my whole life. Err, I was very frustrated about not being able to see my parents, err, because I was removed from my home by the authorities, so there wasn't so much I could do other than go along with it. (7-9).

The participants' reaction to the power the authorities had over visiting rights with their families was that of acceptance. For some, as in this example given by Ben, this acceptance was positioned as being the same for everyone:

> Interviewer: Could you visit them when you liked?
> Ben: Not really
> Interviewer: What were the visiting arrangements?
> Ben: In the weekends
> Interviewer: Yes
> Ben: They could also come and visit me, but not on weekdays. It was like that for everyone. (105-110).

Ben's acceptance was interpreted as his belief that when guidelines were the same for everyone, they were fair. However, Miker had a different situation, he had been removed from his family home by a court order. Miker recalls the need to receive permission from the authorities before he can be with his family overnight:

> Miker: Yes, it took a couple of months before I got permission to stay overnight with my mum, for just a day and my dad.
> Interviewer: Yes
> Miker: At the start I could only see my mom errr 2 hours a week.

This account suggested a meaning making that through his acceptance of the situation he had encouraged an improvement in his visiting rights.

All the participants who were in contact with their families believed that the care system had not replaced the role of parenting by their biological parents. Sacha, who was one of the two participants who did not have a close connection to their biological family, sought a family-like relationship with the foster parents who had raised her before entering residential care:

> Sacha: "… actually they wanted me back, at home as you say. It wasn't possible…. Erm, we have even talked about them adopting me, erm, so they would be my real family you could say. But then I began to investigate my biological family and well I became 18, so it was too late, erm.
> Interviewer: Yes, am I right in saying you think of your foster family as a part of your family?
> Sacha: Yes. (183-188)

Sacha throughout her account had explained a lifeworld where her care home had provided her with an acceptable physical environment. However, Sacha contended that her psychological needs were fulfilled elsewhere, that is through her continued connection to her foster family, friends outside of the home and her boyfriend with whom she now lived. Sacha emphasised her conviction that she had the right to normal family life, and that the circumstances of not having contact with her biological family did not mean that she could not have a family of her own as an adult.

Marcus was the other participant who had no established connection with his biological family. Marcus' negative experience of only being of interest to his father during his parents' divorce had given Marcus the belief that his family had had a negative impact on his well-being:

> Marcus: Yes, just like my father, he was never interested in me, it was always me that had to show interest in him, and it was the … well …. the only time we managed to have any form of dialogue between us was when my parents got divorced ... (185-189).

Marcus was adamant in his account that his parents had failed in their role, with this perception of being let down possibly impacting Marcus' ability to interact with the people around him. At the time of the interview, he lived on his own and maintained a strict regime of self-help which included becoming free from drug dependency and monitoring his own economy, as a means of navigating his daily life.

The findings suggested that the participants who had stable family connections found value in being able to talk about family life. The ability to connect with family members, at any time of the day, was reported as important. Ben explained how he had spoken to his parents every single day during his life in care. In addition, the young people reported that when life in care became difficult for them, they had asked their family to back them up in discussions with the care home. Belonging to a family was considered normative, and for Caroline, Sacha, Ben, Jene and Miker being able to identify themselves as a part of a family unit was important to them. The stories, albeit positive or negative, of family life were given with an emphasis on how each participant staked a claim to belonging to a family.

Miker, Caroline, Jene and Ben perceived their families would always be in their lives. Having a connection with family was considered a safety net, both against future unknowns and the possible risk of loneliness in adulthood. Caroline explained how her mother was the most consistent person in her life.

> Caroline: I believe that at the end of the day I have just me.
> Interviewer: Mnn.
> Caroline: And my mum. (299-301).

The knowledge that when care ended the relationships with peers and staff would also end was a common understanding in the participants' accounts. Therefore, relationships with peers and carers were perceived as temporary and any form of continuous relationship had to be found elsewhere, either through family or friends outside of care.

Jene who came from a closely-knit immigrant community, explained how continuity in his life also involved his cultural heritage:

> Jene: It is very difficult to just let it lie, there are people you are close to, who you love to be together with and have grown up with. With all that stuff it is very difficult, and it is not because I will always, from my side, I will always be from there where I came from always … (83-85).

Jene revealed in his account that he was divided between loyalty towards his friends who shared his cultural heritage and what he understood was best for him. Jene offered an acceptance of being involved with more than one place at a time, both in terms of culture and in terms of living arrangements. Jene claimed he looked forward to visiting his family and then, when the visit ended, looked forward to coming back to his residential care home. This apparent ease of movement between two very different lifestyles may have been facilitated by Jene's earlier experience of growing up in two cultures simultaneously; the Danish where school and sport were located and the immigrant cultures his family and friends represented.

For the participants who had been placed in non-specialist homes, connecting with other young people was complex and at times difficult. The young people appeared to have spent their earlier years in care investing in the maintenance of a continuous connection to their biological homes, establishing contact with their carers and, as young adults, investing their energy in efforts concerning their education and transitions out of care. While peers were a part of this experience, they were not considered a stable part of care; peers were people who came and went, unlike the biological family. None of the participants in this group felt inclined to maintain contact with peers following care.

However, two participants, Bee and Kris, offered an alternative to this finding. Both Bee and Kris had moved into a home specializing in autism. They found, within this home, the opportunity to form solid friendships, as Kris explains:

> Interviewer: Would you say that it's important to have good friends in care or good adults to help you?
> Kris: Friends, they are the most important thing. (82-83).

Kris, Bee and Sacha were the participants who actively sought friendship from peers, with Sacha choosing friendships outside of her residential care home. Thus, it can be interpreted from the findings that Caroline, Marcus, Ben, Jene and Miker were in situations where friendship with peers was difficult to access and therefore did not fully experience the social opportunities of their age group.

Bullying and violence were described in both Caroline and Miker’s accounts, and a third participant, Marcus, admitted that others were wary of him. This group reported how they had lived in homes where the young people were able to establish an abusive hierarchy of power among residents. Miker in this quote recalled how he was bullied in his first placement:

> Miker: They tried to hold him back, and there was someone who was 18 there then when I was 13, he held him back so I could come past him into my room and lock the door. (43-44).

Miker had, within his account, a strong belief that because he was the youngest resident it would always be him who was bullied. Miker, in his early placements, recalled keeping the carers close to him as a form of protection against peer harassment. However, not all the negative reports within peer relationships were connected to peer violence. There were also accounts of peer relationships encouraging poor behaviour:

> Ben: Restlessness, you know when three or four boys are together. Well, it happens quickly when they get bored. Then you know, you get stupid ideas. (165-166).

As with Ben, Caroline was influenced by the group she was in. She recalled how, at her first placement where she, at 9 years of age, was the youngest within her group, copied the older girls which led to behaviour she believed was unsuitable for her age:

> Caroline: …they went up to 16-17 years in age, and to start with I was with the older girls. I smoked cigarettes, wore a G-string, wore make-up all the things I shouldn't do, but I wanted to. (18-20).

Both Caroline and Ben recalled how they connected with peers through participation in the group's activities. The participants who recalled group acceptance revealed pleasurable memories of inclusion, whereas the opposite occurred when there was no room for them in existing groups, recalling distress and loneliness.

For Caroline, Kris, Marcus and Miker loneliness had been a part of their care home experience, with their accounts including few interactions with non-care home peers. In fact, only one participant, Sacha, had been successful in creating an active social life outside of her home. For some of the other participants contact with young people outside of the home occurred online, through gaming and joining groups with similar interests on the internet.

This group experiential theme has revealed that except for the two participants in a specific care home for autism, the social life offered by residential care homes was experienced as inferior to the participants' own family and friends from home. Peers who were met in care were regarded as casual acquaintances who, on leaving residential care, would no longer be a part of their lives. Equally, for nearly all the participants, friendships outside of care were largely non-existent, with only one participant recalling an active engagement in a local initiative. For the two young people who had enjoyed the residential care home's social life, they believed this was because their peers were like them, which in turn encouraged the feeling of being accommodated and understood. This last point is of interest as these two participants both experienced improvement in their well-being through being placed in a home where they fostered perceptions of similarity and experienced an ease as they fitted in.

"I said yes, she told me that was good…": Making sense of receiving help and developing self-help.

This group experiential theme is concerned with participants' recall of how help in residential care had been offered and used. Help was for some participants readily available and for others less attractive and harder to access. Finally, this theme draws upon the participants' accounts of how they developed strategies which improved their understanding of how offered help could benefit them.

The offer of help from carers and case workers was accounted for as a natural part of living in residential care. In addition, some participants had also been offered help from psychologists and therapists. The participants' experiences of engaging in the offered help were found to vary according to their perception of the context in which the help was given and how much trust the participant felt they could place in the offered help.

All the participants' accounts suggested that they were aware that, like any other young person, they should have access to help in any new or difficult situation. However, for Sacha, Marcus, Caroline and Miker the channel from which help came was perceived as untrustworthy, as the people offering to help them were the same people who had contributed to their separation from their family home. Sacha explained how difficult it was to receive help on arrival in her new home:

> Interviewer: What about your case worker did you involve him or her?
> Sacha: No. I didn't like her, she was one of the people who made me move, so I wasn't going to contact her. No. (54-56).

As minors, none of the participants had chosen to be placed in care. In addition, on arrival in their new home, they experienced a period of insecurity. They were estranged from their family, they did not know the carers in the new home, and their case manager was positioned as either too far away from their situation to understand their needs or untrustworthy as they were responsible for the situation. This in turn created the experience of help being difficult to access. However, for most of the young people, the ability to receive help from the care home increased as they settled in, as exemplified by Bee:

> Bee: Err yes well it was very difficult because with my diagnosis, well with completely new surroundings. (6).

> Bee: … I don't know, I just think it was like finally I was getting the help I needed. (49).

Bee as with Miker, Kris, Ben and Jene, was one of the participants who experienced a positive outcome from the help the carers gave. The participants who found conforming to the norms of the home difficult remembered fewer instances of engaging with the offered help. Caroline, Marcus and Sacha, the three participants who recalled a general experience of challenge while in residential care, had different experiences and therein a variation in their experience of why help-seeking and receiving was difficult. Caroline believed that the carers were not active enough in their attempts to understand things from her point of view:

> Caroline: Uhmm, the carers were really bad at understanding children, understanding what it is like as a child to be really angry. I think they should have been more open-minded. (72-73).

Marcus believed that carers gave up on the young people too easily:

> Marcus: No, I did not [get enough help]. No, and there, errr, was not enough potential the err professionals that worked with me in residential care, they did not do enough, they could not get me activated, away from where I chose to be in my comfort zone. Today I can see that it was that move which was needed, to get me to move forward. (69-71).

And Sacha believed that it was not possible to seek help from people who were trying to control her:

> Sacha: You had to live up to their demands with everything. For example, if you wanted to go out with your friends, you well, you had to be at the breakfast table on time for a week or something like that… (105-107).

The experience of being met with an understanding of the participant's perspective, as well as a belief that the carer's intentions were based on the participant's needs, was revealed as essential for the establishment of positive help-seeking actions. When the participants experienced a lack of understanding and good-will, barriers to cooperation were established which created a reduction in developmental opportunities.

Few of the participants had chosen to engage in help from psychologists. Sacha, Marcus, Kris and Ben related an association between mental illness and psychological help; the stigma of serious mental illness had made a barrier, which in turn limited help-seeking choices.

> Sacha: I got offered that [psychologist] when I moved in. Uhmm, but I didn't want it at that time. I have considered it again later, but actually, I decided no, because I did not want anything else in my papers. I think I have enough. (157-158).

Of those who had engaged in help from a psychologist only Caroline reported benefit from talking therapy and she hoped this service would continue for as long as she felt the need:

> Caroline: I have had the same psychologist Sara, who was just so good, she worked with psychodynamic therapy with me. (236-237).

The lack of trust some of the participants had in the confidentiality of psychological help could be perceived as a deficit in the system. Caroline, on the other hand, did not have these barriers. Caroline explained how she was able to improve her situation by seeking and receiving help outside of her placement.

Help from outside the care homes was, in most instances, recalled as coming from the young people's families. However, for Marcus, help came from a more impersonal route: a self-help video. Marcus identified with the person in the video as he believed they had similar difficulties in life. Marcus, following his viewing of the video, used this person as his role model:

> Marcus: It has actually come from YouTube. I have seen a lot of motivational videos, and there has been one particular person who I felt really could talk to

> me, David Gorkins. He used to weigh too much and was in a difficult situation in his life with a very low income, he could hardly survive. He was so insecure and because of this he had a facade that was not who he really was. He chose to go through a very difficult training of three hell weeks which no one had done before, he kept going… (180-184).

Marcus' belief that the carers had given up too easily on him was underpinned by his use of a video which could be viewed on demand and therefore constantly available. This was, in Marcus' experience, a more reliable form of help than a living human, who was liable to change their opinion, leave him for another job or, as Marcus had experienced, send him to another home.

Not all the young people had, in times of difficulty, been able to find help for the problems they had encountered, and, for some, this had contributed to deviant behaviour including running away, criminal activities and the intake of drugs and alcohol. While the majority of those who had engaged in drugs perceived this action as self-medication, one young person, Jene, believed his route to drugs and crime came from the environment in which he had grown up:

> Jene: But that is because I have been, uhm, people where I grew up around, and err, smoked hash. I grew up amongst drugs and crime 50 meters from my flat, so, and I wasn't particularly clever. (75-76).

The experience of feeling unable to live up to the expectations of multiple cultures was interpreted as difficult by Jene. Jene, who had moved from a culture where smoking cannabis was accepted, to, through his placement, a culture where avoidance of drugs was equally common, experienced an inner conflict which was perceived as an extra burden.

Caroline and Marcus engaged in self-medication after they moved to residential care. Both participants described an intolerable existence as the reason for their actions.

Caroline revealed in this excerpt how, following an experience of being bullied, she began to run away and take drugs:

> Caroline: Yes, it ended up with well, I began to run away, I didn't want to be there, I ran to Northbridge, to the ghetto area, which is dangerous for young girls.
> Interviewer: Mnn
> Caroline: Well, one day I was caught by the police with two grams of hash on me, so I went to the station and a carer from Little Fjord came and, well, I ran away again. I ran away a lot with another girl from Little Fjord, Marie, and a new girl who was younger than me. In the end one of the heads at Little Fjord asked me if I would like to go into a project where I was alone, no other young people. Just me and my team of carers. I said yes, she told me that was good because if I had said no, two policemen would have taken me to yet another place. (154-162).

Thus, the young peoples' behaviour was attributed to a situation where they lacked the necessary help to make an informed decision and therein chose risk-taking alternatives. Caroline, who, in response to bullying had run away, was confronted with the experience of being excluded from the decisions made regarding her future placement.

Marcus, as with Caroline, was aware of the problems drug dependency gave him, however, he believed that, at that time, there was no alternative to tackle the pain he felt:

> Interviewer: Did you get any help with your addiction?
> Marcus: No, and errm, I felt I was sort of being pressured, it was like
> something I felt I had to do, so I chose to just do it.
> Interviewer: Yes
> Marcus: Because, well it gave me a sort of feeling of false, erm, power over the feeling of powerlessness I felt in general. (102-107).

The experience of feeling powerless was evident in the accounts. If the appropriate help to address those feelings was not accessible, then self-medication became, for some participants, a way of containing negative thought patterns and low self-esteem.

Marcus also suggested in his narrative that addictive behaviour was normative in residential care:

> Marcus: No, well, I had more or less got myself out on a limb where I was until urrm, well, right off target, where I felt completely alone because despite the addiction and the stigma that comes with that and er the residential care, I was in well I was also in an environment where addictive behaviour was the norm. (114-116).

Marcus believed his addictive behaviour caused him to be stigmatised which in turn contributed to the loneliness he experienced in residential care. Marcus sought help by asking to move away from the residential care home and into his own apartment, which was following this request accommodated.

This theme has revealed that for most young people within the study, proactive help-seeking developed over time. However, for some of the participants, a different account unfolded. Difficulties resulting in a belief that the care home could not provide a secure base created a lack of trust between the young person and staff in their residential care home. When this occurred, the young people chose to find help from other sources; for example, one young person was successful in finding help through friends and activities outside of the home, and two young people chose self-medication as a relief from their problems. However, both these young people, following this difficult period, had become drug-free and appeared more inclined to seek help from the carers with whom they had developed a stable connection.

Chapter 5

Discussion

5.1 Summary of the findings

This chapter is concerned with how the findings from this study are positioned in the wider literature. The positioning of new knowledge pertaining to therapeutic residential care into the wider literature is a complex task. Therapeutic residential care is a relatively new term, within which the defining characteristics are not always fully visible within a particular country or domain (Whittaker et al., 2016). Indeed, Whittaker et al. (2016) consider cross-national disparities as an opportunity to learn how the different cultures and experiences can shape service responses.

This study aimed to explore the experience of living in Danish therapeutic residential care. The analysis yielded four group experiential themes: (1) “They [carers] go up to the young people and talk to them”: Navigating the challenge of staff-system-resident relationships. (2) “I am just more grown up”: The experience of transitions towards adulthood and life beyond residential care. (3) “… actually, they wanted me back”: The experience of having family and friends while living in care. (4) “I said yes, she told me that was good…”: Making sense of receiving help and developing self-help.

The study has produced findings which both support those in the systematic review and areas which offered alternative viewpoints of the experience of living in residential care. While the study due to its small design does not claim to have generalisable findings (Silverman, 2013) it does, however, offer an insight into how Danish therapeutic residential care was experienced and therein offers an opportunity to compare and contrast the findings from the review and the study.

The review’s four analytical themes (1) autonomy and control; (2) relationships and support; (3) safety and security; and (4) child to adult transitions in care, were all evident in the findings of the empirical study. Authoritarian control was evident within the participants' accounts in both the review and this study. Both revealed a reduction in well-being due to experiences of limitations on freedom of movement and accounts of decisions being made on the participant's behalf without any consultation with the participant. These forms of control were, in both cases, experienced as personally diminishing. Indeed, they appeared, for some young people, to lead to self-stigmatisation towards their situation of being in care.

Relationships, and the form of relationships within residential care, varied between the review and the study. In the review there were many examples of young people finding benefits from peer friendships in residential care, whereas, in this empirical study, only two participants experienced this gain. However, in this study family relationships appeared to play a major role in the young people's lives, while in the review, family relationships appeared less central to the young person's experience of residential care.

