“Youth voices matter!”

Safety and meaningful participation: Perspectives of youth and staff in Norwegian residential facilities

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Summary

In recent years, safety considerations have been at the forefront of work with children and youth (hereafter, youth) in residential facilities. In particular, the awareness of safety as fundamental to staff-youth relationships and to youth well-being has informed the research in these environments. The underlying assumption of this dissertation is that perceiving that one is safe is essential if one's care and treatment are to be effective. Studies have shown that youths' descriptions of life in residential care can reflect feelings of unsafety and lack of participation. Reports suggest as well that both staff and youth at Norwegian residential facilities experience a lack of safety and security. The three aims of this dissertation are (1) to illuminate youth and staff perceptions and experiences of safety in residential facilities, (2) to investigate staff and youth experiences of meaningful participation and conflict management, and (3) to investigate staff perceptions of the effects of their having attended the Basic Training Program in Safety and Security.

The first article of this dissertation, a mapping literature review (Slaatto, et al., 2021a), included 14 studies that were conducted in residential and hospital/psychiatric facilities and a small number that were conducted in juvenile justice facilities. The review indicates that both youth and staff have had negative experiences of physical restraint. The findings also show that the number of conflicts/aggressive incidents and the use of restraint and seclusion (R&S) can be reduced by implementing various interventions, such as education and training programs. Additionally, the results of the review show that research is limited and that further studies are needed on both the effects and experiences of physical restraint and the effectiveness of de-escalation measures in preventing violence and aggression. The second article (Slaatto, et al., 2021b) investigates staff perceptions of their safety and their experiences with the Basic Training Program in Safety and Security. Findings show that staff regard safety as essential and perceive enhanced safety to correlate with increased predictability, stability, team coordination, education and training, organizational support, and trusting and supportive relationships. Also, staff believe that the basic training program has improved their safety by enhancing their awareness of conflict situations before, during, and after they occur and by contributing to more systematic work processes and more cooperative and coordinated teamwork.

The third article (Slaatto et al., 2022) examines youths' perceptions of their safety and experiences of staff behaviors and attitudes. Findings suggest that youths' private rooms and the location of the rooms, as well as youths' relationships with staff are important to their

perceptions of safety. Another important finding is that some youths perceived their everyday life in residential facilities to be on hold, and that they are just waiting for their lives to start. Youths also reported that they do not see themselves as meaningful to others and so have nothing to get up for in the morning. The study also found that youths who voice their opinions feel powerless, reporting that it is pointless to argue with staff or complain to state administrators. Findings with respect to youths' perceptions of staff attitudes and behaviors indicate the importance of staff's communication abilities.

One of the main findings reported in the fourth article (Slaatto et al., 2023) is the shortcomings in the facilitation and implementation of meaningful participation for youth living in residential facilities. The article finds weaknesses with respect to the level of information that youth receive and how they receive it. The extent of information provided is dependent on youths taking the initiative to ask for it. The article also identifies challenges to the fulfillment of the requirement that youth be permitted and encouraged to express their views freely and have their views taken into account. These findings indicate that youth in residential facilities experience a lack of control and influence over their lives. Several youths stated that, no matter what they say, they cannot change staff members' minds. The article concludes that the three dimensions of participation are not all fully present.

Each of the four articles presents a different picture of life in residential care in Norway. The dissertation has several novel findings and contributes to knowledge of how youth and staff experience safety, conflict management, and meaningful participation in residential care. It also deepens understanding of youth perspectives on living in residential facilities and highlights safety as an important concern for youth as well as for staff. The main positive finding is that staff experienced an increased feeling of safety after attending the Basic Training Program in Safety and Security. Findings also point to two concerns. One is that both staff and youth perceive challenges to achieving meaningful participation of youth, with one possible consequence being that the youth do not experience real influence over their lives. The other concern is that youth describe sitting in their rooms, waiting for life to start and not knowing what the future will bring.

Sammendrag

I arbeid med barn og ungdom på barneverninstitusjoner får trygghet og sikkerhet stadig større oppmerksomhet i flere land. Særlig rettes det fokus på trygghet som noe fundamentalt for relasjoner mellom ansatte og ungdom, og for ungdommens personlige utvikling og helse. Tidligere forskning og offentlige rapporter viser at ungdom beskriver livet på barnevernsinstitusjoner som tidvis utrygt og med mangel på medvirkning. I tillegg viser rapporter som omhandler arbeidsmiljø at personale opplever utrygghet ved blant annet å være utsatt for vold i ulike former. En antakelse i denne norske avhandlingen er at opplevelse av trygghet er grunnleggende for den relasjonelle kontakten mellom ungdom og personale. Videre antas det at trygghet er avgjørende for at omsorg og behandling skal virke etter intensjonene. Målene med denne avhandlingen er derfor (1) å belyse ungdom og ansattes oppfatninger og erfaringer med trygghet på barnevernsinstitusjoner, (2) å undersøke ansatte og ungdoms erfaringer med meningsfull medvirkning og konflikthåndtering, og (3) å undersøke ansattes erfaringer med å delta i opplæringsprogrammet i trygghet og sikkerhet.

Hver av de fire artiklene som denne avhandlingen bygger på, belyser ungdoms og ansattes perspektiver på hvordan det er å bo og jobbe på barnevernsinstitusjoner. Ett av fem hovedfunn knytter seg til hvordan ungdom har mulighet til meningsfull medvirkning. Avhandlingen viser svakheter ved både om ungdom får tilpasset og tilstrekkelig informasjon om sine rettigheter og om hva som skal skje fremover. Særlig byr det på utfordringer å skape muligheter for at de får gitt uttrykk for sine meninger på et fritt grunnlag, da det er store forskjeller i maktposisjon mellom ungdom og ansatte. Flere ungdommer uttrykker at uansett hva de sier så endrer ikke personalet sin mening om hvordan noe kunne være eller bli. Flere sier også at det heller ikke fører til noe om de klager til statsforvalteren. Samtidig som ungdom har lovhjemlet rett til beskyttelse, har de også rett til medvirkning. Funnene i denne avhandlingen kan tyde på at disse to hensynene er utfordrende å forene i praksis, og at ungdom ikke opplever medvirkning etter intensjonene. Deres erfaringer er preget av mangel på kontroll, oversikt og innflytelse i egne liv. Ytterligere et funn handler om hvordan ungdom opplever hverdagen. De lever et liv på vent og bare venter på at livet skal begynne. Noen av ungdommene rapporterte at ingen trenger dem, og at det ikke er noen vits i å stå opp om morgenen. Dette tyder på at deres liv på barnevernsinstitusjon har lite innhold og mening for dem. Videre viser avhandlingen et tredje funn; at ungdom opplever trygghet relatert til fysiske omgivelser, særlig deres egne rom og plasseringen i huset, noe som har fått lite

oppmerksomhet i tidligere forskning. De angir også at opplevelse av grad av trygghet relateres til ansatte og andre ungdommer. Funnene som gjelder ungdoms erfaringer med hvordan ansatte møter dem, indikerer at det har stor betydning hva de ansatte faktisk gjør og hvordan de gjør det. Ungdommenes stemmer i denne avhandlingen bidrar til en utvidet forståelse av perspektiver på å bo på en barnevernsinstitusjon.

Det fjerde hovedfunnet er knyttet til ansattes erfaringer med å delta i opplæringsprogrammet i trygghet og sikkerhet og viser at de opplever å ha fått økt bevissthet i forebygging, håndtering og bearbeiding av konfliktfylte og uønskede situasjoner. De rapporterer også økt bevissthet og trygghet før de tar i bruk fysisk tvang. De har bedret sine ferdigheter i kommunikasjons, bruker metodisk refleksjon mer, søker å forebygge aggresjon og konflikt, har bedre teamkoordinering og samhold ansatte mellom, samt har en økt oppmerksomhet på egne og andres reaksjoner og aksjoner.

Avhandlingens gjennomgang av litteratur viser at forskning er begrenset på effekt av intervensjoner for å forebygge og håndtere aggresjon og vold i barnevernsinstitusjoner. Det samme gjelder effekt og erfaringer ved bruk av tvang. Forskningen indikerer også at både ungdom og ansatte har negative erfaringer med bruk av fysisk makt. Funnene i gjennomgangen viser at antallet konflikter og aggresjon, samt bruk av tvang kan reduseres ved å implementere ulike intervensjoner, slike som opplæring og ulike treningsprogrammer. undersøke ansattes erfaringer med å delta i opplæringsprogrammet i trygghet og sikkerhet.

Denne avhandlingen bidrar til å forstå viktigheten av trygghet og meningsfull medvirkning i barnevernsinstitusjoner, og hva som påvirker dette. Selv om funnene er begrenset til norske statlige barnevernsinstitusjoner, vurderes de som relevante for ungdomsinstitusjoner generelt, både for ungdommene og for de ansatte der. Offentlig forvaltning kan gjøre seg nytte av funnene i avhandlingen og sørge for tilstrekkelig kompetanse, utvikle støttesystem og innvilge ressurser som bidrar til økt kvalitet. Ettersom de ansatte spiller en viktig rolle i ungdommenes liv, er det deres kommunikasjon og interaksjoner med de som i stor grad påvirker hvordan ungdom opplever både trygghet, innflytelse og mening i sine liv. Oppsummert viser avhandlingen at trygghet, medvirkning og kompetent personale er viktige forutsetninger for å være en god barneverninstitusjon.

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Attachments

Approval–Norsk Senter for forskningsdata (NSD)

Information letter and consent–staff

Information letter and consent–youth

Interview guide–staff

Interview guide–youth

Published articles:

Article 1: Conflict prevention, de-escalation and restraint in children/youth inpatient and residential facilities: A systematic mapping review (Slaatto et al., 2021a). *Children & Youth Services Review*, 127, 106069. DOI: https://doi.org/10.1016/j.childyouth.2021.106069

Article 2: Safety in Residential Youth Facilities: Staff Perceptions of Safety and Experiences of the "Basic Training Program in Safety and Security" (Slaatto et al., 2021b). *Residential Treatment For Children & Youth, 39*(2), 212–237.
DOI: https://doi.org/10.1080/0886571X.2021.1978035

Article 3: Youth in residential facilities: "Am I safe?", "Do I matter?", and "Do you care?" (Slaatto et al., 2022). Residential Treatment For Children & Youth, 40(1), 87–108.
DOI: https://doi.org/10.1080/0886571X.2022.2082628

Article 4: "I Never Win"—How Children and Staff in Residential Facilities Experience Meaningful Participation (Slaatto et al., 2023). *Child & Family Social Work, 29*(2), 374–385. DOI: https://doi.org/10.1111/cfs.13090

1 Introduction

My interest in the field of social work arose in my early twenties when studying for a bachelor's degree in child welfare. Over the next decade, I worked with child protection services and various residential facilities, both as a milieu therapist and as a manager of a private-owned residential facility. In 2018 I joined the Expert Group on Safety and Security for Children and Staff at Residential Facilities (Spisskompetansemiljøet for trygghet og sikkerhet for barn og ansatte i barnevernsinstitusjoner) in the Eastern Norway Regional Office of Children, Youth and Family Affairs (Bufetat). After a year working for Bufetat, I was asked to start the process of planning and applying for funding and admission at a university for a public Ph.D. project on safety and security at residential facilities. In this process, I cooperated with Øystein Stockvold (Bufetat) and the first co-supervisor (2019-2022), John Kjøbli, at the Center for Child and Adolescent Mental Health, Eastern and Southern Norway (RBUP). The project received funding from The Research Council of Norway, The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir), and Bufetat. Oslo Metropolitan University accepted my application and project description.

This dissertation in the field of social work is a result of a challenging and ongoing learning process that investigates the experienced practices within residential facilities for youth. In particular, it explores how safety, conflict situations, and meaningful participation are perceived by both staff and youth. The specific research questions are

1. How do staff and youth perceive safety in residential facilities?
2. What are the staff experiences with the Basic Training Program in Safety and Security?
3. How do youth experience staff behaviors and attitudes?
4. How do youth and staff experience the three dimensions of meaningful participation—informing, hearing, and involving—and are these dimensions being practiced according to professional standards of best practice?

The dissertation comprises four articles, starting with a literature mapping review of residential and inpatient care and treatment facilities, followed by three articles based on data from focus-group interviews and individual interviews with staff and youth. This dissertation uses the terms children and youth in somewhat overlapping ways. In the main, "children" is used as a collective term for people under 18 years of age, and "youth" is defined by the WHO as people between 15 and 24 years of age. The dissertation uses the word children when discussing rights laws, which conventionally use this term for anyone under 18. The

term is used even if youth participating in this dissertation and other studies refer to themselves as youth and not children. This dissertation also refers to some research in which the participants were older than 18.

A residential facility is a home for children and youth who have individual needs and live there for various reasons. At the same time, it is a workplace for employees who are expected to safeguard the needs and development of the residents. Staff are responsible for helping ensure that children experience a safe environment. This dissertation approaches the study of safety issues in residential care with the assumption that residential facilities should offer a safe environment in which youth receive the best available care and treatment to ensure healthy development of the youth. These goals are influenced by staff behavior and communication with youth as well as by the extent to which youth are able to participate meaningfully. Understanding youth's perspectives and sense of their experiences is important. The experiences of youth in residential care are shaped by a complex interplay of factors, including a youth's background and reasons for being in a care facility, the building itself and its location, other residents, and the rules, routines, and work shifts of the staff.

Existing research underscores the importance of youth voice, youth relationships with staff, and youth perceptions of safety (Bath, 2015; Chama & Ramirez, 2014; Jolivette et al., 2015; Moore et al., 2017; Sellers et al., 2020). Children's healing and developmental progress occur largely through their engagement with supportive adults, provided that the children experience a consistent sense of physical and psychological safety (Sellers et al., 2020). When youth have been asked what they need to be safe, they have generally identified relationships with trusted adults or peers, some autonomy and control over their environments, and opportunities to influence decisions that affect their lives (Moore, 2017). Residential facilities are experienced as safe when the children experience supportive relationships, stability, predictability, fair rules, and control over their own lives (Van der Helm, 2011). A study examining youths' prospective assessment of group-home treatment quality on their treatment outcomes finds that youths' perceptions of the staff as caring and fair and of the group home as safe significantly predicted improved youth behavioral and mental health at discharge (Ballentine et al., 2023). Quality of relationships between youth and staff as well as overall safety seem to be the most salient factors associated with positive youth outcomes (Attar-Schwartz, 2017; Kor et al., 2021; Moore et al., 2018; Sellers et al., 2020). In contrast, poor relationships with staff may indicate a broader safety concern (Mazzone et al., 2018).

Many of the children placed in residential facilities need extensive help in a number of areas simultaneously. The number of reported serious incidents in residential facilities in

Norway increased in 2022 (Bufdir, 2022a). An increase in runaways from facilities was also registered in the last few years, despite a decrease in the number of placed children. There has also been an increase in children in residential care who have connections to criminal networks. This information suggests that more children with heavy needs can challenge the residential care and treatment system.

The rights of children are not always sufficiently guaranteed by current legislation, by internal (Bufdir) or external (Statsforvalteren) facility supervision, or through concrete protection measures, such as providing opportunities for children's participation. The children's ombudsman report, "Grenseløs omsorg" (2015), conveys concerns that children's rights are not attended to in residential facilities. According to Ulset and Tjelflaat (2012), youth who live in Norwegian residential facilities often feel unsafe and afraid. One out of five children do not feel safe in the facility in which they reside (Rambøll, 2022). The feelings of being unsafe relate to the staff who work there, the other children who live there, and uncertainty about the future.

A summary of the nationwide investigations of 60 residential facilitates by the Norwegian Board of Health Supervision in 2018 (Helsetilsyn, 2019) shows that 45 facilities violated regulations and/or needed to make improvements. In the institutions where deficiencies were detected, the institutional leaders lacked adequate knowledge of whether or not their personnel followed up on plans and decisions. They did not ensure that mistakes were detected, evaluated, and corrected, and they lacked sufficient education and training. As a result, the youth did not receive adequate care. At more than half of the facilities that violated regulations regarding participation and safety, one or more youths reported feeling unheard, uninformed, or unsafe. For example, they stated that they did not know which staff member would come to work when. Further, the youth said that they felt that staff did not respect and engage with them, and that some could not be trusted. At the same time, evidence indicates that youth's opinions and needs were not documented, updated, or evaluated.