Both the reviews and the study's findings revealed violence in residential care as a serious and ongoing problem. Both evidenced not only examples of psychological and physical abuse between residents but also accounts where the young people expressed that those who should look after them had not been able to keep them safe. Thus, it can be argued that violence in residential care should receive further attention from the research community and the authorities which licence and support residential home care for children, youths and young adults.

The findings in the review's theme 'child to adult transitions in care' were, to a certain extent, mirrored in the study. In both the review and the study there were examples of burdensome accounts of worries about life following residential care. Equally both reported accounts of young people who felt ready for this transition. However, this study, possibly due to the participants' current situation as residing in aftercare and age at interview, offered findings which suggested that, even with an extended period of care, transitioning out of care could be burdensome to a level where avoidance strategies were engaged. Finally, in the study it was suggested by some of the participants that a prerequisite for feeling ready to leave residential care was the belief that they had to become successful at living in care. These participants revealed a form of over-dependence on the security their residential care home offered, which was found to encourage a belief that they were not ready to move into an independent living arrangement following aftercare. Thus, these participants predicted their future from a dependent, non-agentic position. The successful development of agency emerged in the review as a major contributor to well-being during care. Thus, the findings from the study support this finding in the review.

5.2 The empirical study

The major findings of this study contend that the participants who had initially experienced living in residential care as stressful revealed a gradual improvement in their well-being as they progressed from care as a young person under 18 years of age through to young adulthood and aftercare. In addition, this study's findings revealed that even with the extra years in care, most of the participants reported they did not feel ready to engage in activities which could enhance their opportunity of having a successful transition to independent living following care. The findings from this study are discussed in the next section including how this study's findings are situated in the current literature. Finally, this chapter concludes with a section outlining where the systematic review and the empirical study offer an original contribution to knowledge.

5.2.1 Different perceptions of residential care

While the participants' satisfaction with their lives in care varied, all the participants, following a period in care, were able to cooperate with their carers and reported areas where they had experienced relevant help. For some of the participants this process occurred over months, for others it took several years and placements before trust in their care home was achieved and cooperation could take place. All the participants were placed in care homes which followed Danish Governmental guidelines; thus, their residential care home had a therapeutic orientation which was considered, by the relevant authorities, to be the best possible fit for each young person. The participants' accounts revealed that even with this specialist approach the variation in how well they believed their residential care home had supported them, during their younger years in care, was similar to other countries, for example: reporting a lack of available help (Henriksen et al., 2008), experiencing stress through the unexplained authoritarian decision making (Johansson & Andersson, 2006) and a lack of freedom of movement and opportunities for social interaction outside of the home (Nurcombe-Thorne et al., 2018). However, the experiences following the transition to aftercare during young adulthood suggested that all the participants had experienced progression and a perception of improved well-being.

Four of the eight participants reported a sense of satisfaction regarding their time in care. These participants gave accounts of gradual maturing and a belief in the residential care homes' ability to assist them as they developed. Thus, the findings of Holmes et al. (2018), who contend residential care can be the best choice for some young people, are supported in the findings of this study. The group of satisfied participants believed their carers were interested in their development and help was available according to their needs. This group, while experiencing continuous connection with their family, appeared to have transferred some of their needs for support and security away from their family over to their carers. In addition, these participants offered some explanation of why residential care in their current placement had been successful for them. Two participants found benefit living in a home where everyone had a similar diagnosis, they experienced a situation where peers had more understanding towards each other's situation. This was considered an important finding and relevant for further investigation by the organisational authorities, as these two young people explained how elements of social equality were of benefit to them. Equally, the two other participants in this group both explained how their home was like living in a family home, which was perceived as both comforting and socially satisfying. Thus, while family was positioned by all participants as an important part of their lives in care, having a residential care home with a family-like atmosphere was experience as contributing to well-being.

These four participants described a living situation with no recalled violence or bullying. The carers they met were considered helpful and able to take time to ensure their individual needs were fulfilled. However, the participants who recalled their placement with dissatisfaction recalled being unable to engage in the support they were offered and recalled experiences of rejection, which they connected to their behaviour during periods of stress and social instability. Thus, these participants had both the burden of feeling ostracised and the additional burden of perceiving their ostracisation as a failure on their part. Their recall of rebellious and isolating behaviour, as well as incidents of drug abuse and violence, suggested that at times residential care had been experienced as trauma laden with a resulting reduction of their well-being, not least as their meaning-making of these behaviours appeared to encourage feelings towards their own poor behaviour strategies and lower worth. In addition, this finding aligns itself to the work of Harder and Knorth (2015) who emphasis the need for evidence-based treatments to encourage better outcomes in residential care.

5.2.2 The burden of transitioning into residential care

Adjusting to life in residential care can be fraught with uncertainties and worries, including the belief of victimisation through being placed in care (Jansen, 2010). Hallett et al. (2018) have argued that the lives of foster youth are framed by residential insecurity and mobility. The reported experiences of multiple moves, bullying, lack of choice in living arrangements and limited contact with close family members suggested that the findings presented by Hallett et al. (2018) could also apply to residential care. In addition, the findings revealed the experience of possible trauma-laden events that could lead to an overload of stressors (Khoury et al., 2010). While the intention of residential care is to help young people, including those with previous trauma, develop successfully, the participants' accounts confirmed the findings of Oransky et al. (2013) that carers are not always equipped to meet the needs of young people in residential care. The capacity of the carers to display interest and create spaces of time where the participant could receive individual attention was experienced by all the participants as fundamental to their well-being in residential care. However, the participants who struggled in care did not share this experience with those who experienced satisfaction; indeed, the recall of situations where rejection and disinterest from their carers were more common for these participants than recall of situations where carers demonstrated interest in their well-being.

5.2.3 Attachment theory and relationships with carers

Attachment theory focuses on relationships between people, including those between a parent and child (Bowlby, 1979). Attachment is defined as an affectional bond formed with a preferred individual or attachment figure (Bowlby, 1979). The attachment bond is perceived as both persistent and emotionally significant. While the development of attachment bonds during infancy is conceptualised as survival-driven, it is fundamentally important not only during childhood but also throughout the life cycle (Bowlby, 1979). When the bond is not perceived as secure by the infant the status of attachment can change to an ambivalent or insecure attachment which can adversely affect the infant's well-being and development (Berry, 2013). According to attachment theory, children develop an internal working model of themselves and their caregivers in accordance with their attachment experiences (Bretherton & Munholland, 2008). Internal working models control information processing in social and emotional situations (Bretherton & Munholland, 2008). While young people with secure attachments will expect emotionally responsive caregivers, insecurely attached young people will expect unresponsive or unreliable responses. These expectations can affect young people's self-concept, creating negative or idealising distortions (Zimmermann & Iwanski, 2019).

Attachment theory posits the development of a meaningful bond is contingent on a relational component, where the attachment figure is willing to attune to the specific needs of the younger person (Moses, 2000). However, evidence suggests that some residential care home carers preferred to invest their time in young people who have a respectful attitude and engage in proactive behaviour (Moses, 2000). The experiences revealed by the participants who had difficulty in settling into residential care appeared to support the findings of Moses (2000). These participants believed that some of the carers they had met were indifferent to their needs and did not spend time engaging with them. This formed a foundation for the experience of rejection and exasperated both their feeling of incompatibility with their placement and their belief that they were at times underserved. This finding implies that even with a focus in Denmark on training staff to degree level, participants met carers who were unable to readjust their methods and expectations and create a meaningful bond with the participant. Indeed, poor pedagogic practice was experienced by some participants as contributing to a reduction in their well-being and development. García-Ruiz et al. (2013) in their work on quality of communication between adolescents and their parents report a connection between anxious attachment and critic and arguments with parents. Thus, it can be argued that focusing on secure attachment relationships between the young residents and their carers is an important contribution towards a more well-balanced cooperation between the resident and the care home.

Tucker and MacKenzie (2012) argue that the internal working model of relationships is sensitive to change. This sensitivity was apparent both in the positive accounts where improved behaviour was equated with a calmer and more comfortable experience of residential care and in the more negative accounts. The participants who experienced poorer relations with their carers tended to experience multiple moves. These participants recalled situations where they anticipated rejection, with a follow-up of negative behaviour and further rejection. While this self-fulfilling prophecy was described by two participants, another participant described the opposite, that of a gradual improvement in her fit with each new home’s norms and culture. This participant, however, believed her moves were unrelated to her behaviour and that, as each move occurred, she recalled an increase in her own ability to fit in, thus increasing her repertoire of skills and perception of self-worth. A further participant who recalled several moves revealed how settling into his new home was contingent on his strategy of compliance to ensure he found carers who would respond to his need for company and protection from other residents. This experience of compliance in return for active help is in alignment with the findings of Moses (2000). Thus, social adaptation and positive beliefs in own self-worth and proactive decision-making appeared to encourage further development of a more socially directed internal working model of relationships.

Young people who have experienced a non-traumatic life trajectory have attachment representations which have been found to be stable over time (Weinfield et al., 2000), however when difficult life experiences are encountered attachment representations can be open to change (Weinfield et al., 2000). The findings suggested that the young people who were unable to draw upon successful coping strategies in adverse situations (Dahlstrand et al., 2021), such as moving to care and perceived experiences of failing to find stability, experienced representations of these negative markers when new stressors emerged which encouraged poor coping strategies and avoidance of interaction with carers. Interestingly, even the participants who recalled more extreme negative behaviour, such as fighting and drug abuse, recalled an improvement in their ability to cope with life in care. This recall included improved communication with their carers and a willingness to conform to the homes’ rules and norms as they matured beyond the age of 18 years. This suggested that for these participants their internal working models realigned to a more cooperative and flexible model when a calmer period in their lives was encountered. While it cannot be concluded that this calm was a result of reaching 18 years of age and experiencing an adjustment in the level of freedom and responsibility as a young adult, it does suggest that more research should be conducted to explore how perceptions of reduced control affect well-being.

5.2.4 Trust as a component for well-being in residential care

The legal boundaries for the participants, while they were minors, were at a minimum set by their home, their case worker, and their family. Thus, they were sheltered both legally and developmentally (Lenz, 2001). This sheltering was experienced by some of the participants as difficult to accept. The experience of not being asked or listened to, when believing the move to care was wrong, established, for four of the participants, a belief that the care system was untrustworthy. This lack of trust was, a belief they held for many years, causing difficulties in communication and general disbelief in the possibility to progress in residential care. Two of the participants maintained this belief throughout their residency. Finally, it should be noted that general age-related maturing and increased knowledge through school attendance are factors which may have contributed to this improvement in the way the participants interacted with their residential care home (Lerner, 1985).

Trust is a vital component of quality social interaction and well-being (Valenti et al., 2020). The establishment of a form of mutual trust between providers and young people is a significant component of a strong working relationship (Valenti et al., 2020). Erikson’s stages of psychosocial development (Erikson, 1993) and attachment theory (Bowlby, 1969) posit that trust is developed through ongoing interpersonal interactions. The findings revealed that participants who were distrustful of the system of care were more likely to avoid interpersonal interactions with carers. Thus, residency in care appeared to contribute to an increase in stressors for these participants.

For some participants, however, their maturation allowed them to look back on previous experiences with a deeper understanding of the events. These participants appeared to acquire a belief that encouraged trust towards the decisions the homes made for them, including an increased belief that these decisions were well-made and in their interest. For the participants who achieved this level of reflection and maturity an increased desire to cooperate was apparent in their accounts. The findings pertaining to authoritarian control and the establishment of a trustful attitude towards adult guidance suggested that for some young people interpersonal interactions can be negatively affected when young people are excluded from decision-making and involvement in decisions regarding their own situation.

5.2.5 Maturity and transitions in residential care

While there was a discrepancy between the participants' beliefs in how well they were placed, all the participants reported they had matured positively in care. Their maturing was observed to be slower than their peers outside of the care system, with few of the participants attaining age-appropriate milestones such as school leaving certificates, educational training, etc. The findings revealed multiple factors for later maturation, including the mention of diagnosis-related factors such as ADHD and autism. However, the impact of the stressful events which caused the residential care placement, followed by the process of moving into care, including a change in school placement, created a period of stress for all the participants. The disruption of primary attachment, through moving to care and the trauma of events both prior to residential care and during care, have been connected to a slower and less secure mastering of stage-salient tasks, including autonomy, emotional regulation and acquisition of age-related learning skills (D'Andrea et al., 2012; Spinazzola et al., 2018).

The slow maturation was found to affect the participants' capacity to engage in the major transitions they had experienced or were working towards. Two, overarching behavioural markers appeared in the findings, avoidance and over-dependence. Adolescent and young adult life-phases are transitory situations where successful navigation of normative milestones, such as turning 18 years of age or moving into a first apartment, are contingent on cooperative actions and social competences. These findings confirm the suggestions of Stein (2012) that the transition to young adulthood should be embedded in the context of a stable placement, whereby resources are continuously available to encourage proactive engagement. For some participants a situation of dependency on known and reliant relationships was evident. These participants revealed a form of over-dependence on the security their residential care home offered, which was found to encourage a belief that they were not ready to move into an independent living arrangement following aftercare. Thus, these participants predicted their future from a dependent, non-agentic position. This finding was also evident in the systematic review which concluded with recommendations to investigate further how the development of constructive agentic behaviour can be understood and developed in residential care environments. In addition, Cunningham and Page (2001) in their case study on a traumatised 13-year-old boy resident in care, argued for residential care homes to be more aware of how external control can affect the developmental prospects for young people. The study posited that external control encouraged an external locus of control (Galvin et al., 2018) which could inhibit long-term planning abilities and the ability to compromise. Indeed, they argued for an approach base which encourages stable attachment between young people in care and their carers.

5.2.6 Worries about leaving residential care

Within the accounts, some participants expressed a fear of not being able to stay in their residential care home for as long as they wished. This fear appeared to contribute to a lack of agency regarding their future and increased their dependency on authoritative figures. This lack of interest in future events also appeared to be connected to a lack of knowledge on how to address the future; indeed, without role models demonstrating how to achieve educational and employment milestones it was difficult for these participants to articulate what independence actually meant (Manso, 2009). In addition, these participants, as with many peers outside of care, may have been influenced by the current societal trend which accepts young adults living at home longer due to the high cost of home ownership or rental (Bessant et al., 2017). Without the typical family network to assist with housing, a belief that their residential care home would ensure their immediate safety suggested a possible transfer of reliance from a family type base over to the residential care home.

The two participants who did not display over-dependent behaviour gave alternative accounts which revealed a determined commitment towards avoiding, where possible, any form of help from their home. Both these participants had moved from the care home to an apartment. Their life story had similarities as both participants were without family support, however, they enacted their avoidance in different ways; one strove successfully to find social contact and relevant work independently of the care home and the other participant chose an isolating lifestyle where help-seeking was limited and largely replaced by self-help strategies.

Thus, even with the extra years of care, many of the participants were reluctant to consider independent living. While it can be argued that this is a failure from the residential care home, the participants' accounts suggested that the effect of events leading to a placement in residential care, followed by the transitional burden of moving into residential care in childhood and adolescence is psychologically overwhelming. This level of burden, regardless of the residential care home's ability, was seen to hinder development to a level where it was unlikely that maturing could follow the typical age-related milestones. Therefore, it is posited from the findings that the evaluation of when a young person is ready to move out of care should be conducted through the evaluation of skill sets and perceived social capacity and not through age-related expectations. Indeed, Dixon (2008) argues that the abrupt nature of leaving care according to externally determined age attainment creates an accelerated and compressed transition, which may add a burden to mental health problems. This is further discussed by Stein et al. (2011), who suggest young people in this position often become disadvantaged in the main pathways to adulthood with a reduction in success within the domains of education, employment, accommodation, health and well-being.

Research and the development of theories of transitions, for example, leaving home for university, have focused on normative development within the societies of interest (Lenz, 2001). Indeed, relatively little is known about transitions in care. However the findings from this study confirm the conclusions in other studies, for example, on the need for mentorship after leaving care (Sulimani-Aidan, 2018) and the advantage of contact with supportive adults following the transition to adulthood (Schofield et al., 2017). Sanders et al. (2017) posits the importance of positioning transitions as fundamentally contextually sensitive, thus, the possibility to develop well during and following a major transition is influenced by the young person's family, network and the community in which they live as well as the wider cultural and socio-economic situation in which their lives are embedded during their transition. Thus, specific focus should be given to the specific context each young person has and, in particular, to young people with additional needs (Sanders et al., 2017).

The participants' slow maturing suggested not only the necessity of having sufficient time in aftercare to build skills for a successful life following care but also to counter the negative effect of the turbulent and at times damaging effect of living in a less stable and secure family environment during adolescence. All the participants had experienced at least some of their adolescence in residential care homes. Adolescence has been characterised as a time when individuals begin to reflect and examine the characteristics of self (Steinberg & Morris, 2001), to discover who they are and how they fitted into the world they encountered. All the participants had experienced maturing towards society's normative milestones. Kerpelman and Pittman (2018) theorise the processes of identity development and identity formation are flexible, with identity varying in its emergence with relational factors. The findings suggested that, while the participants' experiences during residential care had contributed to an initial slowing down of identity formation and self-awareness, during the later years of care a re-emergence of identity formation had occurred, whereby the participants experienced a more positive self-image.

Okpych and Courtney (2015) in their analysis of care leavers' prospects beyond care, inform of, in comparison to non-care peers, a difficult period following care where unemployment, mental health problems, housing difficulties as well as educational and employment experiences are severely reduced compared to non-care peers. Thus, it is argued from the findings in this study that a well-executed extended care programme can encourage processes which limit barriers to progression and difficulties beyond care through allowing the young person to mature at a pace which is compatible with their individual developmental stage.

5.2.7 Family attachments and social opportunities

The participants in this study had noticeably few relationships, with most being limited to their family, their carers, and their peers in care. The typical social network of sports clubs and youth activities was only represented in one account. Pittman et al. (2011) suggest personality growth and social adaptation are closely linked, thus, nearly all the participants in this study appeared to lack a platform to experience how their identity could evolve through social opportunities. This finding is of concern, indeed, Whittaker et al. (2016)

support the arguments raised by Pittman et al. (2011), with emphasis on the importance of a residency in therapeutic residential care being integrated in the community to encourage a web of social relationships which go beyond the care home and immediate family. Without this continuous interaction with the world beyond care and immediate family, the young person's understanding of how to navigate life outside of care will be severely limited and possibly cause extra burden when transitioning out of care.