The incorrect use of coercion was also discovered at some facilities. One facility was criticized for failing to take seriously its responsibility to provide for and protect the youth in its care (Helsetilsyn, 2018). This facility also set the threshold for the use of coercion too high, and staff failed to set proper boundaries to reduce risks and prevent unhealthy youth development. Staff failure to intervene was related to the way staff interpreted youth's right to participate and make decisions about their own lives. In contrast, another facility was found to be routinely and extensively using coercion, at times illegally, in its treatment of youth (Sivilombudsmannen, 2018).

Existing research points to concerns about staff safety as well. Conflicts, aggression, and use of R&S have been found to affect stress levels and work satisfaction, and to lead to increased levels of anxiety, distress, fear, anger, and hostility toward staff and to power struggles between staff and youth (Harris & Leather, 2012; Lombart et al., 2020; Miller, 1986; Nyttingnes et al., 2018; Smith et al., 2017; Steckley, 2018). A Norwegian study of the psychological well-being of 506 child protection workers found that 70% reported moderate symptoms of burnout and 37% reported moderate symptoms of secondary traumatic stress (Baugerud et al., 2018). Staff turnover has been associated with reduced quality of service to children in residential care (Tremblay et al., 2016). Workers also experience stress as a result of time pressure and the emotional and physical pressure of managing and intervening in youth behavioral crises (Smith, 2014). Such crises present potentially dangerous situations, and staff are sometimes compelled to intervene despite lacking effective and safe strategies for doing so (Smith, 2014). Lazarus and Folkman (1984) assert that uncertainty can generate conflicting thoughts, feelings, and behaviors which, in turn, create feelings of helplessness. Staff turnover and burnout are considered harmful and disruptive to the youth in residential facilities, who often have difficulty forming trusting relationships with staff. They also undermine the efforts of the facilities to provide youth with stability and predictability (Connor et al., 2003). The research review by Storø et al. (2017) concludes that international, research-based knowledge is lacking about how factors such as the organization of everyday life, staff, and other youth residents affect the way that individual youths experience life in residential facilities.

More research is needed on how both staff and children perceive and experience different aspects of residential facilities and which factors contribute to the best possible care for children in residential facilities. As Backe-Hansen et al. (2017) point out, placements in residential facilities can be necessary and a good choice for some children. It is therefore essential to gain knowledge about inadequacies as well as about what is working with respect to the safety and participation of children and youth in these facilities.

In the analysis and discussion of the empirical data, this dissertation conveys the importance of safety to the children living in residential facilities as well as to the staff who work in them. It also contributes to the understanding of how meaningful participation is experienced in these facilities. The dissertation draws on information from participants at facilities in which children have been placed due to receiving inadequate care at home and/or due to the children's behavior. The participants have not been sorted according to the facility in which they reside. The report from Barneombudet (2020), the Norwegian children's

representative, shows that youth, staff, and child protection services do not perceive differences among care facilities and treatment facilities; therefore, comparisons have not been made between the two types of facilities. Additionally, the decision not to distinguish among the facilities supports the ethical importance of protecting participants' anonymity. Through analysis and discussion, this dissertation aims to enhance understanding of safety and participation in residential settings, contributing to the broader field of social work and child welfare.

1.1 The context of residential facilities

Residential care differs around the world (Courtney & Iwaniec, 2009), and facilities differ in size and purpose (Ainsworth & Thoburn, 2014; James, 2011). Therefore, comparisons among countries are not easily performed. Denmark, Finland, Norway, and Sweden have many similarities in the way they organize child welfare (Shanks et al., 2021). The welfare systems in these countries emphasize and build on ideas of universalism and solidarity, and they are largely publicly funded. It is believed that basic human needs should be secured by the systems and that all citizens should be granted equal access to the services (Cox, 2004). Since the late 1980s, the New Public Management (NPM) movement has impacted the services offered (Hood, 1995; Pollitt & Bouckaert, 2011), with differences among countries and welfare sectors (Sivesind, 2017; Stenius & Storbjörk, 2020). Since the 1980s, Finland and Sweden have increased the outsourcing of residential care. In both these countries, the proportion of for-profit actors has increased significantly, and today they dominate the field (Lundström et al., 2020). In Sweden, close to 80% of residential care facilities are run by private companies, and a number of them are large, for-profit corporations (Lundström et al., 2020). Trends in the UK mirror those in Finland and Sweden (Jones, 2015). Norway's public and non-profit sectors have retained a reasonably strong hold, even if the market was also opened up to for-profit providers in the 1980s. In Denmark, non-profit providers maintain a dominant position (Shanks et al., 2021). In the 1990s, there was a drive in Norway to invite for-profit actors to provide residential care and to reduce the number of publicly owned facilities. The motivation was in part ideological and in part budgetary. At the same time, the view of residential care as the last resort became predominant. This led to a systematic reduction in the number of available places since 2004 (Anglin, 2004; Backe-Hansen et al., 2017; Knorth et al., 2008; Shanks, 2021; Souverein et al., 2013), and to an emphasis on residential care as a short-term arrangement only (Thoburn, 2016; Whittaker et al., 2016). The Norwegian Child Welfare Reform of 2004 prescribed the reduced use of

institutional placement (Bakketeig et al., 2011). The current goal of several European countries, including the Nordic countries, is to reduce the number of children and youth living in residential facilities. Norwegian policy is to put resources into local prevention and empowerment measures, such as programs for parents. At the same time, these residential facilities are expected to improve their ethical and professional standards (Thuen, 2002; NOU 2000:12). Bufdir highlights the requirement that every facility should have a defined target group and a clear objective for its professional activities. The basic ethical principle underlying the policy is in line with the idea of inclusion; the facilities should allow their residents to influence decisions that affect them personally. Coercion should only be used to avoid harm.

The child welfare systems are responsible for investigating children's needs, offering help, and providing support and protection. The Child Welfare Act (CWA) (Barnevernsloven, 2021) allows the state to support, control, and correct parents who are seen as not safeguarding their children's best interests or providing satisfactory care. The general aim is to provide the best help possible to children and their families and create good conditions for youths to grow up in. In line with the family-oriented child welfare policies (Gilbert et al., 2011; Shanks et al., 2021), the preferred choice of intervention is that which is least intrusive. Interventions are, to the extent possible, voluntary and cooperation with the parents is preferred. Most of the children who receive help get it through some form of in-home treatment. If these services have not helped and there is a need for a child to be placed in care, foster care is generally preferred to a residential facility (Backe-Hansen, 2011; Pösö et al., 2014). In comparison to Denmark, Finland, and Sweden, Norway places a small proportion of children in residential care. Around 9% (approximately 1,000) of placed children in Norway reside in residential care (SSB, 2022) at any given time. The percentage in Finland is 50%, in Denmark, 33%, and in Sweden, 22% (Lausten & Andreasen, 2019; Swedish National Board of Health and Welfare, 2019). Residential care and treatment facilities in Norway are run by Bufetat, non-profit organizations, and for-profit private companies. As of autumn 2023, Bufetat was running 51 facilities, with 102 departments, and 442 places for children (NOU, 2023:24).

The state's assumption of responsibility for providing residential care in 2004 was part of the centralization of specialized residential facilities. This created the basis for establishing the Directorate of Children, Young People, and Families (Bufdir) and dividing the country into five regions of responsibility. Norway differs from the other Nordic countries in that the state plays a central role in managing, operating, and financing residential facilities (Kjelsaas

et al., 2020; NOU, 2023:24). This has facilitated the establishment of clear national requirements for quality and guidelines for equal and uniform practice. Bufdir mandates staffing requirements, routines, standardized procedures, and competence levels and it specifies that a facility's professional approach must be rooted in recognized theory (Bufdir, 2020). Bufdir is responsible for developing routines, standardized procedures, and overall planning of the institutional sector. It is responsible for providing residential care in all localities—except Oslo municipality, which runs its own facilities—whether or not the youth placement is voluntary or mandated by civil law. A placement document may be the result of an emergency decision, a voluntarily request for assistance, or a forced measure (Barnevernsloven, 2021). The decision to place a child outside the home can be based on a finding of inadequate care, abuse, or maltreatment, or on a serious concern for the child's health and development or behavior, for example, evidence of the child's criminality or drug use (Barnevernsloven, 2021, kap.3-6). Regardless of the factors underlying or explaining youth behavior, society seeks to stop negative and destructive behavior. The main goal of residential treatment facilities is therefore to reduce the risk of undesirable development and the need for another coercive placement in the future. In Norwegian residential facilities, coercion is not allowed. However, in cases where children pose imminent harm to themselves, others, or property, different forms of coercion may be used to safeguard and protect them from harm. The child's best interest should always be considered by staff in these situations.

Today's child welfare practice leans on the concept of the "included child," that is, the idea that children have their own independent interests, needs, and rights (Thuen, 2002). Modern ideas that children should be included, supported, and stimulated have influenced the child protection service's definition of good care and necessary interventions as well as its expectation that the children themselves should be included in child protection processes (Ericsson, 2009; Frønes, 2018). The relationships between staff and youth are characterized by staff's expectation of comprehensive influence by and participation of the youth in their own care. Staff are expected to listen actively and seek to understand and involve youth. They are supposed to negotiate and find solutions and new options in line with the concept of youths as autonomous beings.

The Norwegian residential care system has not always functioned on the basis of the "included child." The mandate of facilities has varied over the eras, from punishment and protection, to control and help, to treatment and care (Thuen, 2002). The concept of "the child worth saving" arose in the 19th century and was rooted in notions of Christian mercy, natural idealism, and utilitarianism (Thuen, 2002). The child was seen as a worthy subject for help;

engagement with the child was moral and based on personal and private relationships between the helper and the helped. At the same time, it was believed possible to influence and improve individuals in the direction considered socially desirable. At the end of the 19th century, the notion of "the protected child" came to the fore (Thuen, 2002), and was enshrined in the Guardian Council Act of 1896. The Act made children under 16 years old the subjects of educational measures, and they were to be raised to obey the law. The law's purpose was to provide children with protection from dangers in the home, in the prisons, and society. These educational measures came under criticism for their repressive and coercive practices (Thuen, 2002).

Beginning in the 1930s, child psychology gained attention. This field contributed to a renewed view of children as vulnerable and led to an increased focus on the child. Greater attention was paid to children's natural tendencies, their need to explore, their inner lives, and their need for bodily integrity (Thuen, 2002). Child welfare began to professionalize, moving from common sense to knowledge-based practices. If a residential facility used coercion, the intention was to safeguard and protect children from harm, not to control or punish them. In 1953, the Child Welfare Act (Barnevernloven, 1953) was passed to create a more unified and coordinated set of laws and systems to prevent unpredictability and unfairness. The Act of 1953 focused less on the needs of the society and more on the best interests of children themselves (Hennum, 1997; Thuen, 2002).

As social work evolved from voluntary work to a profession, the concepts of love, utilitarianism, and private relationships gradually disappeared from residential care and treatment. ”Love” returned, as a legalized value and ethical ideal for professionals in the child welfare services and was included in the Child Welfare Act (2021) in response to national and international criticism of offensive child welfare practices as well as to pressure from user organizations (Neumann, 2021). It is widely understood that children need love; when the state has the responsibility to care for children, it becomes the task of child welfare workers to give love to them. This requirement poses several challenging questions. Feelings are personal; can the state expect and require professionals to feel a certain way? Further, is there a shared definition of "love" and, if so, how can it be put into practice? Additionally, does the state mandate that professional social workers produce feelings of warmth, care, and love toward the children under their care conflict these workers' professionalism, their training in knowledge-based practice (Messel, 2014), and their reflexive relationship with themselves both as humans and as exercisers of power in interactions with children (Neumann, 2021)? Social workers are clearly expected to engage in a careful balancing act.

1.2 Children and youth in residential facilities

Children placed in residential care have been referred to as the most vulnerable of the vulnerable (Gatwiri et al., 2020); as such, they need special care and protection. At the same time, they are rights-holders, with rights to provision, protection, and participation (Cantwell, 1993; Freeman & Toope, 1996; Verhellen, 2000). This understanding of children's needs and rights is rooted in child psychology research, beginning in the 1990s, that abandoned the notion of children as "becomings" in favor of regarding them as "beings" in their own right (James et al.,1997). Children have come to be seen as a social actors in their own lives with their own views, rights, and experiences.

The majority of children in residential settings have experienced incidents of neglect, abuse, and maltreatment, and they have histories of abandonment and experiences of failure (Briggs et al., 2012; Carr et al., 2020; Collin-Vézina et al., 2011; Jaycox et al., 2004; Rivard et al., 2004; Van Dam et al., 2011; Quiroga & Hamilton-Giachritsis 2016). As a result these experiences, they are more likely to present and be at risk for physical and psychological health challenges and educational, social, emotional, and behavioral problems (Attar-Schwartz, 2008; Bronsard et al., 2016; Jozefiak et al., 2016; Vasileva & Petermann, 2018), as well as emotion regulation difficulties (Kim & Cicchetti, 2010). They have higher-than-average rates of anti-social behavior, aggression, and/or delinquent behaviors (Braga et al., 2017; Collin-Vézina et al., 2011; Connor et al., 2004; McPherson et al., 2018; Norman et al., 2012). They have high rates of substance abuse and criminal activity, and they have a lower quality of life compared to youth in general (Jozefiak et al., 2016; Leloux-Opmeer et al., 2016). Several children have also experienced multiple placements outside their original homes, which has created instability and unpredictability (Hyde & Kammerer, 2009).

A residential facility is a dynamic mix of home, workplace, and institution (McIntosh et al., 2016). Typically, four to five children reside in a home, with the children having their own bedrooms. They most commonly share a kitchen, living room, and activity room. Most children are between 13 to 17 years old, with ninety percent of them 12 years and older. A few are over 18. Residential facilities typically provide a safe, secure, supervised, and structured environment with adequate support from staff and opportunities for healthy development (Knorth et al., 2010; Van der Helm et al., 2011). Routines are established to make everyday life predictable for residents and to create continuity (Tjelflaat & Ulset, 2007). These routines, it is assumed, contribute to giving residents feelings of certitude and safety. All facilities—whether emergency, care, or behavioral treatment facilities—are open facilities

with no fences, locked doors, or other external way of restricting children's actions or movements. Children who are assessed as being at high risk of offending are placed in treatment facilities rather than handled in the justice system, not to safeguard society, or punish or contain the children, but rather to provide the children with care and treatment (NOU 2023:24). This policy is in line with the view that prison is not a humane solution for children (UNCRC, 1989). Additionally, the psychiatric treatment system has limited its inpatient care for children. Thus, the child welfare system is the most common emergency, care, and treatment option in Norway for these children.

The methods used by the facilities are required to be professional, to be based in evidence and knowledge, and to be ethical, justifiable, and adjusted to the youth who live there. Each child's personal integrity must be respected, and the facility staff should in all cases provide the care and treatment that the child needs as well as make decisions based on the child's best interest. Therapeutic residential care encompasses an extensive array of models and programs to provide better quality care of practice (Pecora & English, 2016; James, 2017). James (2015) categorizes the treatment approaches as either milieu-based or evidence-based. Evidence-based treatments have been scientifically tested and determined to be appropriate for the treatment of a given individual, population, or problem area (Sorensen et al., 2009). These treatments have been rigorously tested and have been proven to have effective outcomes. The review by James (2017) indicates that research about the processes and outcomes of the implementation of evidence-based practice in residential care settings is limited. The milieu-based approach focuses on cultivating a congruent care environment in which children can achieve a sense of normality and safety through interactions with staff (Anglin, 2002; Huefner & Ainsworth, 2021). Therapeutic changes in residential care occur in "the other 23 hours" outside of formal therapy sessions (Trieschman et al., 1969). Many milieu-based models are underpinned by trauma-informed care, emphasizing cultural change in the organization to equip staff at all levels to be sensitive to the impact of trauma on children (Macdonald et al., 2012). Current evidence suggests that, regardless of which exact model is used, having a milieu-based framework has improved practitioners' knowledge and skills in providing therapeutic care (Macdonald & Millen, 2012).