The participants' experiences of relating to and integrating with their families varied. All the participants who were in regular contact with either their biological family or their previous foster family were adamant that the residential care home could not replace their parents' role in their upbringing. These participants revealed the symbolic power of the wording of family (Kendrick, 2013), with their accounts emphasising the importance of family loyalty and family supremacy over residential care. The connotations the participants had, regarding their interpretation of what their family could be, appeared to include family being a favourable continuous resource when compared to the residential care system's temporal limitations. The impact and value of family ties were strong for six of the residents. These participants appeared to identify themselves through their family, with the family identity considered more important and prestigious than the identity of being a young person in care. Thus, the investment this group made in maintaining family contact and their position in their family took both time and focus. This effort encouraged some participants to pursue the experience of being divided between two lives. For those who were unhappy with their placement, this division also appeared to encourage a form of stigmatisation by the participant towards the system in which they were placed.

This group understood that their family could not care for them, however, they did not interpret this as that their family did not care about them; indeed, all the young people who had a strong interest in their family believed this was the case. The transfer of responsibility for their upbringing, from the family home to the care home, when the participants were younger, was portrayed as a necessity. The findings did not support the work of Kendrick (2013), for example, who suggested that young people in residential care choose to refer to carers and peers with family-associated names such as sister. The participants in this study kept a clear demarcation between family and the residential care home as an institution, with, for example, the positive recall of good individual relationships with carers not being perceived as the same type of relationship as a family can offer. This finding, however, may be connected to the age difference between this study’s participants who are over 18 years of age, and the participants in the Kendrick (2013) study who appeared to be younger.

With the exception of two participants, the people who appeared to matter most within the participants’ lives were their family or, when the family was unavailable, previous foster carers. Family representations could also include friends of the family and people known in the family neighbourhood. For this group, the neighbourhood symbolised home. The temporal nature of care, in that other residents came and went, appeared to limit investment in peer friendships within the residential care home. Peers were people met along the way; for six of the participants, peers in care were acquaintances rather than friends. Two participants offered an alternative to these findings as they had found a social life which was meaningful to them in care. They claimed this was because the other residents were like them; both participants lived in a residential care home for young people with autism and, they, while acknowledging their family, appeared to have less need than the other participants to claim family as identity markers within their lives. Thus, the findings of Emond (2003) which suggested that the residential group culture was central to their experience of residential care were only partially confirmed in this study. While peer relationships were a positive experience for some participants, many did not find support through peer friendships in their shared situation.

The development of a network outside of the care home is one of the defining parameters for the definition of therapeutic residential care (Whittaker, 2005). The participants offered few examples of networks outside of their care home beyond their own families, with only one participant experiencing a continuous social connection outside of the home. The Consensus Statement of the International Work Group on Therapeutic Residential Care (Whittaker et al., 2016) within its principles of good therapeutic residential care state that a continuous partnership should exist between the families of the residents and the professionals who serve the young people. Thus, each home should strive to help young residents and their families achieve a stronger connection during their residency. The findings suggest, from the participants' accounts that the Danish care system is inclusive of this principle.

5.2.8 Bullying and violence in residential care

Being the victim of bullying and peer violence while in care was described by two of the participants. The reflections within their accounts suggested that these experiences were traumatic and affected their representations of safety in care. In addition, each participant's accounts reflected the harm bullying and violence can create, with one of the participants developing an overdependent strategy to compensate for fears of further peer violence and the other participant reacting with her own violent behaviour and strategies aimed at isolating herself from others. The findings in this study contend with the observations and suggestions formulated by Moore et al. (2017), that safety in residential care is a major factor in a successful residency, and an improvement in general satisfaction within residential care residency would be improved if the risk factors of residential care were further highlighted and acted upon.

5.2.9 Friendships in residential care

The findings on family and peer relationships revealed that many of the participants had difficulty in transferring their social needs from their original home base to their residential care home. The social opportunities the care home offered were unattractive to this group, which in turn created barriers to the development of social strategies and social adaptation. The development of these skills was noted as difficult for this group with one exception, a participant who found social opportunities outside of her residential care home. However, despite this claim that friendships in care were not real or permanent, peer social interactions were recalled as readily available; indeed, two of the participants believed one of the benefits of residential care was, due to the high number of peers, that there was always someone with whom to talk.

For the participants who did not make lasting friendships in care and relied on their families to provide social opportunities, limitations to their development could have occurred. Without adequate social interaction, loneliness can occur, with the ensuing risk of depression, anxiety and general low well-being (Kehusmaa et al., 2022). In addition, without peer social opportunities both in the care home care and in non-residential care, the opportunity to develop social strategies becomes difficult, and an increasing belief in social inadequacy can develop.

The findings also suggested the level of social interaction with young people outside of their residential care home was affected by the continued and important need to keep family contact intact. Creating time to visit their family on weekends limited the time available for integrating with local social opportunities. While Allen et al. (2005) posit the importance of adaptive social development during adolescence, this study's findings suggest that the development of social adaptivity may be a slower and more ongoing process than in peers outside of the care system. Poorer social competence is connected to a disorganised form of attachment (Manso, 2009), thus, the participants who presented a disorganised form of attachment had an additional barrier when social opportunities were present.

5.3 Original contribution to knowledge

The findings from both the systematic review and the empirical study have sought to ask questions and investigate areas which have not previously received sufficient research attention. While some of the findings contribute to knowledge through the confirmation of previous research findings, the review and empirical study go beyond this with new findings which offer an original contribution to knowledge.

The systematic review has:

- revealed a link between agentic behaviour and a proactive residency in care.
- highlighted how perceptions of control affect the well-being of young people in care.

The empirical study has:

- revealed a link between moving into care and delay in maturing.
- revealed how extended care encourages a recovery process following the trauma of moving into care.
- revealed that extended care does not equate with being mature enough to move into independent living.

Finally, the empirical study as well as the review have raised arguments for the need to conduct more research on how perceptions of control affect both well-being while residing in care and the carer/resident relationship.

Chapter 6

Conclusion

6.1 Strengths and limitations

This study has followed the principles of IPA and contends that the idiographic experiential focus in which this method is grounded has ensured findings with a high level of depth and richness (Smith et al., 2009). In addition, the generation and analysis of the eight individual case studies ensured that all the participants have, through their participation, attained a voice in the study’s findings, discussion and recommendations on how residential care for youths and young adults can be improved for future users.

The country of choice for this study, Denmark, has not only a comparatively well-developed and well-funded commitment to social issues, but it has, along with Norway, laws on the offer of aftercare (Socialstyrelsen, 2022). Thus, this study has been able, through a deep and exacting methodology, to enquire into the experiences of a unique group of young people. Through the young people’s accounts, it has also been possible to gain insight into care and extended care within Danish therapeutic residential care settings.

The choice to conduct two interviews has enhanced the quality of the findings. Six of the participants validated their transcripts from their first interview and offered additional information regarding their experiences. Thus, it is posited that the findings drawn from the interviews offer a very deep and rich insight into how the participants’ experienced living in residential care.

The choice to recruit young people via the residential care homes may have created a pathway which inhibited some young people from choosing to enquire into the study. Equally, the choice to conduct one-to-one interviews may have been perceived as intimidating by some possible participants. Had the invitation been to group interviews it is conceivable that young people with different experiences of residential care may have chosen to participate.

The choice not to investigate the experiences of events which led to the first placement in care have not been included in this study, this decision may have affected some of the conclusions drawn. In addition, the analysis and conclusions may have been affected by the researcher's lack of experience. This process has evolved with the researcher, one participant at a time. While all transcripts have been revisited during the analysis, discussion and conclusion the researcher contends that if a project like this was to be conducted by the researcher in the future, the next analysis would reflect the knowledge gained from the experience gained from conducting study.

6.2 Quality assurance

It is the researcher's belief that the close attention to detail during the analysis of each of the participant's accounts has ensured a full representation of the meaning making of their lived experience of residential care. The findings presented in this study are grounded in the conducted interviews and through the researcher's interpretations reflect, as closely as possible, the experiences and lifeworld of the participants.

The idiographic lens this study has used to gain insight into how young residents in care facilities have experienced this service has demonstrated the value of a phenomenological approach. IPA has facilitated a deep analysis which has generated rich findings which reflect both the idiographic nature of IPA and the opportunity of merging the individual experiences and meaning-making each participant has offered. From this, a cohesive whole has been developed which can contribute to a better understanding of the experience of living in care.

This study is grounded in the qualitative paradigm and therefore has not sought to test a hypothesis or explain how and why a specific intervention should be used. Rather it has sought to understand the individual experience and how individuals make sense of what they have experienced. Thus, the recommendations drawn from the findings are broad. However, when the findings from the empirical study are compared with the findings from the systematic review, it is perceived reasonable to posit that some of the findings confirm what is already known within research and therefore deserving of attention from service and organisational institutions. However, the ontological position of this study, critical realism, contends that there is a reality which, while not necessarily observable, exerts forces that can affect the events we experience. Thus, as suggested by Willig (2012) the findings in this study are not limited to the experiences of the eight participants, they form a body of knowledge which has observations on the underlying mechanisms of residential care that are relevant to a wider audience.

The findings of the study conducted in Denmark are of value to decision-makers and those engaged in research on decisions relating to extended care, and to decisions regarding the further development of a well-educated work force within this area.

6.3 Concluding comments

This study has conducted a systematic review which through enquiring into relevant peer-reviewed literature answered the following research question:

What is known about the experiences of youths and young adults who live in residential care, and how do these experiences impact on their well-being?

The review revealed how experiences of residential care varied, and how for some of the participants in the individual studies residential care had a negative impact on their well-being, while for other participants there was a sense of security and well-being connected to their placement. The findings from the review highlighted how the individual experience was affected by care community culture, with some young people experiencing stability and security and others experiencing a lack of understanding from their care home. The review also revealed the need for an improved understanding by the care homes of the psychological well-being of the residents.

This empirical study which has formed the main study within this thesis was intent on answering the research question:

How do young adults experience and understand life in Danish therapeutic residential care?

Through the activation of the objectives:

- To explore young adults' individual stories of their lived experience of therapeutic residential care in Denmark.
- To examine young adults' perspectives on the current system of therapeutic residential care in Denmark.

The findings as discussed in chapter 5, demonstrate this study has undertaken a deep exploration of the experience of eight young adults who have lived in Danish residential care.

The major findings of the empirical study posit that all the participants recalled an improvement in their well-being as they matured into young adulthood. Thus, this study's findings support the beliefs of the International Work Group for Therapeutic Residential Care who suggest therapeutic residential care is a relevant offer to some young people (Whittaker et al., 2016). In addition, the findings revealed how some participants expressed a belief that they were not ready to prepare for leaving care, despite their knowledge that their time in aftercare was ending as they aged out of the aftercare programme. This finding suggests that the extra years in care designated to encourage the necessary maturity to establish a foundation for a successful start on independent living can create a new barrier to an independent life, whereby the resident establishes a preference for a continuous institutionalised lifestyle. This study's findings revealed an increase in well-being due to the extended care arrangement and conclude that extending residential care for a period following the 18th birthday is a fundamental necessity for this group. The findings also suggested decisions on when it is time to prepare for leaving care should be based on individual assessments. The last conclusion from the findings is the positive effect of experiencing staff who have time for each resident. Indeed, the participants in both the review and the study expressed the benefits of carers who ensure the young people in care receive the individual attention they need and that the staff are both sufficiently motivated and trained to always ensure safety for all residents.

Eurochild, Unicef and Lumos promote deinstitutionalisation and reunification with families. Through initiatives to decrease poverty and the ensuing neglect of children, they strive to establish a solid, caring family base for every child (Lumos, 2020; Sandbæk, 2017; Unicef, 2021). While these goals are fundamentally of great importance, they are not directly applicable to all children, youths and young adults who are living outside of their own home. The argument in Lumos (2020) which contends that out of home care can severely harm children and young people's development is not, from the findings in this study, applicable to all residents within Danish therapeutic residential care. This study's findings are in alignment with Holmes et al. (2018) and Whittaker et al. (2015) that a well-planned, well-staffed residential care home which is inclusive of family and the community can provide the necessary high quality, nurturing care for children, youth and young adults with significant behavioural and psychological needs.

6.4 Policy implications

The findings in this study support the current policy in Denmark of offering aftercare to all who have resided in residential home care in Denmark. While alternative programmes may be better suited to those with severe physical impairments, this study contends that the aftercare programme is of benefit to the population it serves. Policy makers are advised to consider the benefits of an aftercare offer with a flexible timeframe, thus placing the perceived needs of the individual in the forefront when planning goals and milestones during aftercare. The current policy of placing young people in residential care homes has not been, within this study, positioned as a negative event. The study's suggested benefit of aftercare should be of relevance to policy makers outside of Denmark. The Danish model offers a well-established programme, knowledge of which could enhance integration of an extended care programme in new areas.

6.5 Service implications

The findings in this study revealed the importance of continued help for young people who have lived in residential care during their youth. The late maturing, lack of social skills and decision-making abilities evident in the findings imply that discontinuation of assistance for this group beyond the age of 18 would exasperate the risk of reduced well-being for the young care leaver and encourage a burdensome lifestyle for the young person. This in turn, will affect not only the young person's life opportunities but possibly the community at large. In addition, it is proposed that existing and future offers of assistance to this group should engage a flexible approach regarding how long the offer of assistance, following adulthood, should extend.

6.6 Organisational implications

The negative impact of multiple moves while in residential care needs further consideration. The findings suggested that the participants who struggled in their first placement did not find a more qualified home following a move. While there can be multiple reasons for a residency breakdown, it is suggested from the findings that involving young people in decisions regarding moving would benefit this process. This study supports the work of Wigley et al. (2012) who posit the importance of multi-agency work when developing residential placements for vulnerable young people. In addition, the participants who recalled well-being in care and satisfaction with their placement due to living with young people in similar circumstances is an important finding for improving the organisation of residential care homes.

6.7 Implications for practice

The findings have revealed the positive impact of the interested and flexible carer on the well-being of the participants. Equally, the participants have reported the negative effect of carers who are not equipped to help the young person in their development. While carers in Denmark are generally well educated, this finding highlights the need for continuous professional development with, for example, clinical supervision for all those working with this group. The findings also revealed the importance of having enough carers, the findings revealed individual time spent with the young person was one of the fundamental criteria for a positive residency.

Feeling safe in care was raised as an important parameter in both the systematic review and the empirical study for well-being while in care. The prioritising of a culture where new residents, as well as experienced residents, know that while they are in care, they will be safe should be perceived and worked towards as a necessary as well as an achievable goal.

6.8 Recommendations for further research

The findings of the study conducted in Denmark are of value to decision-makers and those engaged in research on decisions relating to extended care, and to decisions regarding the further development of a well-educated work force within this area.

Both the review and the study revealed the need to conduct further research on how the young person's agentic ability affects their well-being and developmental opportunities during residential care. Further research on how the development of agency is affected by residency in care and how, for residents who are struggling to attain an agentic repertoire as they mature in care, this can be supported is recommended. The study has contributed with knowledge towards the effect of living in care on normative maturing, with as discussed in the findings a general period of acclimatisation to a new way of living which, affected both well-being at the time and the maturing process. Thus, it is recommended that further research should be conducted to improve our understanding of how the process of moving into and residing in care affects the normative maturing of young residents.

The study was directly involved with young adults in aftercare, with the accounts giving an insight into how extended care was perceived as beneficial by the participants. This finding should be further researched with a larger participant pool. More insight into extended care is needed to identify which factors have a positive universal effect on residents in aftercare and their ensuing transition into independent living and which factors are relevant for different sub-groups of those placed in residential care.

The study's discussion has opened a debate regarding attachment theory and internal working models. The findings indicated that of some of the participants, who had previously developed ambivalent attachments could, with support, adjust their internal working model to a more trustful and socially adaptive approach. This finding is linked both to further research on how staff can be facilitated with the right knowledge to support this positive development and research on which parameters within the care homes culture are supportive of this positive development.

Finally, as mentioned previously in the discussion in Chapter five, the reporting by young people in both the review and in this study of young people of being subjected to or witness to violence is of concern. Equally, the perception that some of the young people held that the staff who looked after them are not able to ensure their safety is disturbing. More research into the practices of homes which have residents who report feeling safe and secure needs to be conducted to ensure this negative aspect of residential care can be replaced by safe cultures within care.

6.8 Reflections

Conducting this study has required a considerable effort to understand the hermeneutic circle and the effect of misinterpretation and over-interpretation during analysis. The first analysis was extremely difficult. As the first analysis developed, I realised that I had unwittingly brought preconceptions into the analysis. I accepted that I was, at that time, unable to fully bracket-off (Chan et al., 2013) thoughts arising from my professional position as a head mistress within special needs education, and this conclusion brought new thinking to my work.

I chose, following the first failed attempt of conducting the analysis in Danish, to translate the interviews from Danish to English, prior to analysis. While this deviates from current practice, I believed the introduction of a language I do not use in my daily work was of value. My thoughts were, in the English language, attuned to the role of a researcher. To further assist my quest for avoidance of pre-conceptions, biases, and any form of conclusive thought I, on the completion of each interview, wrote down my immediate thoughts. These notes became valuable markers, as they reminded me to address any preconceptions that may have been affecting my clarity of observation and thought.

It was my intention to understand as closely as possible the participant's meaning making as they related their experiences (Smith et al., 2009). Without doubt as I immersed myself in the process my abilities improved. I needed to redo the first two analyses I had conducted.

Engaging in such a close and deep analysis was causal of many thoughts and at times I was confronted with accounts which were both sad and distressing. I have during the period of interviewing and analysis ensured my well-being through contact with my supervisor at Lancaster University and through the supervision I receive at my place of work.

As I conclude my reflections on conducting these studies and writing my thesis, it is my belief that this research is grounded in good scientific practise. The results of this endeavour offer new knowledge to an area which is of great importance to many people.