Most of the 3,900 employees responsible for providing proper care to the children have educations in health or social work (Backe-Hansen et al., 2017). Prior to 2021, the state required that 50% of the skilled workers in residential facilities hold a first-cycle degree (bachelor's degree). Beginning in 2021, all employees at residential facilities were required to have a first-cycle degree in the field of child welfare, health, or social education. Staff

members work in shifts, which means that children have to balance being both close to and distant from individual staff members, depending on staff members' schedules. Despite this, facilities by law are to be considered the home of the youths who are placed there, and to the extent possible, unwanted and unplanned relocations are to be avoided (NOU, 2023:24). The staff provide the framework through the CWA, which emphasizes taking control when considered necessary (Barnevernsloven, 2021). Gharabaghi (2014) defines care work with children as involving changing children's behavior, preparing them for independence, strengthening their resilience, imposing containment, promoting safety, increasing performance, and advocating for social change. The work involves different activities, such as counseling, managing group interactions, working and playing alongside youth in activities, and preventing, de-escalating, and physically managing behavioral crises (Smith, 2014; Smith & Spitzmueller, 2016). Staff have the obligations of substitute caregivers; they assume responsibility for youth and for preparing them for life after placement. Staff members should shape their professional roles in flexible ways to meet the children's needs for mutual and equal relationships (Sommerfeldt, 2022). Research with children as participants has shown that children's descriptions of life in residential care are connected to feelings of otherness and deviance (ibid.). These findings challenge the goal of having a residential facility function and feel like "home." According to the report by Gundersen et al. (2023), youths' perceptions of a residential facility as similar to a home were linked to their having safe and trusting relationships with the facilities' adults.

1.3 Participation as a fundamental right

The right to participate is enshrined in both national and international legislation, and a broad consensus exists across institutions in society that participation is important. Child welfare and child protection services are arenas in which there are invasive interventions in children's lives and in which child participation is therefore essential. A document from the Norwegian authorities (Q-27/2006B) emphasizes that children's right to participate must be real and not merely symbolic. Children should get time and space to participate on their own terms, so that they can express themselves in relation to both other children and adults. As active citizens, they should have the possibility to take part in real democratic processes and to exert influence over their own lives. This document applies to all children, including those in residential facilities.

According to Article 12 of the UN Convention on the Rights of the Child (UNCRC, 1989), a "child who is capable of forming his or her own views" has the right "to express

those views freely in all matters affecting the child.” This is also a fundamental legal principle in the Norwegian child protection system (Ministry of Children and Equality, 2009, p. 5), and it has been central to the recognition of children as independent individuals and subjects (Sandberg, 2020). The Norwegian law states that children who live in a residential facility have the right to participate in and have influence over decisions about their care, and that the residential facility should facilitate participation (Barnevernsloven, 2021). The law demands that staff cooperate and actively include children in their care and treatment plans (Barnevernsloven, 2021, §1-4). Children are invited and even expected to participate in meetings, set goals for their future, and develop plans for how to achieve the goals. This places significant demands on children who often do not trust the staff, oppose the staff, or may not know how to participate (Kanestrøm et al., 2023). To ensure that the participation is valid and meaningful, children must be properly informed. The authorities must also provide an environment in which children feel respected and safe so that they can freely express their views ("Generell kommentar nr.12 Barnets rett til å bli hørt", 2009).

The extent of children’s participation is influenced by the child’s age, maturity, and ability to understand their cases (Barnevernsloven, 2021; Grunnloven, 1814, UNCRC, 1989). This constitutes children’s participation, even if decisions are then made that differ from the one that the child preferred. Children’s participation can thus be regarded as fundamental to all decisions affecting them, including decisions made when they are placed in residential care. The aim of the Child Welfare Act (Barnevernsloven, 2021) is to protect children’s personal integrity and legal rights. Policy documents refer to participation as a basic principle, together with the best-interest principle, the biological principle, and the least-intrusive intervention principle. This implies that no decisions should be made without informing the children, hearing their views, and giving these views due weight and influence. According to the Child Welfare Act (Barnevernsloven, 2021), the child’s best interest is the goal; to achieve it, the child must be listened to. A proper assessment of the child’s best interest is only possible when the requirement in Article 12 (UNCRC, 1989) is fulfilled; children must have had opportunities to express their views and those views must have been sufficiently taken into consideration ("Genrell kommentar nr. 14 om barnets rett til at hans eller hennes beste skal være et grunnleggende hensyn", 2013).

1.4 The Basic Training Program in Safety and Security

Education and training in dealing with critical situations are the norm in service-providing settings dealing with people in crisis and conflict, such as the police and fire

departments, the military, prisons, and acute adult healthcare clinics. The training in these workplaces is designed to equip practitioners with knowledge and skills to enable them to de-escalate a crisis or conflict. This training often involves acquiring effective communication and active-listening skills, in addition to engaging in role-playing. It is well documented that when practitioners apply de-escalation skills appropriately, the probability that they will effectively intervene in a crisis increases and the need for physical force is minimized. Residential safety and security must be managed properly to prevent unwanted incidents and to create an environment that promotes physical, emotional, and social well-being for both staff and children. Feelings of well-being, safety, and job satisfaction influence the work practices of staff (Knorth et al., 2010).

To address the safety needs of youth in residential facilities, high quality services that address those needs must be implemented. National and international legislation cannot guarantee that youth's rights are safeguarded. A prerequisite to fulfilling the purpose of residential care and treatment is that staff have sufficient knowledge and training to act consistently in accordance with professional and ethical conduct. This contributes to children experiencing predictability and safety in their everyday lives, which, in turn, supports their development and contributes to an overall positive experience (Ulset, 2014). Norwegian legislation, the Working Environment Act (Arbeidsmiljøloven, 2022), also assigns employers responsibility for providing staff with sufficient education and training to ensure safe work environments and health-promoting jobs.

To improve the quality of practice, facilitate participation, and enhance the prevention and management of aggression and conflict in residential facilities, Bufdir developed and implemented a four-day education and training program, The Basic Training Program in Safety and Security, for staff at residential facilities. This was the first national safety and security program for these facilities and, as such, it was groundbreaking. In conjunction with developing the program, in 2015 an expert group conducted a systematic literature search and summarized knowledge both about the effectiveness of efforts to prevent, reduce, and manage violence and aggression (Lillevik et al., 2016) and about how different efforts were experienced by youth and by staff. The training program was inspired by "No power – No lose," a method of solving conflicts (Hedman-Lindgren, 2011).

Regardless of the type of public residential facility or kind of care and treatment provided, all staff in Norway must complete the Basic Training Program in Safety and Security. One of the aims of the program is to increase staff's ability to predict, prevent, and safely manage aggression and conflict. To a large extent, the program focuses on staff

behavior and attitudes. Another aim is to reduce youths' feelings of powerlessness and thereby enable participation, promote self-determination, and improve the living and working environments in residential facilities. To achieve these aims, it is important to reduce the number of aggressive incidents and the use of restraint and seclusion (R&S) and to teaching staff to make correct decisions about when and how to perform R&S if it must be used. During the four-day training course, staff practice de-escalation techniques during different communication exercises and scenario-training. These exercises constitute one-third of the program. The scenario-training involves simulation exercises in which participants play the part of youth, staff or an observer. One scenario might involve a conversation with a youth who is showing signs, such as distress or anger, that warn of a potential escalating conflict. The other two-thirds of the program comprise lessons in theory (described in Article 2), and teaching staff how to restrain a child using the least force possible and producing the least amount of pain.

The training program focuses on changing the attitudes and behaviors of staff and influencing how staff think about, plan, and interact with youth and other staff. Managing stress, being able to regulate oneself, learning to plan for and prevent aggression and to stop and think before acting are all essential aspects of the program. Being present, de-escalating conflict, and (re)building the relationship between staff and youth are all crucial. Staff members learn to delay their responses, to pay special attention to communication (both verbal and non-verbal), to resist discussion, to reduce the number of rules imposed on youth, and to find ways to disrupt negative interaction patterns.

Almost 4,500 staff who work in residential public facilities in Norway have now attended the Basic Training Program in Safety and Security and are working to implement systematic maintenance training at their local units. Designated local trainers from each residential facility lead the training sessions at their facilities. These sessions elaborate on aspects of the prevention and management of aggression and violence that were presented in the 4-day training course. Additionally, they provide participants with practice-based reflection, theory sessions, scenario-based training, and physical-control training. The training sessions are meant to build individual and collective competence and to develop skills.

1.5 The structure of the dissertation

This first chapter of this dissertation has introduced the theme. Chapter 2 presents a review of previous research. Chapter 3 contains the theoretical and conceptual framework of the dissertation. Chapter 4 presents and discusses methodology. Chapter 5 presents a

discussion of the main findings of the dissertation. Chapters 6, 7, and 8 offer, respectively, conclusions, applied relevance for practice, and recommendations for future research.

2 Previous research

This chapter considers previous research relevant to the issues and research questions addressed in this dissertation. This includes research that deals with staff who work in residential facilities, education and training programs, relationships between staff and children, coercion, aggression, conflict, violence, and children's right to participation.