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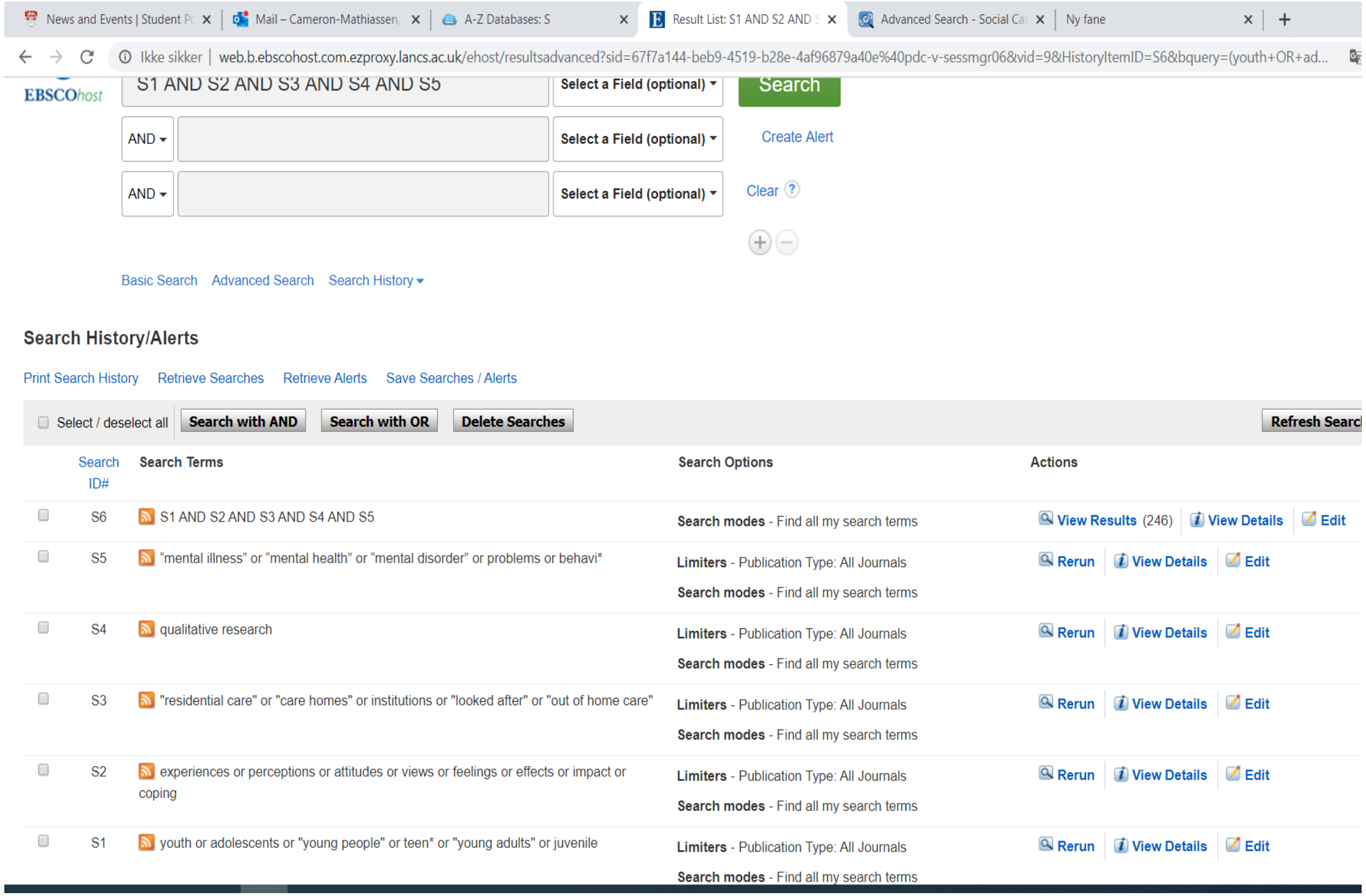
Appendices

Appendix I

Screen prints illustrating the search process for the systematic review: SocIndex:

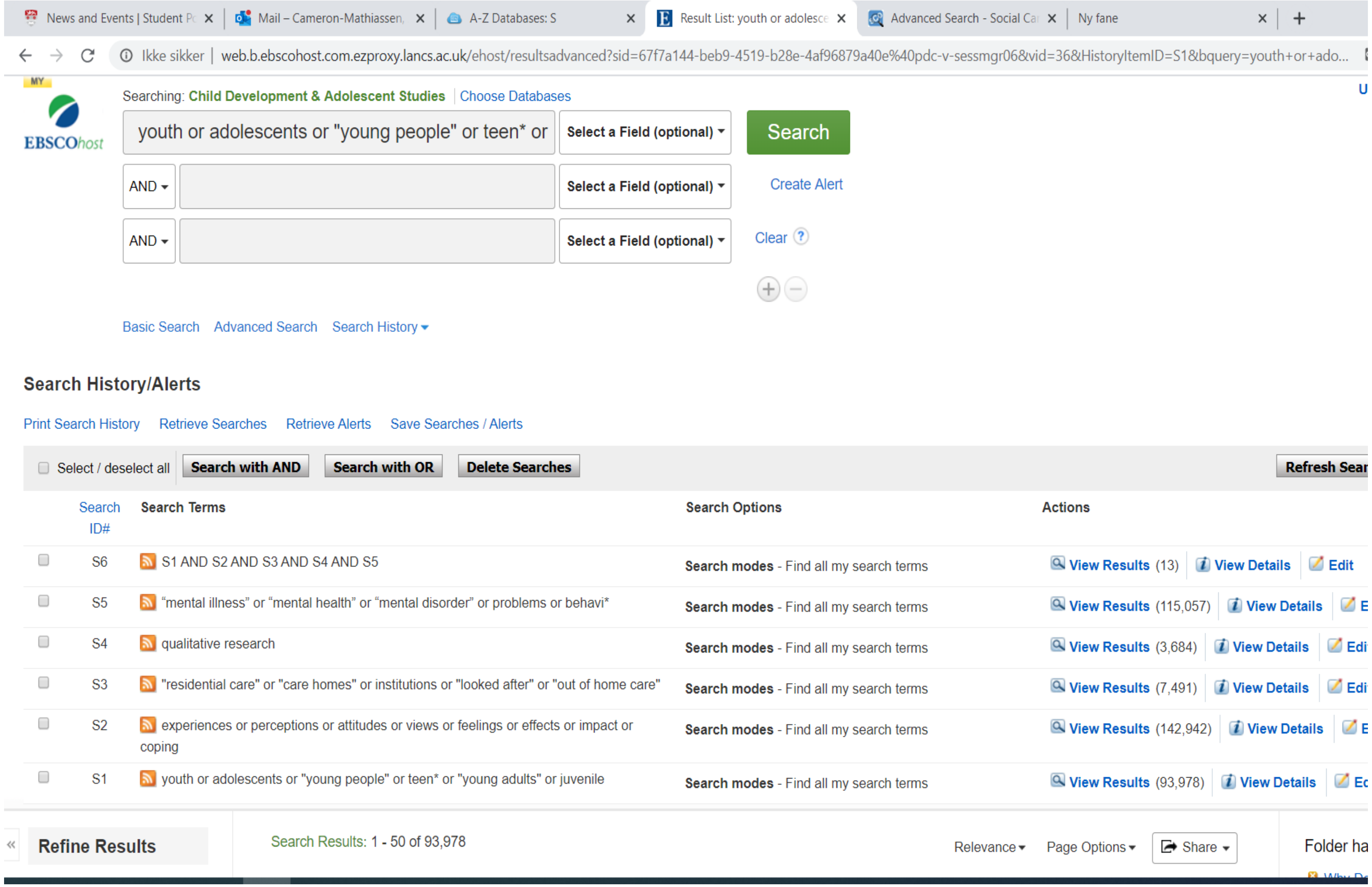


web.b.ebscohost.com.ezproxy.lancs.ac.uk/ehost/resultsadvanced?sid=67f7a144-beb9-4519-b28e-4af96879a40e%40pdc-v-sessmgr06&vid=9&HistoryItemID=S6&bquery=(youth+OR+ad...

S1 AND S2 AND S3 AND S4 AND S5

Search ID#	Search Terms	Search Options	Actions
S6	S1 AND S2 AND S3 AND S4 AND S5	**Search modes** - Find all my search terms	View Results (246) View Details Edit
S5	"mental illness" or "mental health" or "mental disorder" or problems or behavi*	**Limiters** - Publication Type: All Journals **Search modes** - Find all my search terms	Rerun View Details Edit
S4	qualitative research	**Limiters** - Publication Type: All Journals **Search modes** - Find all my search terms	Rerun View Details Edit
S3	"residential care" or "care homes" or institutions or "looked after" or "out of home care"	**Limiters** - Publication Type: All Journals **Search modes** - Find all my search terms	Rerun View Details Edit
S2	experiences or perceptions or attitudes or views or feelings or effects or impact or coping	**Limiters** - Publication Type: All Journals **Search modes** - Find all my search terms	Rerun View Details Edit
S1	youth or adolescents or "young people" or teen* or "young adults" or juvenile	**Limiters** - Publication Type: All Journals **Search modes** - Find all my search terms	Rerun View Details Edit

Child Development and Adolescent Studies:



Searching: **Child Development & Adolescent Studies** | Choose Databases

youth or adolescents or "young people" or teen* or

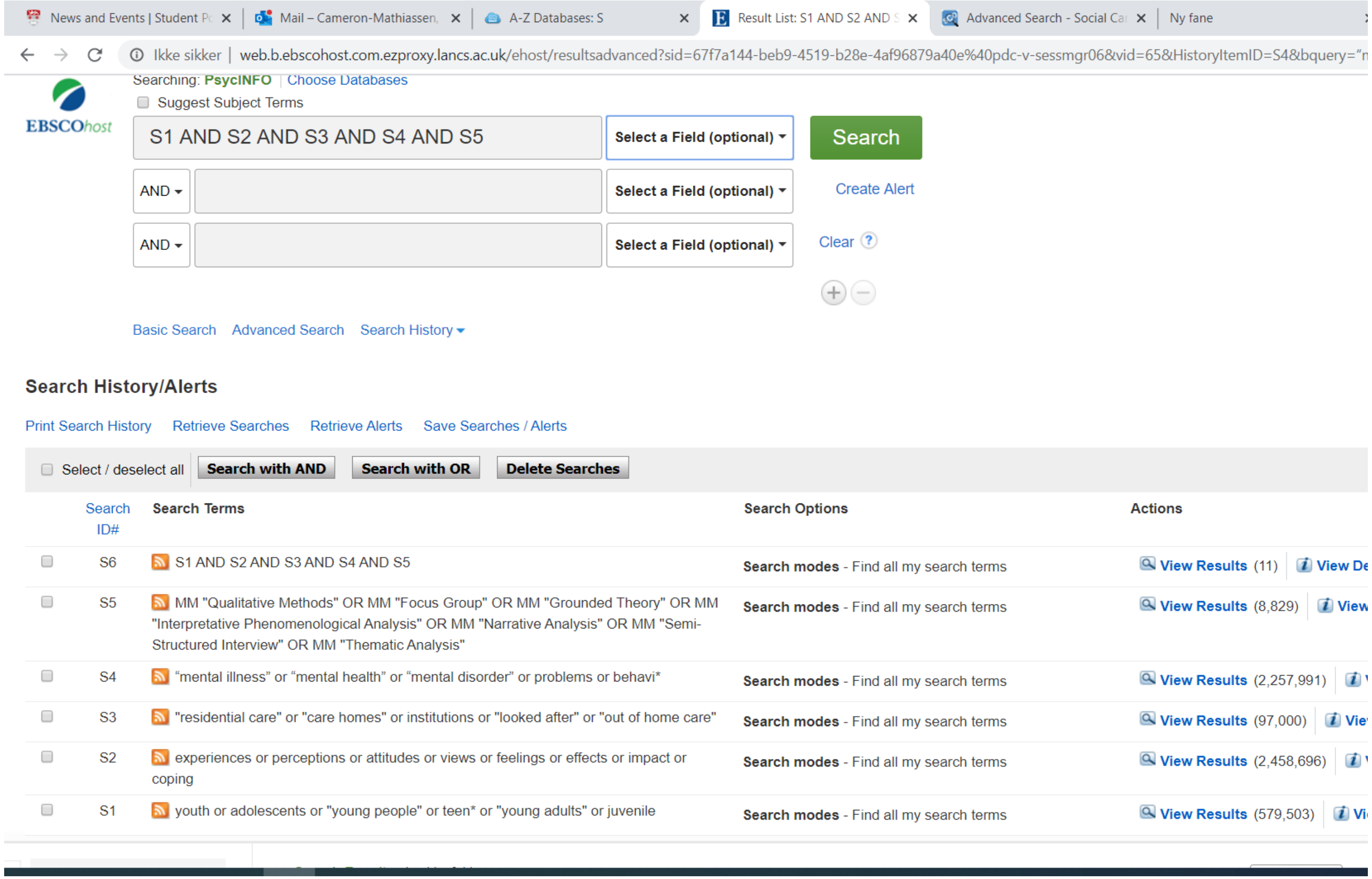
Search History/Alerts

	Search ID#	Search Terms	Search Options	Actions
☐	S6	S1 AND S2 AND S3 AND S4 AND S5	**Search modes** - Find all my search terms	**View Results** (13) **View Details** **Edit**
☐	S5	"mental illness" or "mental health" or "mental disorder" or problems or behavi*	**Search modes** - Find all my search terms	**View Results** (115,057) **View Details** **E**
☐	S4	qualitative research	**Search modes** - Find all my search terms	**View Results** (3,684) **View Details** **Edi**
☐	S3	"residential care" or "care homes" or institutions or "looked after" or "out of home care"	**Search modes** - Find all my search terms	**View Results** (7,491) **View Details** **Edi**
☐	S2	experiences or perceptions or attitudes or views or feelings or effects or impact or coping	**Search modes** - Find all my search terms	**View Results** (142,942) **View Details** **E**
☐	S1	youth or adolescents or "young people" or teen* or "young adults" or juvenile	**Search modes** - Find all my search terms	**View Results** (93,978) **View Details** **Ec**

Refine Results

Search Results: 1 - 50 of 93,978

Psych Info:



Searching: PsycINFO | Choose Databases

S1 AND S2 AND S3 AND S4 AND S5

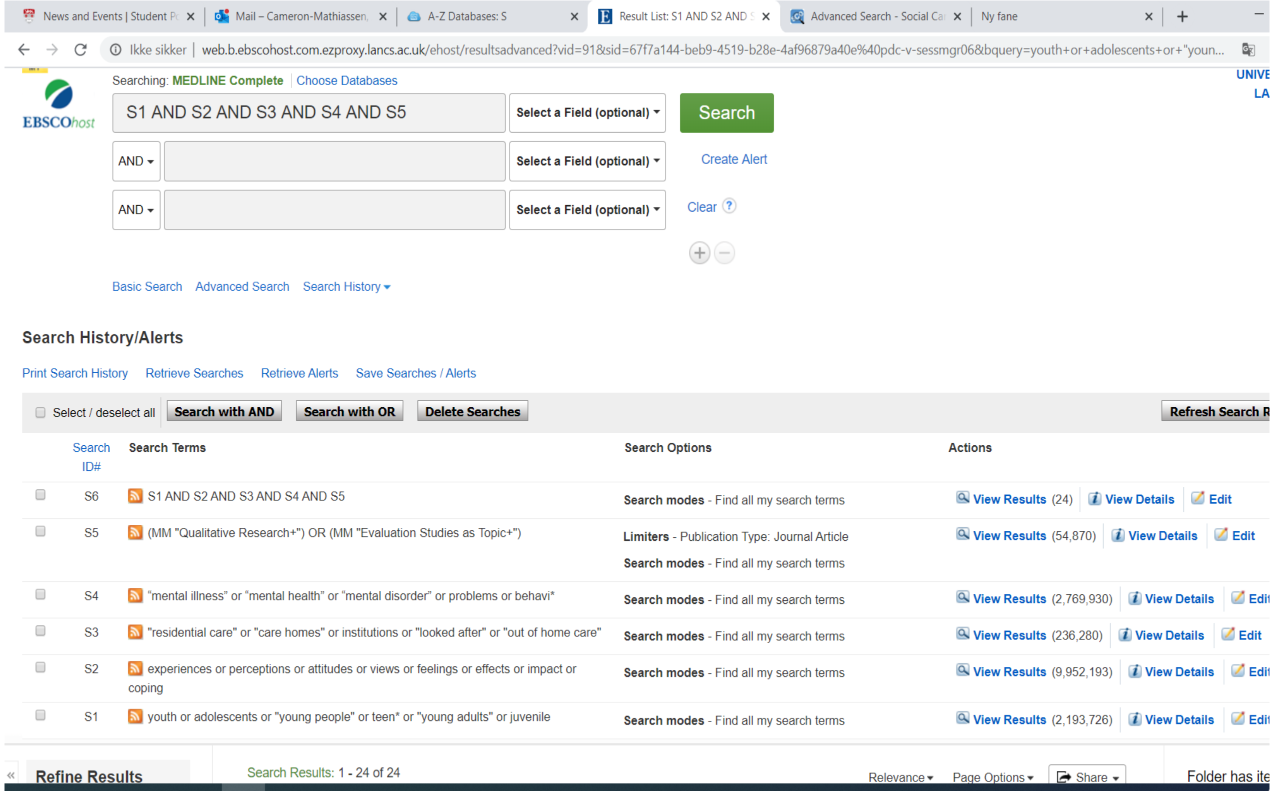
AND

AND

Search History/Alerts

Search ID#	Search Terms	Search Options	Actions
S6	S1 AND S2 AND S3 AND S4 AND S5	Search modes - Find all my search terms	View Results (11)
S5	MM "Qualitative Methods" OR MM "Focus Group" OR MM "Grounded Theory" OR MM "Interpretative Phenomenological Analysis" OR MM "Narrative Analysis" OR MM "Semi-Structured Interview" OR MM "Thematic Analysis"	Search modes - Find all my search terms	View Results (8,829)
S4	"mental illness" or "mental health" or "mental disorder" or problems or behavi*	Search modes - Find all my search terms	View Results (2,257,991)
S3	"residential care" or "care homes" or institutions or "looked after" or "out of home care"	Search modes - Find all my search terms	View Results (97,000)
S2	experiences or perceptions or attitudes or views or feelings or effects or impact or coping	Search modes - Find all my search terms	View Results (2,458,696)
S1	youth or adolescents or "young people" or teen* or "young adults" or juvenile	Search modes - Find all my search terms	View Results (579,503)

MEDLINE Complete:



web.b.ebscohost.com.ezproxy.lancs.ac.uk/ehost/resultsadvanced?vid=91&sid=67f7a144-beb9-4519-b28e-4af96879a40e%40pdc-v-sessmgr06&bquery=youth+or+adolescents+or+"youn...

Searching: **MEDLINE Complete** | Choose Databases

	S1 AND S2 AND S3 AND S4 AND S5	Select a Field (optional)
AND		Select a Field (optional)
AND		Select a Field (optional)

Search History/Alerts

	Search ID#	Search Terms	Search Options	Actions
☐	S6	S1 AND S2 AND S3 AND S4 AND S5	**Search modes** - Find all my search terms	View Results (24) View Details Edit
☐	S5	(MM "Qualitative Research+") OR (MM "Evaluation Studies as Topic+")	**Limiters** - Publication Type: Journal Article **Search modes** - Find all my search terms	View Results (54,870) View Details Edit
☐	S4	“mental illness” or “mental health” or “mental disorder” or problems or behavi*	**Search modes** - Find all my search terms	View Results (2,769,930) View Details Edit
☐	S3	"residential care" or "care homes" or institutions or "looked after" or "out of home care"	**Search modes** - Find all my search terms	View Results (236,280) View Details Edit
☐	S2	experiences or perceptions or attitudes or views or feelings or effects or impact or coping	**Search modes** - Find all my search terms	View Results (9,952,193) View Details Edit
☐	S1	youth or adolescents or "young people" or teen* or "young adults" or juvenile	**Search modes** - Find all my search terms	View Results (2,193,726) View Details Edit

Search Results: 1 - 24 of 24

Appendix II:

Paper	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Barter (2003)	🟩	🟩	🟩	🟨	🟩	🟥	🟥	🟨	🟩	🟩
Bundle (2002)	🟩	🟩	🟩	🟩	🟩	🟥	🟩	🟨	🟩	🟩
Emond (2003)	🟩	🟩	🟩	🟩	🟩	🟥	🟩	🟨	🟩	🟩
Henriksen et al. (2008)	🟩	🟩	🟩	🟨	🟩	🟩	🟩	🟩	🟩	🟩
Jansen (2010)	🟩	🟩	🟩	🟩	🟩	🟥	🟥	🟩	🟩	🟩
Johansson and Andersson (2006)	🟩	🟩	🟩	🟨	🟩	🟨	🟥	🟩	🟩	🟩
Kelly et al. (2019)	🟩	🟩	🟩	🟩	🟩	🟥	🟩	🟩	🟩	🟩
McCarthy (2016)	🟩	🟩	🟥	🟩	🟩	🟩	🟩	🟨	🟩	🟨
(Moore et al., 2017)	🟩	🟩	🟩	🟨	🟩	🟩	🟩	🟩	🟩	🟩

Nurcombe-Thorne et al. (2018)	🟩	🟩	🟩	🟧	🟩	🟩	🟩	🟩	🟩	🟩
Schofield et al. (2017)	🟩	🟩	🟩	🟩	🟩	🟥	🟩	🟩	🟩	🟩
Stevens (2006)	🟩	🟩	🟩	🟧	🟩	🟧	🟩	🟥	🟩	🟩

🟩 Yes 🟧 Can’t tell 🟥 No

Appendix III:

Data extraction form for the systematic review

Heading	Subheading	Guidance	For completion by reviewer		
			Journal Title:		
			Authors:		
			Publication date:		
			Publisher:		
	Name of reviewer	*Circle*	Reviewer 1	Reviewer 2	

<table>
<tr><td></td><td>Eligible</td><td><i>Does the evidence fit within the scope of the review?</i></td><td></td><td></td><td></td></tr>
<tr><td></td><td>Methodology</td><td><i>Define what type of study it is</i></td><td colspan="3">Methodology:</td></tr>
<tr><td></td><td>Participants</td><td><i>Evidence from whom?</i></td><td colspan="3">☐ Youths
☐ Mental health professionals
☐ Social workers
☐ Others, state:</td></tr>
<tr><td></td><td>Study aims</td><td><i>What are the study's aims and purpose?</i></td><td colspan="3"></td></tr>
<tr><td></td><td>Key findings</td><td><i>What are the key study findings?</i></td><td colspan="3"></td></tr>
<tr><td></td><td>Evaluative summary</td><td><i>E.g. strengths, weaknesses, is further work required? What are the implications for policy, practice and theory, if any?</i></td><td colspan="3"></td></tr>
<tr><td></td><td>Youths, HCP, and other professionals' perspective</td><td><i>Does the study report on the experience of those listed? How were they involved in the study (e.g. as advisors for the research, in the design and execution of the study, in dissemination?</i></td><td colspan="3">
<table>
<tr><th></th><th>Experience</th><th>Advisor</th><th>Designer</th><th>Disseminator</th></tr>
<tr><td>Youths</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Healthcare professionals (HCP)</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Other professionals (e.g. social workers, case managers)</td><td></td><td></td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td></td><td>Ethical standards</td><td></td><td colspan="3">
<table>
<tr><th></th><th>Yes</th><th>No</th><th>Unclear</th></tr>
<tr><td>Ethical approval?</td><td></td><td></td><td></td></tr>
<tr><td>Informed consent?</td><td></td><td></td><td></td></tr>
<tr><td>Ethical issues addressed?</td><td></td><td></td><td></td></tr>
<tr><td>Confidentiality maintained?</td><td></td><td></td><td></td></tr>
</table>
</td></tr>
</table>

CONTEXT	Aims	*Are the aims and the purpose of the study clearly stated?*	Yes	No	Unclear
SETTING	Area and setting	*What is the geographical and setting for the study?*	Urban	Semi-urban	Unclear
			Rural	Semi-rural	Mixed
		Where is the physical placement of the interactions	Private home	Residential home health care	Therapy
	Rationale	*What is the rationale for this choice?*			
	Detail	*Is there sufficient detail about the setting?*	Yes	No	Unclear
	Timing	*What period did the data collection take place?*			
SAMPLE	Inclusion criteria	*Who was included in the study?*			
	Exclusion criteria	*Who was excluded from the study?*			
	Selection	*How was the sample selected? Were there any factors that influenced this, i.e. access, risks, timescales?*			
	Size	*What was the sample size?*			
	Appropriateness	*Was the sample appropriate in terms of its ability to meet the aims of the study, the depth and breadth of data that it*	Yes	No	Unclear
			Comments:		

		enables to be collected?					
DATA COLLECTION	Methods	*What methods for data collection were used?*	Surveys	Interviews	Focus groups	Observa-tion	MM Other
		Was the data collection adequately described?	Yes		No		Unclear
		Was the data collection rigorously conducted?	Yes		No		Unclear
	Role of researcher	*What is the role of the researcher? Are there any conflicts of interest?*					
	Fieldwork	*Is the process of fieldwork adequately described?*	Yes		No		Unclear
	Data analysis	*How are the data analysed? How adequate is the description of the data analysis? Is adequate evidence provided to support the analysis (e.g. use of original data, iterative analysis, efforts to establish validity and reliability)? Is the study set in context in terms of findings and relevant theory?*					

	Researcher's potential bias	*Are the researcher's/ researchers' own position, assumptions and possible biases outlined? Indicate how they could affect the study in terms of analysis and interpretation of the data*			
	Reflexivity	*Are the findings substantiated by the data and has consideration been given to any limitations of the methods or data that may have affected the results?*	Yes	No	Unclear
OUTCOMES	Outcomes	*What outcome measures were adopted? What was the impact of the study for those involved, and/or those responsible for delivering the service*			
FINDINGS	Themes				
	Conclusions				
	Opinions	*What does the researcher argue?*			
POLICY & PRACTICE	Generalisability	*To what extent are the findings of the study generalisable? Are the conclusions justified?*			

	Implications for policy	*What are the implications for policy?*			
	Implications for practice	*What are the implications for practice?*			
OTHER COMMENTS	Format	*Comments on the study format and how this may have implications for style and presentation of the text*			
	Links to other references	*Other references that should be followed up*			
DECISIONS	Name of second reviewer				
	Agreement or disagreement with original reviewer				
	Inclusion	*Should this study be included in the final review*	Yes	No	Unclear
	Date of data extraction				

Appendix IV:

Application for Ethical Approval for Research

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Guidance on completing this form is also available as a word document

Title of Project:

A qualitative study exploring the lived experience of young adults who reside in Danish therapeutically orientated residential aftercare.

Name of applicant/researcher: Jacqueline Cameron-Mathiassen

ACP ID number (if applicable)*:

Funding source (if applicable)

Grant code (if applicable):

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

X Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM

2. Contact information for applicant:

E-mail: j.cameron-mathiassen@lancaster.ac.uk **Telephone**: 0045 2836 5424 (please give a number on which you can be contacted at short notice)

Address: Mernvej 5, Kindvig, 4735 Mern, Denmark

3. **Names and appointments of all members of the research team (including degree where applicable)**

Jacqueline Cameron-Mathiassen, MSc.

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis X PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health X MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☐

4. Project supervisor(s), if different from applicant:

Professor Elizabeth McDermott

Professor Jane Simpson

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Professor Elizabeth McDermott, Professor of Health Inequality, Faculty of Health and Medicine, Health Research. Lancaster University.

Professor Jane Simpson, Professor of psychology of neurodegenerative conditions, Faculty of Health and Medicine, Health Research. Lancaster University.

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' no

4c. If yes, where relevant has permission / agreement been secured from the website moderator? no

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? no

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? no

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

This qualitative study aims to explore the lived experience of young adults who live in therapeutical residential care within the Danish aftercare programme. This is a vulnerable population that has received little interest from research communities, to date no study of this nature has been conducted with this group. The knowledge this study brings forward will contribute to the continued development of youth residential care and young adult aftercare. In addition, it will inform countries that do not have an aftercare program of how the users of this service experience the program. Data will be gathered from between eight and ten participants during two separate semi-structured, individual interviews. Participants will be between eighteen and twenty-three years of age and currently residing in residential care. The interviews will be conducted at multiple locations across Denmark. The Study will engage interpretative phenomenological analysis as its methodological framework.

2. **Anticipated project dates (month and year only**)

Start date: August 2020 End date August 2025

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

Approximately eight to ten participants will be interviewed with a mixed gender representation.

Inclusion criteria	Exclusion criteria
Age eighteen to twenty-three years.	All other ages, as they will not be engaged in the aftercare programme.
Currently living in the Danish aftercare programme.	Young adults on alternative programmes.
Minimum of twelve months of residential care prior to their eighteenth birthday.	Less than twelve months in residential care prior to their eighteenth birthday. As this will limit the experience of the therapeutical interventions.
Able to converse in either Danish or English	Any other languages.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Sampling: Purposeful sampling.

How: The organisation Landsorganisationen for sociale tilbud (LOS), the leading private network for child, youths, and adult residential care homes in Denmark has agreed to promote the study and endorse the researcher's approach to relevant homes. Los will publicise information about the study and the author via their Facebook site, which is visited by their members and business partners as a place where news updates are launched. This opportunity will promote knowledge regarding the studies existence and purpose. Equally the endorsement LOS has given to the project will promote the worth and credibility of the study within the residential care community. It is expected that by engaging in this form of publicity the individual residential care homes will be more accommodating towards learning more about the project and the projects entailment when individual contact to the RC facilities is made. In addition, this publicity will encourage a population representation from the whole of Denmark.

Recruitment procedure:

1: Relevant homes will be contacted directly by the researcher via email and asked if they are interested in cooperation with the project. (Appendix I). Homes that respond to the publicity through the LOS initiative will receive a direct telephone call.

2: On agreement the researcher will arrange either a telephone call to the manager(s) of the home, or a personal visit whereby full information regarding the purpose of the project and the impact the project, as perceived by the researcher, could have on: the participants, the institution, and the primary carers.

Included in this discussion is the consideration of possible coercion. Support workers may believe they are acting in a particular person's interest by either leading them towards participation or away from it. Time will be taken to discuss this issue with the homes and reiterate the importance of autonomous decision making by the young people. Thus, the importance of personal choice and free will in decisions made will be clearly stated throughout the recruitment process. Whilst it is not possible to avoid all influence from other people towards choices made regarding participation, it is believed that through clear and transparent communication throughout the recruitment process, participants will feel enhanced towards operating their personal choices. In addition, when the researcher meets the young people during the pre-interview meeting, they will, as a part of the consent procedure have the opportunity to discuss if they have felt any form of pressure to participate. Should this occur they will be offered the chance to reconsider if participation is something, they personally want to pursue. Should they choose not to participate they will be thanked for their time, any questions they may have will be, where possible, answered. Should they demonstrate any signs of distress the distress protocol will be engaged.

3: On receiving approval to approach the young adults, the forwarded posters (Appendix II) will be sent to the homes. The staff are briefed to help any young adults who would like to discuss participation with them.

4: The young adults who express interest through contacting the researcher at her university e-mail address or on the study's unique telephone number, will receive an e-mail with a letter of invitation to participate (Appendix III). The choice of e-mailing correspondence as a PDF is to aid any prospective participants who use electronic reading programs. If they choose, after reading these letters, to continue as possible participants a time for an information meeting will be agreed.

5: The information meeting will take approximately 30 minutes, although should the participant wish to discuss the research in more depth time will be available for this. The information meeting will include:

an appraisal of what has been sent, including:

- The purpose of the study

- A full explanation of withdrawal rights including the deadline for the withdrawal of their data, which is fourteen days after the last interview. Should any participant wish to withdraw after this time, they will be assured that within the following six months their wish to withdraw will ensure that any direct quotes they have made will not be included in the final paper. However, the data from their interviews will have been amalgamated with the other data sets and therefore it will not be possible to retract the data.

- An affirmation of the promise of anonymity including possible limitations, how confidentiality is conducted and how the gathered data will be stored including the encryption facility under recording to ensure that no one beyond the researcher and the university project supervisors will have access to their original names, or the sound of their voice.

- The dissemination plans, including explanation of the possibility of future researchers using this study in systematic reviews as well as a ten-year period of access for approved academics.

6: If the possible participant is still interested in participation the researcher will follow up by explaining the practicalities of engaging in the project and how much time the interviews are expected to take. The researcher and participant will discuss the interview schedule, whereby the participant will hear and learn about each question (Appendix V) and be affirmed that if they do not wish to discuss an aspect of their life in residential care then they may say so and the interview will quietly move on. If the possible participant is still interested in participating the consent form will be read by the participant or read out for the participant and then signed should the possible participant wish to participate (Appendix IV).

Please note that whilst all appendices are supplied in English these will be translated to Danish for actual use, unless the residential home informs of English-speaking young adults who have not learnt or are weak in Danish. In this case the original English versions will be used.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data collection:

1: A pilot study will be initiated prior to the actual data gathering, to ensure the interviewer is fully immersed in the schedule and to identify any questions or prompts which need rephrasing. The pilot study will involve a small group of three or four young adults who are within the inclusion criteria. They will offer feedback on the interview schedule and offer good advice on how to encourage a relaxed and respectful atmosphere during the interviews. The pilot study will be conducted in collaboration with a care home serving this population. The pilot study will have the following format:

On receipt of permission from the care home to approach the young people who fulfill the study's inclusion criteria the researcher will contact the young people and ask if they would like to hear about participation in the pilot study. A full explanation of the purpose of a pilot study will be given, including the full assurance that the data collected is only for the use of improving the quality of the researcher's interviewing skills and the wording of the questionnaire. The pilot study will be recorded. The pilot study's recording will be encrypted on collection and stored on the secure site, at Lancaster University until the PhD thesis is completed. The recording will follow the same procedure of translation and analysis as in the actual study. This in turn will opportune a process of engagement and therein improvement of the application of the study's methods by the researcher. Whilst the findings in the pilot study do not contribute towards the actual study findings the participant is engaging in a process whereby personal information is given, therefore the study's distress protocol will be engaged if necessary, during the pilot study. Each participant will be asked to sign a pilot study participation form (Appendix VIII) and receive a pilot study debriefing form (Appendix IX).

2: The data will be gathered in two sequential recorded semi-structured interviews, with approximately 14 days interval.

3: The researcher will use an interview schedule (see appendix IV) to guide the interview and ensure that all the areas of interest come forward. The open-ended questions within the proposed schedule will be underpinned by the results of the ongoing systematic review. The Recovery Model, which is one of the overarching approaches to adult mental health care in Denmark, will offer a framework towards the structuring of the semi-structured questions.

4: The interviews will be conducted in a quiet room, at the participants place of residence. Participants will be able, should they choose, to invite a member of the staff where they live to be present. Any member of staff who are asked by a participant to be present will be asked to be as silent as possible. Should the participant use the staff member as a support through verbal or body language communication, these conversations will not be a part of the study's findings. It is expected that each interview will take approximately 40 minutes. The interviews will be recorded on an encrypted recording app in the studies unique iPhone.

5: Second interviews will be arranged at the participant's convenience, approximately fourteen days after the first interview, the second interview is positioned as an opportunity for the participant and the researcher to build upon the initial interview, conversing on the raw data which was gathered in the first interview. This will encourage a deeper understanding of the entity in hand, this will in turn offer a more rigorous approach. The second interview is also expected to take 40 minutes.

Analysis:

This is a qualitative study reflecting the researcher's research paradigm of a realist ontology and an relativist epistemology and this is consistent with interpretative phenomenological analysis (IPA) (Smith & Shinebourne, 2012). This form of enquiry allows for the constructs of IPAs four constructs which are embedded in the understanding that previous experience influences present and future experiences to form the framework for the interviews and analysis. Thus, lived experiences will be explored through lived space, lived body, lived human relation and lived time, each representing a part of the lived experience of being (Tuohy et al., 2013). IPA facilitates identification of the essences of unique personal experiences, thus revealing the meaning within the experience as opposed to establishing a point or abstract theory.

During analysis, codes will be applied, and from these codes' themes will be identified, originally in each individual transcript. These will then be clustered both within and later across transcripts, to identify the superordinate concepts. The software program NVivo will be used to aid the analysis process. At all times the researcher will be vigilant towards transparency and provision of first-person findings when assumptions are delivered. In addition, the researcher will maintain a diary of the thoughts and impressions occurring during data collection, analysis and write-up. These will be coordinated with the study's supervisory team to help ensure clarity and onus towards the projects aims and objectives during the projects life-cycle.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

All digital data will be encrypted on site and uploaded onto Lancaster University's secure server via the university secured platform OneDrive. Access to the files is limited to the researcher and the study supervisors. The researcher will be the only person to transcribe and translate the original transcripts from Danish to English. Signed consent forms will be photographed on completion, the photographs will then be encrypted and uploaded onto the universities secure database. The participant will keep their signed copy. This study proposes to have a 0% paper trail, beyond the participants paper copies of all they have signed.

The recorded interviews will be destroyed on completion of the PhD thesis. The researcher will initiate this destruction. The remaining anonymised data will be deleted by the designated authority at Lancaster University 10 years after the files are uploaded.