Several of the studies are international, but most reflect European and Northern American contexts. The structure of residential care, the legislation governing it, and the organization of social services and psychiatry vary from place to place as do the physical environments and the types of children living in them. Further, different treatment methods in different contexts can influence the results of research. Thus, the transferability of conclusions to the Norwegian context must be considered carefully. Despite the differences among studies, their results show some similarities, which suggests good transfer value among different countries. A critical point and limitation are that most of the studies are based on self-reported data, mostly from professionals.

2.1 Safety and relationships between staff and children

The dual role of staff—to provide care and to exert control—creates tense emotional zones for youth living in residential facilities (Furnivall, 2018; Moore et al., 2017). Staff spend a lot of time with the children. Therefore, the relationships between them are essential for creating the sense of safety and fostering the emotion regulation (Mota et al., 2016; Santos et al., 2023) that is necessary for these children to develop in a healthy way. Costa et al. (2020) indicate that the quality of relationship between youth and caregivers moderates the effects of risk factors on youth's development. Previous studies have shown that youth need to feel safe and be able to trust their caregivers if the treatment they receive is to have the desired effect (Van der Helm et al., 2012). A recent study by Costa et al. (2022) showed that the quality of the relationship between staff and youth positively influences the capacities of youth to regulate their emotions. Research shows that the ability to regulate emotions develops through a child's social interactions (Calkins & Hill, 2007; Eisenberg et al., 2010; Thompson & Meyer, 2007). Several studies document the importance to effective treatment of a therapeutic alliance based on trust, care, and empathy (Engström et al., 2023; Engström et

al., 2020; Harder et al., 2013; Henriksen et al., 2008). Youth in residential care stated that staff need to devote time to developing relationships that are based on reciprocity and show genuine interest in the youth in their care (Ulset & Tjelflaat, 2013). Interacting mutually with supportive and caring staff can build understandings and expectations of agency and can enable youth to construct meaning in their lives (Gundersen, 2021). Such experiences can help youth to build a positive view of themselves and the future. A Swedish report (Vårdanalys, 2018) on foster and residential care found the involvement and participation of children, social relationships, care, and safety to be central to securing the quality of the placements. These elements coincide with the intentions of the law and with research that highlights the essentials for good quality residential care and treatment.

Overall, despite the relatively large number of children placed in residential care and treatment facilities and the concerns about quality and safety in these facilities, the available literature on treatment and outcomes is limited, in part because of the wide variety of residential care settings encompassed by the literature (Farmer et al., 2017). Current research follows a few primary lines of inquiry. Most research focuses on youth outcomes from the perspective of residential care staff (Kor et al., 2021). Other research suggests that this perspective may be limited and emphasizes the importance of youth voices in obtaining accurate assessments of youth experiences (Attar-Schwartz, 2017; Mazzone et al., 2018; Sellers et al., 2020). A second line of research focuses on long-term, group home care outcomes and draws its data primarily from retrospective accounts of adults who had been placed in such settings (Kor et al., 2021). Some of this research suggests the positive, long-term impact of trusting relationships with staff (Gallagher & Green, 2012). Sommerfeldt (2022) studied youth in residential care in Norway and found that recognizing relationships between youth and staff decreases the potential for youth to experience stigma. A third research thread focuses on amplifying youth perspectives while they are living in residential care (Côté & Clément, 2022; Moore et al., 2017, 2018; Moore, 2017). This research suggests that youth's sense of safety largely depends on influential adult caregivers listening and responding to their safety concerns and on the quality of their relationship with staff (Sellers et al., 2020). Research also shows that the absence of stable relationships with caregivers leads youth to avoid others and not count on their support (Nourian et al., 2016).

Several studies examine the elements that affect the quality of care provided in residential facilities. Among these elements are feeling safe and building relationships between staff and children (Anglin, 2004; Bath, 2015; Daly et al., 2018; James, 2011; McLean, 2015; Whittaker et al., 2016). The findings of Ballentine et al. (2023) imply that

building trusting, safe relationships with youth should be a top priority for staff. Experiencing an emotional connection to another human being is considered a condition for healthy development (Gilligan, 2008). Adults who reflected on their experience in residential care reported that staff who were caring and invested in their well-being were among the most memorable contributors to their long-term outcomes (Gallagher & Green, 2012; Kor et al., 2021). Informal relationships characterized by reciprocity, genuine interest, and stability over time increase the sense of the residential facility as a home (Ulset & Tjelflaat, 2013).

Rules and routines are part of everyday life in residential facilities and can be unintentional consequences of institutionalization (Egelund, 2009). Backe-Hansen et al. (2017) demonstrates that rules and routines may compromise a facility's potential to become a home; Ulset and Tjelflaat (2013) suggest that they influence whether a residential facility is perceived as a home or an institution. Another study (Tjelflaat & Ulset, 2007) found that incomprehensible rules and routines made the children feel inferior and not in control of their situation. A survey of young people in residential care situations in which they were considered participants shows that rules and routines affect relationships between staff and youth (Gautun et al., 2006). It is possible that the youth avoided engaging in confidential conversations with staff members, fearing that their disclosures would be discussed with other staff members. Central to ensuring that children and staff achieved and maintained good contact was allowing children to show feelings and to argue without concern that doing so could put their relationship with staff at risk. The research concluded that, even though both children and staff want to be close, the staff have a dual commitment—to the children but also to their colleagues and the workplace.

2.2 Aggression and conflict

Studies show that aggressive behavior, violence, experience of restraint, and involvement in critical incidents are common among youth placed in residential facilities (Alink et al., 2014, Baeza, 2013; DosReis et al., 2010; Green-Hennessy & Hennessy, 2015). Stress and trauma is also common, and can lead to difficulties with emotion regulation (Price & Hooven, 2018), which is a risk factor for aggressive behavior (Röll et al., 2012). Aggressive incidents are often a result of a complex interplay of personal, interpersonal, and circumstantial influences. Research increasingly has found associations among aggression, environmental factors, and facility practices (DosReis et al., 2010; Earle & Forquer, 1995; Fraser et al., 2016; Green-Hennessy & Hennessy, 2015; Gullick et al., 2005; Leidy et al., 2006). Youth who express verbal aggression and engage in intimidation can increase feelings

of stress, irritability, impatience and short-tempers among social workers (Geoffrion et al., 2021; Lamothe et al., 2018). These feelings can hinder staff from exercising the cognitive, emotional, and behavioral skills needed to de-escalate an aggressive incident. The aggressive behavior of youth appears to lead staff to exert greater efforts to control youth behavior; higher levels of staff distress are related to their more frequent and quicker use of restrictive measures (Kaijadoe et al., 2023). The result may be repression, which in turn sets off a reaction by the youth, who may feel coerced (De Valk et al., 2016). This research points to the risk of a vicious cycle developing, with youth behavior and staff behavior negatively reinforcing each other. According to Bower et al. (2003), the most important predictor of aggression in psychiatric settings is interaction between youth and staff. Limiting youth's freedom, refusing their requests, ignoring them, or reducing interaction with them are actions by staff that can lead to aggressive reactions by youth (Anderson & Roper, 1991; Bower et al., 2003). De Valk et al. (2015) argue that staff in residential youth care who are excessively rigid increase the risk of violence. According to a study conducted in Sweden, a "rule-based interaction style," which includes varying degrees of punishment for violent, rough, impatient, or threatening behavior, contributes to youth frustration, increased levels of aggression in youth, and re-traumatization (Engström et al., 2020). Negative experiences with authority and perceived repression may confirm youth's view of adults as unreliable people who misuse their power (De Valk et al., 2019). This is assumed to lead to youth's socially problematic behavior.

Asymmetric power relations, arbitrary rules, punishments, or boredom can lead to youth frustration. Van der Helm et al. (2012) found that a positive climate is associated with fewer instances of self-reported aggression. Van Wijk-Herbrink et al. (2021) concluded that implementation of a team-based intervention called SafePath may contribute to a warm and supportive group climate and a reduction in use of repressive measures on youth living in secure residential facilities. Ros et al. (2013) shows that a positive living climate in a secure psychiatric setting decreases the incidences of aggression, running away (Attar-Schwartz, 2013), externalizing of problems (Gross et al., 2015), and difficulty with adapting (Pinchover & Attar-Schwartz, 2014).

2.3 Use of coercion

This dissertation considers experiences of coercion in child welfare, psychiatric care, and juvenile justice settings. Children under the care of the state often move among these

different sectors during their time in care, and therefore the three sectors are relevant to this dissertation.