7. Will audio or video recording take place? ☐ no X audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Yes, all gathered material will be uploaded via an encrypting program directly onto the secure storage at Lancaster University via the project laptop.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

The original recordings will be destroyed on completion of the PhD thesis in 2025.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

All digital data will be encrypted on site and uploaded onto Lancaster University's secure server via the university secured platform OneDrive. This storage is secure. The audio recordings will be destroyed on completion of the PhD thesis in 2025, the anonymised transcripts and analysis will be stored for 10 years and then destroyed. Sharing of the anonymised transcripts will only occur on request from reputable research organisations. The original audio-recordings will not be shared.

8b. Are there any restrictions on sharing your data ?

Due to the small sample size, even after full anonymization there is a small risk that participants can be identified. Therefore, supporting data will only be shared on request. Only anonymised transcripts will be available to research bodies that request them with good reason.

9. Consent
a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?
Each possible participant will be asked if they will give consent following the face-to-face pre-interview. The face-to-face pre-interview will ensure the possible participant has understood the rational for the research, what anonymising and confidentiality mean in a practical sense, withdrawal rights and what participation entails. Following this they will read or have read out the consent to participate form (Appendix III). If in agreement they will be asked to sign the form. Only then can data collection commence.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

This is a vulnerable group, and through the conduct of conversation pertaining to life in residential care as a teenager, as a young adult, and possibly as a young child, some discomfort may occur. In addition, this explorative study is investigating the therapeutical environment within residential care including experiences connected to mental health wellbeing, which can also be causal of some discomfort.

To minimise risk to the participants the following actions will be in place: The participant may always choose to have a contact person from their home present during the interview. The participant is fully aware of their right to stop the interview and either commence after a brief pause, set a new time for the interview to continue, or withdraw from the study. At all times when interviewing has ceased the participant will receive a debriefing, guided by the debriefing form after first interview (appendix V), and second interview appendix (VI). The participants, at debriefing, are reminded that they may discuss the interview with whoever they choose if they feel this can help them. They will receive a list of suggested people they can talk to, if they have, or become aware of, any discomfort. It is possible that some participants offer negative comments towards their current situation in front of the member of staff they have asked to be present. The member of staff will have given an oral acceptance of not using this information as requested during the introduction to the study and agreement made between the residential home and the researcher. There has also been consideration towards those who wish to be a part of the study but are not selected. This may be due to more applicants than is required or logistics in terms of time and travel from the researcher's side. In the event of this occurrence, the possible participant will receive an email or a phone call if they prefer where they are thanked, and the explanation given.

For some participants distress may be at a level where the study's distress protocol will need initiation. Prior to interviewing taking place this will be discussed with the home and any accommodated according to their wishes. The principle parameter for this protocol is the immediate stopping of the interview and the assigned employee will be summoned. The researcher is educated and employed within this population and is considered to have the necessary qualifications to initiate immediate assistance and to be able to contain distress to a level where known staff can continue with immediate assistance on arrival.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

The Lancaster University Lone Worker Policy will be adhered to during the conduction of field work. The interviews will be conducted at the participant's residential home where there are always staff on duty in the building the interview is being conducted in. The staff will be fully aware that the interviews are being conducted. The door will be closed but not locked. The researcher's partner will be aware of where the interviewer is. The interviewer will make telephone contact to her partner on the completion of each interview. All telephone contact between possible participants and actual participants will be conducted on a telephone subscribed uniquely for this study.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

No perceived direct benefits.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Participants will receive a £20 voucher to the Danish equivalent of Boots. This will be given as a token thank you for the time offered. The voucher will be given regardless of whether the participant withdraws or not.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Anonymity will be conducted through pseudonyms replacing the names of participants and other named people, places and specific dates. However, the possible participants will be informed that through the use of direct quotes in the write-up they may be able to recognise themselves. Confidentiality is promised only to the extent that no information of risk to own or others health and well-being is disclosed. If the researcher is uncertain if risk is evident, she will contact her supervisors at Lancaster University to discuss the matter. If a participant discloses information pertaining to immediate harm towards themselves or others, the head of staff at the residential home will be directly and quickly informed.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

The pilot study will involve members of the participant pool. The pilot study will involve a small group of three or four young adults who are within the inclusion criteria. They will offer feedback on the interview schedule and offer good advice on how to encourage a relaxed and respectful atmosphere during the interviews.

There is no direct involvement of the participant group in the conduct of the research beyond the reflection on the part of the researcher as to how the participants respond to the interview situation

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

This study will form the thesis for the researcher’s PhD at Lancaster University. In addition, it is intended to pursue submission in suitable peer reviewed journals. In Denmark the study will be offered to LOS for publication in their magazine in an abridged format in the Danish language. The Danish School of Education at Aarhus University will be approached with intent on using the research within the Danish context to further the well-being and opportunities for those who receive residential care in Denmark and other Scandinavian countries.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

SECTION FOUR: signature

Applicant electronic signature: Jacqueline Cameron-Mathiassen Date 27.04.2020

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review x☐

Project Supervisor name (if applicable): Professor Elizabeth McDermott Date application discussed 20.04.2020

Submission Guidance

1. **Submit your FHMREC application by email to Becky Case (**fhmresearchsupport@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.** Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.** Collate the **following materials for your study, if relevant, into a single word document:**
        a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
    a. existing documents/data only;
    b. the evaluation of an existing project with no direct contact with human participants;
    c. service evaluations.

3. **<u>You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application</u>**

Appendix V:

Approval letter from the Faculty of Health and Medicine Research Ethics Committee, Lancaster University.

Lancaster
University

Applicant: Jacqueline Cameron-Mathiassen
Supervisor: Elizabeth McDermott and Jane Simpson
Department: DHR
FHMREC Reference: FHMREC19097

23 July 2020

Re: FHMREC19097
A qualitative study exploring the lived experience of young adults who reside in Danish therapeutically orientated residential aftercare

Dear Jackie,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

E. Suri-Payer

Dr. Elisabeth Suri-Payer,
Interim Research Ethics Officer, Secretary to FHMREC.

Appendix VI:

Interview Schedule

Can you tell me, what the first months at your residential care home were like?

Prompt: Can you remember anything about your first day or week?

Can you think of anything which helped you settle in in your residential care home?

Prompt: Any people you can remember? What did they do? Were there any things or activities which helped you settle in in your new home or maybe your new school? How about new friends?

As you began to settle in did you notice any changes within yourself?

Prompt: Did you feel for example more independent, happier, more worried? Can you remember if you thought about these things at the time?

Can you think of anything the residential care home did, before you were 18 years old, which made a difference for you and your development?

Prompt: Did you learn anything in particular? For example, about taxes, health insurance and such? Did you talk to a particular person about these things? Did you receive help regarding medicine? Did you get the offer of talking to a psychologist?

How big, do you think your influence was on the residential care homes way of doing things?

Prompt: To do with your family, education, friends, worries, case manager or carers.

How do you experience aftercare compared to living in a residential care home?

Prompt: More responsibility, more independence, relationships with the staff, offers of help, is it easier or more difficult?

In what way do you think your psychological profile has had influence on the choices you have had so far in your life?

Prompt: Education, friends, family, relationships, your mindset to do new things?

In what way do you think about the help you have received compared to the help you receive now?

Prompt: Being a part of a community, being treated with value, being supported in maturing at a pace which suits you? Can you imagine how your life would have been if you had not received this help?

Appendix VII:

Letter of introduction

Dear XXX

I am writing to you as the head of a care home with young people who are engaged in the aftercare programme. As a member of LOS you may have seen a post on LOS Facebook site and be aware that I am in the process of conducting research on the experiences of young people in the aftercare programme.

My name is Jackie Cameron-Mathiassen, in addition to my daily work as the head of Faellesskolen, I am a postgraduate student at Lancaster University in England, studying for a PhD in mental health. Lancaster University are my sponsor for this research and are the guarantor that this research has full ethical approval. Research at this level is expected to be of benefit to those who are connected to the area, in this instance young people in residential care. The knowledge gained from research is an important resource within our field. With this in mind, I do hope you will consider learning more about this research.

To gain a qualified insight into the experiences of young people in residential care I would like to offer young people in the aftercare programme an opportunity to participate in this research. Within this research project I have chosen to collaborate with the residential care homes, prior to approaching any young people. This is to ensure that the young people, your staff, and yourself are fully informed about the purpose of the research as well as the procedures and safeguards that are in place to ensure that all involved are treated fairly and with respect.

The initial contact to the young people will be through an information poster (enclosed with this email) asking the young people to consider participation. If any young person is interested, the next step is that they contact me. At no time will any young person be contacted directly by me without their prior consent. On a practical note, the young people who choose to participate will be asked to engage in two individual recorded interviews lasting approximately 45 minutes.

Please let me know if I may contact you over the telephone and discuss the research in more detail.

Yours sincerely

Jacqueline Cameron-Mathiassen

Research telephone.: XXXX XXXX

Research Email: j.cameron-mathiassen@lancaster.ac.uk

Appendix VIII: Poster

Would you like to take part in a study about living in residential care?

Without research it can be very difficult to know what works and what doesn't.

Sharing experiences with researchers can make a difference.

Please take two minutes to read about who can participate and what will happen, then if helping in research appeals to you please ask for more information.

Who can participate?

Anyone between the age of 18 and 23 years and who is:

In aftercare

Has lived in a residential home for at least 12 months before they were 18 years old.

Is willing to talk about their experiences of life in care.

Who feels comfortable with spending 2 x 45 minutes being interviewed by the researcher.

What will happen?

You will meet the researcher and the research will be explained, this will include:

An explanation of why the study is being conducted.

An explanation of confidentiality and anonymity.

A promise that you can withdraw up to 14 days after the second interview.

The list of questions you will be asked.

You will have the chance to ask questions and make decisions about your participation.

If this makes sense to you, and you would like to hear more about being a research participant in a study intent on exploring the lived experience of residential care then please either talk to your contact person who can explain more about this study or contact the researcher at:

j.cameron-mathiassen@lancaster.ac.uk

This research is a part of my doctoral education. The research is fully approved by Lancaster University in the UK and follows all guidelines for research in Denmark. Ethical approval has been granted and all care will be made to ensure that participation is comfortable and ethically correct.

Appendix IX:

Participant Information Sheet

A qualitative study exploring the lived experience of young adults who reside in Danish therapeutically orientated residential aftercare

My name is Jacqueline Cameron-Mathiassen and I am conducting this research as a student on the PhD in mental health programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to explore the lived experience young adults in residential care.

Why have I been approached?

You have been approached because you have shown interest in the study. The study requires information from people who are now living in residential care in the aftercare programme following at least a year in juvenile care.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part in the study.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be asked to arrange a time with the researcher, here you will receive a full explanation of the research, following this you will be invited to participate in two face-to-face interviews, this invitation can be accepted or refused at your discretion. A part of the interview will include hearing about your experience of the therapy you have offered to help you with any mental health problems. The talks will be conducted either just with the researcher or if you would like, with a member of staff present as well. The interviews will be audio-recorded. There will be two interviews in all. They will take about 45 minutes.

Will my data be Identifiable?

The information you provide is confidential only those present at the interview and the study supervisors at the university where I am studying will know what you have said. Your name and any other names you mention, as well as places and dates or times will all be anonymised, this means different names and times will be placed instead of those you offer. The data collected for this study will be stored securely and only the researcher and her supervisors at her university will have access to this data.

The following steps will be made to ensure your confidentiality and anonymity:

- Audio-recordings will be destroyed on completion of the PhD
- The files on the computer are all encrypted (no-one other than the researcher and her supervisors who will be able to access them), in addition the computer is password protected. The anonymised version of your interview is a transcript, this will be secured for 10 years and then destroyed.

- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.
- All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported in a PhD thesis, submitted for publication in an academic or professional journal, and offered to LOS for publication in Denmark. In addition, the University of Education, Aarhus may use the publication to further their research within this area.

The paper submitted to LOS will be in Danish, all participants who wish may receive this as an email.

Are there any risks?

There are no risks anticipated with participation in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet. If at any time during the interview you wish to stop recording this will be done.

Are there any benefits to taking part?

As well as you possibly finding this research interesting you will receive a 200 kr. Matas voucher as a thank you for the time you have offered in this research.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University and by the ethical committee of Denmark.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher, Jacqueline Cameron-Mathiassen at:

j.cameron-mathiassen@lancaster.ac.uk

or on the study phone XX XX XX XX

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Fiona Loban
Department: Health Research

Telephone: +44 (0)1524 593752
Email: f.loban@lancaster.ac.uk
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Mental Health Doctorate Programme, you may also contact:
Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Kind regards,

Jacqueline Cameron-Mathiassen
PhD Student,
Faculty of Health and Medicine,
Lancaster University,
Lancaster
United Kingdom
LA1 4YW

Resources in the event of distress

Should you feel distressed either as a result of thinking about taking part, taking part, or in the future when you reflect upon your participation, the following resources may be of assistance.

Your GP

Your contact person in your residential home.

The head of your residential home.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

Appendix X: Consent Form

Study Title: A qualitative study exploring the lived experience of young adults who reside in Danish therapeutically orientated residential aftercare

We are asking if you would like to take part in a research project research project exploring the lived experience of residential care as a young adult.

Before you consent to participating in the study, you are asked to read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Jacqueline Cameron-Mathiassen.

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study. ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be recorded and then made into an anonymised written transcript. ☐
4. I understand that audio-recordings will be kept until the research supervisors are satisfied with the transcripts, or when the thesis is completed. ☐
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
6. I understand that once my data have been anonymised and incorporated into themes it is not possible for me to withdraw. ☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. ☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐
9. I understand that the researcher will discuss data with their supervisor as needed. ☐
10. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor or the head of the home I reside in. ☐
11. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐
12. I consent to take part in the above study. ☐

Name of Participant__________________ **Signature**___________________ **Date** ___

Appendix XI:

Debriefing after first interview

Thank you for your participation in the first interview. The recorder is now turned off.

Please take a few moments to think about how you feel and let me know if you have any thoughts or concerns you wish to share.

If at any stage between now and the next interview you have any concerns regarding the project, please contact me by e-mail at

j.cameron-mathiassen@lancaster.ac.uk

Or on the study telephone XX XX XX XX

I will then get in touch with you.

Do please remember that you can always talk to your contact person regarding any thoughts or concerns or the head of your home, or indeed anyone you find suitable for the thoughts you have.

Please also remember that on your letter of introduction you have the contact details should you have questions you wish to address to Lancaster University.

If you wish to continue to the next interview, I would like to arrange that date now if that is suitable for you. If you prefer to set a time for me to contact you about a new time that would also be fine.

During the time between now and the next interview you may choose to reflect on what we have talked about and what you think it is important that I learn from your experiences. You are very welcome to write down anything you think is important and bring your notes to the next interview.

Do you have any questions?

Once again, I thank you for your interest in this project and your offer of time.

Kind regards,
Jacqueline Cameron-Mathiassen
PhD Student,
Faculty of Health and Medicine,
Lancaster University,
Lancaster
United Kingdom
LA1 4YW

Appendix XII:

Debriefing after second interview

Thank you for your participation in the second interview. The recorder is now turned off.

Please take a few moments to think about how you feel and let me know if you have any thoughts or concerns you wish to share.

If you find you have any concerns regarding this study, following my departure, please contact me by e-mail at

j.cameron-mathiassen@lancaster.ac.uk

Or on the study telephone XX XX XX XX I will then get in touch with you.

Do please remember that you can always talk to your contact person regarding any thoughts or concerns or the head of your home, or indeed anyone you find suitable for the thoughts you have. Please also remember that on your letter of introduction you have the contact details should you have questions you wish to address to Lancaster University.

Please also remember your withdrawal rights, in fourteen days I will amalgamate your anonymised data into the complete study data, and it will not be possible to withdraw following that.

Do you have any questions?

Your contribution will help the research community to gain knowledge and understanding about residential care, the therapeutic environment care entails and how young people like you experience the current offer of aftercare. This knowledge will be used to improve the current care system by taking more account of how you, the user, experiences your life.

Once again, I thank you for your interest in this project and your offer of time, as a compensation for your valuable time I have a token of my appreciation.

Yours
Jacqueline Cameron-Mathiassen
PhD Student,
Faculty of Health and Medicine,
Lancaster University,
Lancaster
United Kingdom
LA1 4YW

Appendix XIII:

Transcript of the interviews with participant 8, Miker:

I: Super, I have started the recording, the first question I would like to ask is your age?

M: I am 19 years old

I: And how old were you when you were taken into care?

M: 13

I: Thankyou, can you remember anything about how the first day or weeks were?

M: Mnnn yes, the first day was the weirdest day in my whole life, err I was very frustrated about not being able to see my parents, err because I was removed from my home by the authorities, so there wasn't so much I could do other than go along with it.

I: Yes

M: So, I went up there, and I can remember that I could only take my pillow and duvet with me, and during the week, I got, I went out with the boss and bought some clothes and bathroom things, and I it was the worst time in all my life. Err it sits fast how it was, and the carers there they treated me errr differently. Some were more controlling than others. There were some who thought it was nice to have power over young people and tell them what to do. And at that time, I was so young, so I didn't understand so much of it. So, I learnt that I should be in my room for a whole day and, well, if I came out there would be consequences, they said, so I stayed in my room.

I: Yes

M: So, it was really hard at that time.

I: That I can understand. Did you have any idea that you should move?

M: Move where?

I: I mean be placed in care away from your own home?

M: No, I didn't. Err it was from one day to the next.

I: Yes, that sounds quite hard and difficult.

M: Yes, it was

I: And you have told me you noticed a difference in the way the carers were with you.

M: Yes

I: How were the young people?

M: The first place I was at, there were just four of us, we had a young person who was a couple of years older than me he was very aggressive, and I can remember it was actually the second day I was there, the day after I arrived, I was eating breakfast and he attacked me out in the kitchen and beat me up.

I: Okay, was it stopped by the carers?

M: Yes, they stopped him. But he went for me before they stopped him. He had some problems so it suddenly would go klick for him and then he beat someone up. This happened all the time I was there. Sometimes there was a week between his attacks, but they were always in the air. Quite often it was me because I was the youngest.

I: Ah, so you have experienced bullying?

M: Yes, but it was more violence than bullying.

I: Yes

M: Err, it wasn't because anything was said, he could just look at someone and then he could suddenly explode.

I: What did the other young people say about this?