The use of coercion is regulated by national legislation and international conventions such as the UNCRC. The form and frequency of these measures differ among jurisdictions and types of institutions (Henriksen & Øye, 2023). Although these conventions have served as guidelines for national legislation, human rights violations have been repeatedly documented in the last few decades in facilities for children (Furre et al., 2016; Nyttingnes et al., 2018; Pelto-Piri et al., 2016; Roy et al., 2019). Additionally, accessing documentation of coercion is difficult, and comparing different sectors and jurisdictions is challenging due to different bureaucratic systems (Souverein et al., 2022).

Coercion is intended to safeguard and protect children, but in practice, it is often a blend of protection, treatment, and punishment (Henriksen & Prieur, 2019; Pelto-Piri et al., 2016). There are different forms of coercion, such as physical force, the use of restraints, seclusion, surveillance, room/body searches, or restrictions on mobility, contact, or communication (Coutant, 2016; De Valk et al., 2016; Furre et al., 2016; Nowak & Krishan, 2022; Nyttingnes et al., 2018; Pelto-Piri et al., 2016; Roy et al., 2019; Ulset & Tjelflaat, 2012). The meta-synthesis by Henriksen and Øye (2023) highlights coercion as an ambiguous and multilayered experience.

Coercion is often associated with harmful effects and trauma to youth and staff, with significant costs and reduced quality of care (Furre et al., 2016; Johnson, 2007; LeBel et al., 2010). Harmful effects include pain, trauma, harm to well-being and health, and even death (De Valk et al., 2016; Furre et al., 2016; Jones et al., 2021; Nielson et al., 2021; Nowak & Krishan, 2022). Coercion can result in physical injuries, distress, and a weakening of youth's therapeutic relationship with staff (Day, 2002; Smith & Myers-Bowman, 2009), as well as a loss of autonomy and independence (Du Plessis, 2013). Youth experience many coercive practices as punitive and unduly harsh, and as a result, they experience loneliness, anxiety, fear, and feelings of unworthiness (Kendrick et al., 2008; Ulset & Tjelflaat, 2012). Coercion has been found to negatively affect treatment as it undermines youth's trust in staff and fosters youth opposition and resistance to rehabilitation (Furre et al., 2016; Pelto-Piri et al., 2016). It is also assumed to negatively affect youth's adaptive abilities (Kvello, 2015), and pose a threat to the safety of both youth and staff (Bergsund &Nøkleby, 2023). Fraser et al. (2016) found that using coercive measures to deal with verbal aggression in youth residential treatment facilities often leads to an escalation of aggression between youth and staff, damages the therapeutic alliance, and hinders the rehabilitation process.

However, coercion can also confirm children's sense of being cared for and protected from harming themselves or others (Steckley, 2012). Nyttingnes et al. (2018) studied the level of coercion as experienced by youth in Norwegian inpatient care. They found that, if youth perceived restrictions as legitimate, they experienced a low degree of coercion. On the other hand, if restrictions were experienced as violations of their freedom or their rights, youth were more likely to feel that they were being coerced and humiliated.

2.3.1 Restraint and seclusion (R&S)

Staff are responsible for protecting the youth in their care from harm. Coercive measures may include use of retraint or seclusion. Restraint involves immobilizing a child with bodily (not mechanical) means to physically hold the child. Physical restraint is sometimes needed if youth behavior poses an imminent risk harm to the youth involved, to other youth and/or staff, or to property. In such situations, the law of necessity permits physical intervention. Use of physical restraint is meant to be a last resort in situations in which there is high risk of harm to the child, staff, or others (Barnevernsloven, 2021; Bower et al., 2003). The least harmful form of restraint available must be used.

Seclusion covers a broad spectrum ranging from less to more restrictive types (Van Dorp et al., 2023). A restrictive form may involve transferring the child to a locked or unlocked isolation room (Day, 2002; Stewart et al., 2010). A less restrictive type may involve sending the child to their room, leaving the door open, but not allowing them to leave (Van Dorp et al., 2021). Seclusion can be defined broadly as "an involuntary placement in a room or area the child or adolescent is not allowed or able to leave." (Van Dorp et al., 2021, p. 421). Seclusion is used for various reasons, including emergencies and as a consequence of undesirable behavior (Engström et al., 2020; De Valk et al., 2019; Van Dorp et al., 2021).

R&S is more common in psychiatric settings than in residential settings; explanations for its use point to youth characteristics, situational factors (Roy et al., 2019), and facility practices (DosReis et al., 2010; Green-Hennessy & Hennessy, 2015). Multiple studies suggest that the use of R&S is more highly associated with, among other things, organizational factors, including staff-to-youth ratios, program characteristics, and years of staff experience (Earle & Forquer, 1995; Joy, 1981; Larue et al., 2009; Maier et al., 1987). Others have documented how verbal violence sometimes causes residential staff to experience stress, diminishes their level of tolerance, and leads them to become impatient and short-tempered with youth (Lamothe et al., 2018; Smith et al., 2017). Organizational factors, such as working in a "tense" climate, can contribute to an increased use of R&S (Stevenson et al., 2015).

Research indicates that staff are more likely to use R&S when they are exposed to verbal rather than physical aggression, and that verbal aggression can fuel the cycle of aggression in this context (Geoffrion et al., 2021). Staff who have a greater fear of violence, perceive more verbal aggression, witness more aggression against themselves, and perceive themselves more often to be victims of physical aggression are more prone to use seclusion than are staff without these characteristics (Mathieu & Geoffrion, 2023). Other researchers have found similar correlations (Fraser et al., 2016; Leidy et al., 2006). These findings suggest that staff may be using R&S in response to verbal aggression as a tool in tense situations to prevent them from escalating into physical aggression. According to Geoffrion et al. (2021), some staff participants indicated that repetitive exposure to verbal aggression challenged their capacity to maintain an adequate emotional distance and made them more likely to use drastic methods. In these instances, the use of R&S increased. In contrast, settings with good communication and openness were associated with lower rates of R&S (Geoffrion et al., 2021), and a decrease in R&S use (Roy et al., 2020). Staff participants stated that teamwork gave them the emotional space they needed to focus on the needs of youth and find alternatives to R&S. Several participants also mentioned that they did not have the time to prevent aggression and instead found themselves "putting out fires" all day. In such a context, staff explained, they were more likely to use R&S. Further, some staff members shared that they saw the use of R&S in response to verbal aggression as a tool to prevent aggression from escalating (Geoffrion et al., 2021). Some residential workers admitted that they sometimes reacted to stressful situations by disengaging completely from both youth and their colleagues, becoming withdrawn and giving up on communication (Geoffrion et al., 2021). Participants wondered how this hands-off approach affected the rehabilitation of youths and possibly fueled the cycle of aggression.

The few studies of the use of R&S in youth protection settings show that staff sometimes make inappropriate use of this practice. For example, they use R&S as a disciplinary rather than a security measure (Day, 2002). Earlier studies found that psychiatric workers and residential workers sometimes used R&S to punish youths who did not obey the rules (AbuAlRub, 2004; Bellonci et al., 2013; Farragher, 2002; Green-Hennessy & Hennessy, 2015). Furthermore, studies have reported that R&S was sometimes used as an automatic response to resistance posed by youth, despite legal and organizational guidelines against doing so (Sequeira & Halstead, 2004). In such instances, residential workers spent less time investing in de-escalating strategies and opted to use R&S sooner than they should have. The use of R&S creates several other problems and can affect both youth and staff negatively (De

Hert et al., 2011; Haugom et al., 2019; LeBel et al., 2010; Pollastri et al., 2016; Valenkamp et al., 2014). Neither restraint nor seclusion has proven to be therapeutically effective (Day, 2002; Miller, 1986; Smith & Myers-Bowman, 2009), and the use of R&S erodes the trust that youth have in residential staff (Fraser et al., 2016). These interventions may be perceived by youth as offensive, unsafe, and often unnecessary; thus, they can lead to negative interacions between youth and staff (Fraser et al., 2016), and a weakening of the relationships with staff and an erosion of youth's sense of a safe institution (Ulset & Tjelflaat, 2012). Seclusion is potentially traumatizing (Bryson et al., 2017) and retraumatizing (Hammer et al., 2011).