M: They tried to hold him back, and there was someone who was 18 there then when I was 13, he held him back so I could come past him into my room and lock the door.

I: And where were the adults in all of this?

M: That was a bit of a mixture, the man who owned the place lived upstairs above where we lived. He did his office work when we came in from school, so he didn't always notice things straight away. If he heard anything he always came down.

I: OK and how long did you live there?

M: I lived there for two and a half years.

I: OK, and as time passed did things get better?

M: No, and that boy was removed in the end, after two years.

I: OK, and in that period, when you were unhappy, could you see your family?

M: Yes, it took a couple of months before I got permission to stay overnight with my mum, for just a day and my dad.

I: Yes

M: At the start I could only see my mom errr 2 hours a week.

I: OK

M: And my dad, together.

I: May I ask do your parents live together?

M: No, they don't

I: No OK, but you saw them together?

M: Yes, when I was that small my dad drove over to my mom's place to see me.

I: Lovely

M: Yes, they were best friends, they were good at cooperating together with all of that.

I: Good, if we go back to your first care home, there was one young person who was quite violent, but the others, were they nice to you?

M: Yes, they were

I: Did you notice that you got better at things?

M: No, I experienced being let down more than anything else.

I: OK, can you tell me more about that?

M: Because the carers, they promised so many things and said they will see to so many things and nothing ever really happened. Err you got collected by someone who drove you to school and yes there was someone from the school who came and woke us every morning and made breakfast and then we were driven to school and afterwards home again and then you were just in your room.

I: And you moved from there?

M: Yes, it was because he chose to close the care home.

I: When you had to move were you asked about where you wanted to move to?

M: No, I was still removed by law from my home, so they just told me that I was moving, we packed a large van and a trailer with all my things and then we drove to the area I live in now.

I: OK

M: And I had never been there before, so it was a bit strange. We were really out in the countryside, and I moved to a house on the top of a hill, where there was just one house and 30 km to the nearest town. (Gestures with arm)

I: Yes, it is very isolated out there

M: Yes, so it was hard because it wasn't possible to just go out and shop or anything like that, you just couldn't do that.

I: No, and in this house on the top of a hill were their other young people?

M: No, I was the only one.

I: OK so you were placed in a kind of one-to-one project

M: Yes

I: Can you remember what it was like?

M: It was ermmm it was nice, err I didn't have to think about so many other people, and show consideration, it was just me and a carer who were there and he became my key contact person. And the first 2 days we were together were wonderful, we went to different activities, and we had a lot of fun. It was a whole new experience for me.

I: Yes, how lovely, how long were you in this project?

M: Two weeks, well a week there and then a week on vacation.

I: Yes

M: To Crete together with a carer.

I: Oh lovely

M: Yes, it was super good, it was at the end of the summer vacation.

I: It sounds fantastic. And then you came back from Crete.

M: Yes, I was told I had to look at a care home where I should live, it was the same company that had the project I was in. I was shown the bedroom and then we went back to the house on the hill, and I packed my things. But I didn't move in there, instead I was moved to another house they have, a house I had not visited.

I: OK so you didn't go to the place you had seen but to another place,

M: Yes

I: What did you think about that?

M: I asked the man who drove me out there what was wrong because it wasn't the place I had been shown and promised. I was told that was true, but it was here I was going to live. I said "no it isn't I have been to and promised somewhere else". So, I went to this place I hadn't seen, Sunnyside, and it was very special because there were young people there who were also urmmm some of them were violent and yelled and shouted all the time.

I: Yes

M: And I still wasn't that old and some of them were much older than me, and it was like that all the time with a lot of screaming and yelling and noise.

I: Yes

M: I can remember that I was urm when we came, they had placed a new bed in my room and a mattress so all we had to do was move my things upstairs. I stayed in my room the first week. I just couldn't understand it, I had been shown one place and driven to another. The place I was shown, I had met some of the others who lived there and the carers and then to come out to a place where I didn't know anybody.

I: No, you have told me about these young people at Sunnyside who yelled all the time and about the violent boy in your first placement, are you ever violent or noisy?

M: When I was small, I was, but not like those who lived out there. As I said I have always been the youngest at these care homes, there have errr always been some who are 2 –3 years older than me, where they just ran around treating me however they liked. And come into my room and irritate me and stay there until a carer heard them and came and moved them out.

I: Didn't you have a lock on your door?

M: At that time right then they were changing the locks on the doors, I think. Normally, the bedroom doors can be locked.

I: Mnn. You have told me about a wonderful time on Crete but also about some difficult experiences such as moving to a home which you hadn't seen beforehand and a feeling of not really knowing what is going on, as you end up in a different place than you thought. Was there anyone at this time apart from the carers who you could talk to?

M: Yes, err there was a boy at that time his name was Jamie err me and him we could talk really well together, but he wasn't really very good for me because he had made a lot of trouble, smoking hash in his room and so unfortunately I began to smoke hash and I have never taken drugs before not at any time, but we did and we were caught doing it. I have not, of course, taken any since then errr because I got really told off by my parents.

I: Mnn, but you had a friend even though he brought you unto this problem, what about your mum and dad could they understand and listen if something was difficult?

M: Yes, they could, and they were worried about me. There were also a lot of court cases at this time because I was removed from my home, and they wanted me to come back. I kept asking why I was taken away from my home, and I always got the same answer, they couldn't say why. It was frustrating for me and my family, and even now when it has been changed, I have never received a concrete answer from them.

I: Yes, what about your case manager?

M: Uhmm at that time she was, ermm she just lied she changed things around and, in the end, it was proved that she had lied to me and my parents. I could talk to her easily enough, but I don't think she liked children or young people. But she lost her job after the lies she told my family and me.

I: Do you think when all this happened, and you were in this home with a lot of older young people that the carers knew you were unhappy?

M: Yes, err they did because I was very open about it, several times every day I would go down to the office and talk about how I felt, that I wasn't happy.

I: Mnn

M: Err they knew about it, and I err they couldn't do anything about it. They backed me up with all the things that were happening and said these things aren't good for me. They used more time with me than with the others because they knew I wasn't happy. I perhaps was taken on more trips and maybe did more things than the other young people.

I: You have mentioned trips and activities what sort of things did you do with the carers?

M: We drove to the harbours sometimes in the nearby towns and got an ice-cream and ate while we went for a walk, it was really very nice, you get to know the carers better, get a closer contact with them.

I: Yes, and as you matured through your time there did you get to know any of the carers really well?

M: Yes, I did. I had two contact carers at the home. There was one who I told everything to. He knew all about me and my family, at that time we were allowed their telephone numbers, and I got to know him really well, he took care of everything and even came to meetings when he wasn't at work. I think he cared about me. But he lost his job over something that happened.

I: Mnn

M: My mom got ill, and I didn't have a telephone, it was broken so I was allowed to use the staff phone in the office. The boss was called Tanja and from the first day she did not like me. I went down to the office to borrow the phone, even though the boss of the whole company had given permission for me to borrow the phone she said "no, it is sad but no". She didn't care. I got very aggressive and said either you give me the phone, or I will take it. She ran over to me and hit me in my chest, I was pushed to the floor, I got really angry and pushed her onto the floor and said that was the last time she hit me, then my contact person came and helped me. We were called in to talk to the leader of the whole company together, he believed Tanja over me, and I was reported to the police for attacking a female who was trying to defend herself, even though I had been hit and she didn't have a mark on her. My contact person lost his job, well actually he quit his job.

I: Okay, that was a very difficult time for you.

M: Yes.

I: Now you are over 18, how old were you when you moved from that place?

M: I moved here when I was 16 I think, I found out about it in a weird way, I was in the office and I saw a ring binder where it said my name and halfway care, I went into a bit of a panic and asked what it was, because I knew that within the company they had a halfway house attached to another care home, so it happened that I came to Smithby. But I broke down in the half-way house it was too hard because I had never before tried to buy food, or cleaning things you know, I had to do everything myself, so after a month when they could see I wasn't doing well I moved into the care home section and left the half-way house. I lived there until I was 17 and a half and then I came over to the half-way house again.

I: That was a smart solution, but now you have moved back to the half-way house, were you asked if you wanted to or if you felt you were ready?

M: No, I was just told. They needed my bedroom for another young person, I said I didn't want to move, that I liked where I was but errr they said that it was arranged, I was told to move everything out of my bedroom over to the half-way house, I didn't get any help with the move.

I: You live in the half-way house now, is it good?

M: Yes

I: Would you say that you are happier with your life now?

M: Yes, because after I came back to the half-way house well after a couple of months, I began to feel free, freer than I had felt in all my life.

I: Lovely

M: But also, a strange experience because together with a feeling of frustration I was worried that I would be thrown out, I have been moved around so much before, but it didn't happen I got money for food, pocket money and money for clothes because I was still under 18.

I: Mnn

M: Whereas now as an 18-year-old I have to earn my own money.

I: Yes

M: And it is so different because before if I was with other people, I had to give the carers their telephone numbers but now I don't have to. It is such a relief because I can just be with my family. My sister lives close by, so I can just go and visit her as I like, I now have a social network err and suddenly friends, now I can just go out. My life has changed completely, I have lots of new friends something I never had before when I lived in the home before I was 18. But now I have got so old I can, my youth has been wasted I haven't had a life like other young people. Most young people when they are 15 can go out and drink and have fun, but that is closed for all of us in care, because it is not allowed. So, before I was 18 I had never experienced that kind of life.

I: Yes, thank you, and being of age brings the freedom you describe, but it also comes with commitments.

M: Yes, puh ha

I: Has it been difficult for you to learn about things like taxes and insurance?

M: No, but I admit that I had really looked forward to being 18 to being an adult, but it is also full of piss. Because when you are 18, well, within a week I got a letter about my TV-license and from the tax office and from my bank saying that now I am 18 I have to sign some papers and from the council at the start there was fuck too much of it. I earn money but half of it goes to paying rent.

I: How do you earn money?

M: SU [student allowance] because I am a student.

I: Yes

M: I was at FGU doing my last entrance exams, so I could get into trade school, now I am training to be a commercial painter.

I: That is super

M: But it is still a bit shit, when you are in aftercare which I am it is difficult to get your student allowance so I still get pocket money and food and clothing allowances, but in 14 weeks I will notice that I earn more because I will start my practical placement and I get wages for that, and they can't take my money from me.

I: That is good to hear. How about school, you mentioned that you are in a mainstream education now, were you in mainstream when you were younger?

M: I, before I was at FGU I was in a 10th grade class in the local town, in their class where you could get a bit of extra help. I have been expelled from a lot of schools, I wasn't at that time diagnosed for my ADHD and the teachers couldn't manage me. And I wasn't diagnosed with my dyslexia either. But in the 10th class centre I had a warning about my behaviour after 2 weeks and after that I did what I was told.

I: Do you think when you look back at the care homes you have been in, have they backed you up in your education?

M: A bit but uhmmmm they have mostly been worried about my behaviour. You get some status plans where the carers ask about the goals which are set, and the carers they set some goals for the young people, they always ask my opinion and help but I always said don't ask about school.

I: You have mentioned that you have ADHD

M: Yes

I: Do you get medicine for it?

M: Yes, I do

I: Are you good at remembering to take your medicine?

M: Yes, I take it every day. The goal is that I increase my ability to control my behaviour and with time I can stop taking the pills, I don't like taking the medicine, because I don't feel as though I am myself when I am medicated.

I: No

M: I become another person who is just tired and doesn't want to do anything.

I: Yes

M: When I don't take my pills then I am fresh and go out and have fun get a beer and errr when I take my medicine well, I don't have the energy to do anything.

I: That makes sense. Do you get any other form of help? Have you been for example to a psychologist or a therapist?

M: No, I don't go to a psychologist or anything.

I: Have you done so earlier?

M: Yes, uhm but I got thrown out quite quickly her questions were too private, and I said that I did not want to answer but she kept going until I got cross.

I: Even though it ended badly would you like to try again?

M: Yes, I have wanted to because I get some thoughts about the things I have experienced which are difficult and with my ADHD psychologists can give me some techniques which will help me if I get too angry, it hasn't happened for a long time but I can get so angry it goes click and I just can't stop myself. I would like help with that.

I: Yes

M: But mostly I would like help with all the thoughts I have which are connected to my ADHD, that is why I get sleeping pills because otherwise I just can't sleep.

I: Would you say that the psychological demands that come from ADHD have affected the choices you have had in life?

M: No not that much, mostly my ADHD has meant that I have felt very unfairly treated, and I have to work at controlling the short fuse which comes with ADHD so that I don't end up destroying things. But today I no longer hit out.

I: That sounds like a really promising development. You have mentioned a short fuse, has that given you any problems with the police?

M: When I was younger yes, I was a troublemaker, but not today. Today I do not have anything to do with the police.

I: That is a fantastic development.

M: Yes, the message has really landed, you just don't get anything out of behaving badly. You can tell people what you think but you don't get anything out of screaming and yelling or destroying things.

I: Fantastic. Do you feel today that you can achieve some good goals in life?

M: Yes

I: Have you experienced while you are working towards these goals that you are met with respect from the carers that you are more mature and grown-up?

M: Yes but no, yes and no, there are still a couple of people in the staff group that should think a bit more before they talk to me errr because errr well there is one person who like to talk in a kind of urban way, and that is fine we all laugh together, but if we say anything back to her, she just can't take it. She can't stand it when I give as good as I get. I talked to her alone about it, I said she should work on it, it can't be right that she can tease me, but I can't tease her, I said she shouldn't work with young people like that she isn't a policeman or a prison guard. She works in a place where we young people should be happy.

I: So, there are a few where it can be difficult but most of the carers are good with you as a young adult.

M: Yes

I: Excellent

M: Yes, they treat me like an adult because I am an adult. Most of them have understood that if you treat me with respect, I will be respectful in return.

I: Yes

M: I say to the new carers treat me with respect and you will have no trouble with me.

I: Yes, thank you so fine. You mentioned that today you have a good network, with friends, family and study peers. Have you kept any of the friends you have had earlier in your life in care?

M: No

I: Do you talk to any of them?

M: No, it is something I have chosen myself because it wasn't good for me. We didn't have much in common, different interests so well.

I: Yes

M: There have of course been some things we have done together, but I think there is a part of life which is to do with a care home and a part of life which is private. I have never err met with anyone from earlier homes because errr well if someone moved from here and found me on Facebook, I have always said that I am protecting myself, you are not a part of my life anymore.

I: No, I understand, within your groups of friends you have in your private life are there any others who have lived in care?

M: Yes, errr there are, we have always stuck together but those I have known since I was very small.

I: OK, so they are from way back in your childhood?

M: Yes

I: So, you have some common memories?

M: Yes exactly, so in the evening when we ring each other up we can share what is good and bad, carers and that sort of thing.

I: Lovely, there are just two more things I would like to ask about is that OK

M: OK

I: The first is, are you good at receiving help?

M: err

I: You have mentioned a carer you were very happy with and am I right in guessing you would let him help you?

M: Yes, that's right, I still have contact with him.

I: What about school, cleaning, daily life, case workers?

M: Well, I haven't had much help from my case worker the one I have now I can never get hold of.

I: No, who do you turn to if things are difficult?

M: Here at the care home, you can always find someone, but I live in the halfway house so we don't get as much help, of course if everything is wrong, they are there for you 100% but usually you have to wait a bit because otherwise it will take them away from the others who also need help.

I: Are you pleased they can help you?

M: Yes, I am because I admit that that is why I haven't moved out yet, because I still need to learn somethings,

I: Super thank you, how about at school?

M: Before I used to get a lot of help from the carers but now where I am in a specialist education, I find the carers can't help me as much. At school I try to work it out myself before I ask for help. I don't have my mobile with me in school which helps me focus on what I need to do.

I: Thank you, now I would like to ask about being help physically, you have mentioned some violent events, have you ever been held by force?

M: Only once and I was not as old as I am now, now I have become a big and strong guy so if things got out of hand with the carers, I know I have to step back.

I: Super

M: No one wants to hold on to anyone, that is not why they come to work so well I experience those things just don't get that far.

I: I have a last question, if you got the chance to talk to a top politician and were able to give them three pieces of advice what would you say?

M: I would say they should make sure errr that the carers don't think they own the young people.

I: Yes

M: I would say I would like it if they could make sure the young people got more opportunities, that they listened to the young people more about what they would like to do in their free time and not push them out to do things they don't want to do.

Yes, that is my third thing not to push us into doing things we don't want to do, just because the other do and one doesn't maybe they are having the worse day of their lives and just want peace and quiet, but they have to go with the others it can be very unpleasant.

I: Super thank you, you have mentioned personal interests, have the care homes you have lived in overtime listened to you about your interests?

M: Yes, I started going to motocross when I came to this company, I had tried it before with my parents and then it started up again her. They asked me if there was anything I would like to do and I said that and I could go to it. But then Corona came so it had to stop, now because I am 18, I can't go but the young ones sti do.

I: Fantastic.

___________ second interview

I: What would you like to be called in this research?

M: I would like to be called Miker

I: Super, I would like to ask you a bit more about the violence you have mentioned, if I said from violence to peaceful would that make sense?

M: Yes, it does

I: And my question about this is to do with getting help, you have worked hard on this yourself

M: yes

I: And you have had some help along the way?

M: Yes

I: Would you say that the help you received for this came mostly from the carers or was it from your doctor, psychiatry or your family?

M: err

It was probably my family

I: And in that would you say that it has made a difference to you that your sister lives close by?

M: Err, she has been there for me as I have been there for her. It has been nice that she lives close by as I can easily just visit her and get away from it all.

I: Yes, may I ask how old she is?

M: She is 22

I: OK so she isn't that much older than you

M: No

I: Mnn, so in that way you are very close

M: Yes

I: Do you think your family, that is to say your mum and dad and to a certain extent your sister, even though she wasn't 18 when you were taken into care.

M: She was under 18 she must have been 15

I: Yes, so she couldn't have influenced the authorities

M: No

I: Could your mum do anything if you were dissatisfied or unhappy?

M: About my care situation?

I: She couldn't because I was removed by law by the council, they controlled everything, how everything should be done.

I: Yes

M: The only thing we could do was challenge it in court

I: Thank you, I just needed a further explanation thankyou again. You have been through the manuscript now.

I would like to ask about here, where you live now, you have told me you feel listened to, when the half-way house did not work the first time your wishes were accommodated, and when you were ready you were able to try again.

M: Precisely.

I: When you were in the situation where the half-way house did not function was it your mom who talked to the home.

M: I was the one who explained it.

I: Super

M: And then they chose to move me back again I did not have a choice

I: No, but you have managed it the second time

M: Yes, but they threw me into it.

I: Yes, you have said it would have been better with more preparation

M: Yes

I: But that is what happened from day to day.

I: Yes, and the narrative you have given me informs of a lot of things that came very suddenly.

M: Yes

I: With your education do you experience that it is like this as well or are things more predictable?

M: It is unpredictable, but since I have become an adult they have in the care home much less influence on my life, there are some rules though which I have to comply to.

I: Yes, we have talked a bit about your future and where you are heading with your education.

M: Yes, but I am also preparing to move, they are starting to look for an apartment for me.

I: Okay how lovely, and who is helping you with this?

M: Stine, she is the boss of the care home and half-way house.

I: Super do you know where you will move to?

M: Yes, I am moving to Allerton

I: Super, are you going to, in the future choose a life in the town after living in the countryside?

M: Yes, I am

I: Yes, have you chosen Allerton because of your family?

M: Yes, there are people there from my mother's side of the family and my father's side, my aunts and my cousin live there, so I will live there too.

I: Fantastic and is this is close to where you are taking your education?

M: Yes, it is closer so I will get more sleep.

I: Yes, that is important, Stine told me how early you get up in the mornings.

M: Yes ermm

I: What about help in the future?

M: I will get help, some carers will come out to me probably a few times a week and say hello and hear how I am getting on, and if I need some help.

I: Yes, until your aftercare is completed

M: Yes, precisely

I: And when it is finished do you expect you will need more help?

M: No

I: So, you will be completely independent

M: Yes

I: That is fantastic

M: I am looking forward to it

I: That I do understand, you appear to be both learning to be an independent adult and be in the process of moving from one system, the care home to another system your family.

M: I would say that when I move, I will be independent, I don't have to ask about this and that, or think about the consequences if I leave the premises without telling anyone, I will be able to do what the hell I like and that is what I am really looking forward to. It is going to be so much better, because I have never had this opportunity in my youth after I moved into care.

I: No, what does that feel like?

M: Yes, ermm like something ermm my youth the freedom I could have had with my friends has been taken away from me no

I: Yes mnn

M: At the care home you get indifferent because the only person you have is yourself most of the time.

I: Yes, even though you did have friends

M: But you can't see them as much, that has been a big problem.

I: Yes, it is difficult

M: Yes, it is

I: Now, at your education have you begun to find new friends?

M: Yes

I: Do any of them live in Allerton

M: Yes, they do so that is really nice.

I: So, when you move into your apartment you will have a family network and a network of friends

M: Exactly

I: Fantastic, what do you think will be the most difficult thing when you have moved?

M: I don't know. Everything is difficult when it is far away.

I: But do you think about things like economy or something as basic as cleaning?

M: No,no,no I love cleaning, I love it when everything smells nice.

I: Yes

M: I am not worried about economy errr I don’t know maybe because there won’t be as many people, it is nice having the carers around.

I: Yes, I can understand that will be a big difference.

I: Do you think that if everything goes wrong, for example you have an accident, break your leg and lose your apprenticeship, and nothing functions will you contact the care home?

M: When my aftercare is finished?

I: Yes

M: No, I will contact my family

I: Yes, do you think if everything was wrong that you would contact your case manager?

M: Yes, thank you, it is always a good idea to be on good terms with them otherwise you cannot get help.

I: That sounds very sensible. Do you have any questions about what we have discussed?

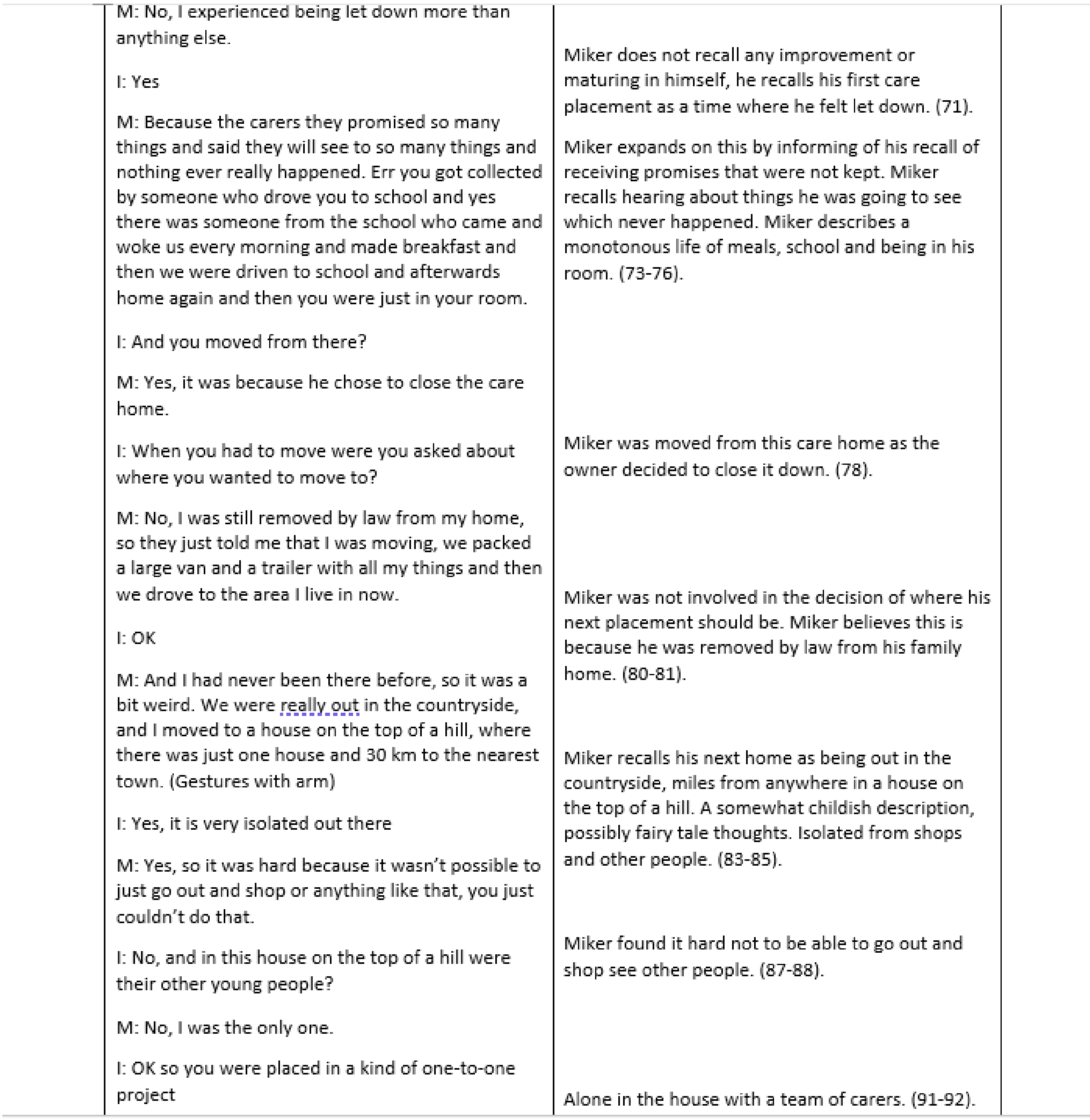
M: No, I would just like to say that I think it has been great to do this, I have felt safe doing it, I haven’t told very many people about my experiences and now I have done this.

I: Fantastic, it is good to hear that you have found benefit in sharing your experiences.

Thank you so much, I am turning the recorder of now.

Appendix XIV:

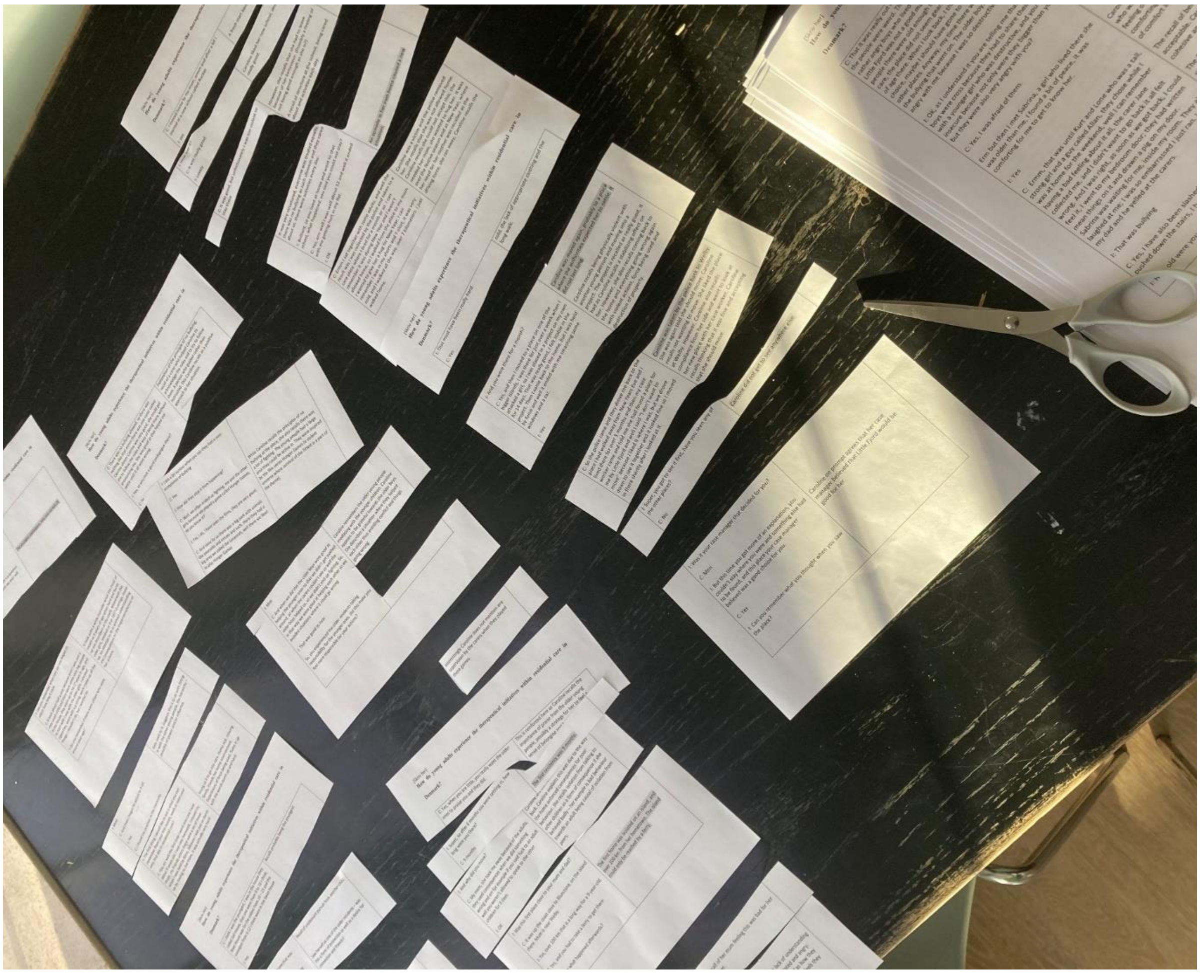
Extract of the work done on notations in Miker's transcript



M: No, I experienced being let down more than anything else. I: Yes	Miker does not recall any improvement or maturing in himself, he recalls his first care placement as a time where he felt let down. (71).
M: Because the carers they promised so many things and said they will see to so many things and nothing ever really happened. Err you got collected by someone who drove you to school and yes there was someone from the school who came and woke us every morning and made breakfast and then we were driven to school and afterwards home again and then you were just in your room.	Miker expands on this by informing of his recall of receiving promises that were not kept. Miker recalls hearing about things he was going to see which never happened. Miker describes a monotonous life of meals, school and being in his room. (73-76).
I: And you moved from there? M: Yes, it was because he chose to close the care home. I: When you had to move were you asked about where you wanted to move to?	Miker was moved from this care home as the owner decided to close it down. (78).
M: No, I was still removed by law from my home, so they just told me that I was moving, we packed a large van and a trailer with all my things and then we drove to the area I live in now. I: OK	Miker was not involved in the decision of where his next placement should be. Miker believes this is because he was removed by law from his family home. (80-81).
M: And I had never been there before, so it was a bit weird. We were really out in the countryside, and I moved to a house on the top of a hill, where there was just one house and 30 km to the nearest town. (Gestures with arm) I: Yes, it is very isolated out there	Miker recalls his next home as being out in the countryside, miles from anywhere in a house on the top of a hill. A somewhat childish description, possibly fairy tale thoughts. Isolated from shops and other people. (83-85).
M: Yes, so it was hard because it wasn't possible to just go out and shop or anything like that, you just couldn't do that. I: No, and in this house on the top of a hill were their other young people?	Miker found it hard not to be able to go out and shop see other people. (87-88).
M: No, I was the only one. I: OK so you were placed in a kind of one-to-one project	Alone in the house with a team of carers. (91-92).

Appendix XV:

A photograph taken during the process of grouping the notations to create clusters.



Appendix XVI:

Cluster example for participant 8

Participant 8 cluster 5 – being moved about and moving about.

Miker explains he had no idea that he would be taken away from his home. It happened from one day to the next. (24-25). Miker's first placement was a small home with 4 residents. (30). Miker experienced aggression and violence on his second day from another resident. (30-32). Miker was moved from this care home as the owner decided to close it down. (78). Miker was not involved in the decision of where his next placement should be. Miker believes this is because he was removed by law from his family home. (80-81). Miker recalls his next home as being out in the countryside, miles from anywhere in a house on the top of a hill. A somewhat childish description, possibly fairy tale thoughts. Isolated from shops and other people. (83-85). Miker found it hard not to be able to go out and shop see other people. (87-88). Alone in the house with a team of carers. (91-92).	This cluster is concerned with Miker's experiences of the moves he has had to make during his life in care. Miker's move into care was abrupt and without explanation. A court order ruled he could not live at home. Miker has never had an explanation regarding this, even today when the court order has been reversed Miker does not feel that he knows what happened during this time. Miker's narrative of his time in care is suggestive of move upon move with little or no explanation, his first home was marred by violence, and he moved from that home as it closed. His next placement started well, living alone for a week with carers he liked followed by a holiday in Crete. However, this feeling of security was removed when Miker got shown where he should live only to be moved somewhere else. Miker describes this situation as very stressful. Miker's next move was also turbulent he was to move into a half-way house, Miker could not cope with the requirements of living a more independent life and moved for a year into the care home beside the half-way house. A year later he moved into the half-way house. Miker was unhappy about this he felt that yet again he had been thrown into a living arrangement he had no say in.	M: No, I was still removed by law from my home, so they just told me that I was moving, we packed a large van and a trailer with all my things and then we drove to the area I live in now. (80 – 81). I: OK M: And I had never been there before, so it was a bit weird. We were really out in the countryside, and I moved to a house on the top of a hill, where there was just one house and 30 km to the nearest town. (Gestures with arm). (83-84). M: I asked the man who drove me out there what was wrong because it wasn't the place I had been shown and promised. I was told that was true, but it was here I was going to live. I said no it isn't I have been to and promised somewhere else. So, I went to this place I hadn't seen, Sunnyside, and it was very special because there were young people there who were also urmmm some of them were violent and yelled and shouted all the time. (112-116).

On return Miker was shown a home belonging to the company he had been in his 1:1 house. He saw the bedroom and then went back to pack his things. (105-107). Miker recalls how it all went wrong, he didn't get moved to the home where he had seen his bedroom, but to another home within the company, a place he had not seen. (107-108). Miker describes a state of panic, asking the man who drove him what was happening when they did not drive in the direction Miker had expected. Miker tells the driver it isn't true, he found out a promise had been broken. Miker recalls his first experience of his new home as violent and noisy with yelling and shouting from the other residents. (112-116). Miker recalls his level of distress, using the phrase couldn't understand it. Miker could not understand how he had been shown one place where he should live and liked and then given another. Miker recalls in his stress staying in his bedroom for the first week. Miker also recalls how, at the promised home, he had met some of the other residents and now he was in a place where he felt he knew no one. (121-124). Miker moved from that home to another home in the company when he was 16. He discovered his move by accident as he found a ring binder in the office with his name on and the new place. Miker knew that this place had a half-way house as well as a residential care home. (185-188).	Today things are different at the second interview Miker explained that he is now working with his house leader, together to find a flat for him in the town of his choice, hopefully in a timeframe which Miker for the first time in his life is comfortable with.	M: Yes, but I am also preparing to move, they are starting to look for an apartment for me. I: Okay how lovely, and who is helping you with this? M: Stina, she is the boss of the care home and half-way house. (423-425).

Miker started in the half-way house, but it did not function for him, he describes himself as breaking-down while there. It was Miker describes to much for him, he did not know how to budget, cook and clean. So, he was allowed to move into the residential care home, where he stayed until he was 17 and a half. (188-191). Miker moved back into the half-way house abruptly, he got told his bedroom was to be used by a new resident. Miker recalls being told to move everything over to his new room in the halfway house. Miker recalls having no help with the move. (194-196). Today Miker is very happy with the half-way house. (198). Miker reflects that once he settled down in the half-way house, he noticed that he was freer than he had felt before. (200-201). Miker explains in all this the frustration he had; he was, in reality, frightened that he would be thrown out. Miker recalls that as he has been moved around so much, he worried that any change would be negative, possibly that they did not want him anymore. Miker recalls that instead he got money for food, clothes, and spending, because while he was in a half-way house, he wasn't yet 18. (203-205). Miker recalls he was the one who sought help when his first placement in the half-way house was dysfunctional for him. (409).		

Miker recalls when he moved back into the half-way house it was not by his choice, he uses the word thrown into it. (413). The move was from one day to the next. Miger would have liked more time. (415) Miker still thinks his life is very unpredictable, however now that he is settled in the half-way house and over 18, he notices others have less opportunity to make decisions over his head. (420-421). Miker is preparing to move into his own flat, this process appears to be going at an OK pace for Miker he is being helped by the leader of the care home the half-way house is attached to. (423-425). Miker knows which town he is going to move to. (427). This town is Miker's choice, it is where he has family members living and closer to his college. (431-432). Miker will have help when he moves, he is still in the aftercare program. (439-440). Miker does not worry about basic things like housekeeping or economy when he moves, but he is worried, it appears to be something that is far away for Miker – possibly he means simply unknown. (471 – 476).		