Children living in residential facilities report experiencing restraint as staff's way to assert power over them (De Valk et al., 2016; Ulset & Tjelflaat, 2012). Qualitative research suggests that the use of R&S in residential care may in fact elicit youth aggression (Aquilina, 1991; Fish & Culshaw, 2005; Meehan et al., 2000). It may also have an emotional impact on youth who witness other youths being restrained (Cox, 2011). Further, some staff perceive the use of R&S as an adequate method of intervention to prevent aggression (Sequeira & Halstead, 2004; Smith et al., 2017). Researchers have found that residential workers were more likely to approve of the use of R&S if they had used it before, in part because they reported that using it gave them a feeling of being calm, competent, and in control (Ledoux, 2013). LeBlanc et al. (2012) found that the situational stress that staff working in Canada experienced due to an unexpected confrontation with an aggressive youth often led to the use of coercive intervention. Although evidence suggests that the levels of stress and feelings of self-efficacy experienced by staff members may be associated with R&S use, the extent of this association remains poorly understood. Specifically, since residential workers are known to experience high levels of work-related stress (Lamothe et al., 2018; Smith et al., 2017), understanding how their emotional state influences their decision to use R&S is important.

2.4 Staff exposure to threats and violence

Residential facilities are not just living environments for youth; they are also workplaces for staff. Staff are mandated to ensure the safety and rehabilitation of the children in their care. Caring for traumatized and troubled children around the clock, however, can be emotionally demanding for staff who find themselves at high risk of being harmed while exercising their mandate (Robson et al., 2014; Smith et al., 2017). Studies show that violence is common in residential facilities (Alink et al., 2014; Andersson & Överlien, 2018; De Valk et al., 2015; Euser et al., 2014; Harris & Leather, 2012; Pelto-Piri et al., 2017; Sekol, 2013; Winstanley & Hales, 2014). Harris and Leather (2012) report that, based on self-reports in the

UK, residential staff appear to be at highest risk of client violence in comparison to other social workers. Data from STAMI (Statens Arbeidsmiljøinstitutt) presented in 2018 show that child welfare workers are one of the occupational groups most exposed to threats and violence. Hagen (2019) reports that 76% of staff in residential facilities in Norway stated that they were exposed to some type of violence during the last 12 months of work. The child welfare sector is characterized by high turnover, lots of part-time staff, and extensive use of temporary workers. Half of the staff members report that they plan to actively look for a new job (Bufdir, 2022b), citing high work pressure, psychological strain, low wages, and lack of professional support and safety at work.

Several researchers have investigated the problem of violence in residential care units (Andersson, 2022; Andersson & Överlien, 2018; Andersson & Överlien, 2021). The results show that working in these facilities is challenging in many ways, not least because violence commonly affects staff members' identity and is hard for them to cope with (Andersson & Överlien, 2021; Pelto-Piri et al., 2017). According to Smith et al. (2017), US residential workers cited youth aggression as one of the most stressful aspects of their work. Workplace aggression constitutes a serious issue for staff and facilities (Dean et al., 2007; Geoffrion et al., 2020). Findings suggest that staff accept being subjected to violence as normal, a call for help on the part of youth, inevitable, and part of the job (Andersson, 2020; Andersson & Överlien, 2018; Andersson & Överlien, 2021; Lamothe et al., 2018; Littlechild, 2005; Radey et al., 2022; Shea et al., 2007; Smith et al., 2017). Such thinking may raise the threshold that staff expect must be crossed before they label behavior as violent (Parveen et al., 2023). Normalization of violence makes staff vulnerable to repeated exposure and may lead to inadequate support from colleagues and work leaders (Shier et al., 2019). It may also contribute to maintaining a violent environment that, in turn, could contribute to heightening staff stress levels. In addition, the normalization of violence as part of the job hinders efforts to effectively intervene to prevent it. Staff may also hesitate to label incidents as violent out of fear of being blamed or to avoid the stigma that can come with being considered a victim (Munobwa et al., 2023).

Studies show that doing work that involves exposure to or confrontation with multiple stressors, such as violence and aggression, often has undesired emotional and professional consequences for and can be injurious to staff (Colton & Roberts, 2007; Dean et al., 2010; Lanctôt & Guay, 2014; Nielsen et al., 2020; Rudkjoebing et al., 2020; Smith et al., 2017). Frequent exposure to youth aggression correlates with poor mental health outcomes (Lamothe et al., 2018; Winstanley & Hales, 2014). This is especially true if workers are exposed to both

verbal and physical aggression (Kind et al., 2018). Several researchers have found that workplace violence and aggression are associated with psychological distress, staff burnout, sick leave, absenteeism, and high turnover (Brend, 2020; Colton & Roberts, 2007; Conrad & Kellar-Guenther, 2006; Knorth et al., 2010; Lamothe et al., 2018; Lanctôt & Guay, 2014; Littlechild, 2005; Munobwa et al., 2023; Robson et al., 2014; Seti, 2008; Shin, 2011; Smith et al., 2017; Winstanley & Hales, 2014). Fear is reported to be a common emotion experienced by staff exposed to violence (Andersson, 2020; Andersson & Överlien, 2018; Harris & Leather, 2012; Knorth et al., 2012). The working conditions at residential facilities place staff at risk for traumatic-stress reactions and anxiety. Post-traumatic stress has been linked to increased turnover rates among child welfare professionals (Middleton & Potter, 2015).

2.5 Education and training

Consistent practices by staff are essential to ensure that children in residential facilities experience predictability and safety (Ulset, 2014). Colton and Roberts (2007) and Euser et al., (2014) conclude that staff need access to appropriate training, supervision, and support to handle the complexity of the work in residential facilities. This conclusion is underpinned by the Swedish study by Ahonen and Degner (2014), which shows that staff in secure units feel that they lack skills to deal with the varied problems they face at work. The staff`s approach seems to be decisive for how youth experience the interaction with staff (Engström et al., 2023). To counteract the negative impact of aggression, violence, and the use of R&S, several inpatient and residential facilities have devoted considerable resources to improving the quality of staff practice (Bogo et al., 2014; MacRae & Skinner, 2011), providing workers with the knowledge and skills needed to prevent aggression. Some education and training programs are designed to equip practitioners with knowledge and skills to enable them to prevent, de-escalate, and handle conflicts and aggression (Smith, 2014; Smith & Spitzmueller, 2016), and thereby to reduce their negative effects on both workers and youth. Training in de-escalation often involves teaching effective communication and active-listening skills, in addition to role-playing, through which the desired skills are practiced. Regular training in verbal de-escalation techniques could be instrumental in helping residential workers properly regulate their emotions during tense moments. Learning to handle situations through de-escalation instead of reacting personally to verbal violence could help some residential workers feel more confident in their abilities to manage aggression and thereby help them manage their stress more effectively (Laiho et al., 2013). Smith et al. (2017) conclude that client violence could be reduced through proper use by staff of de-escalation and behavior

management techniques. Training focused on regulating emotions, such as Non-violent Resistance (Van Gink et al., 2018) and Compassionate Mind Training (Santos et al., 2023) could be helpful to staff when working with youth and in controlling their own emotions at work.

Reviews of strategies to reduce R&S (LeBel et al., 2010; Scalan, 2010) have found that strong leadership, together with staff training, produce positive outcomes. Implementing collaborative problem solving led to a seclusion reduction rate of 95% in few years (Pollastri et al., 2016). Studies have found positive associations between a staff member's level of education and the use of R&S (Lee-Lipkins, 2014). Researchers have suggested that the implementation of alternative therapeutic measures or special training for residential workers could significantly decrease rates of youth aggression and the use of R&S (Farragher, 2002; Nunno et al., 2003). More untrained workers support the use of physical restraint than do trained workers (Bitton & Rajpurkar, 2015). Trained professionals seem to show extra caution and awareness compared to the untrained when it comes to using restraint techniques. The review by Laiho et al. (2013) found that when mental health workers had confidence in their own and their team's abilities to manage patient aggression, they postponed the decision to use R&S, thereby allocating more time to verbal de-escalation. These studies, taken as a whole, suggest that staff education and training can be one of the ways to address the challenges of dealing with patient aggression and to reduce the use of R&S.

2.6 Youth participation in the context of residential care

Children's participation is often noted as a key element to creating safe facilities. Many studies of children's participation in residential care confirm that children want to be listened to and to influence the decisions made about their lives (Henriksen et al., 2008; Moore et al., 2017; Tjelflaat & Ulset, 2007). Although the focus on children's right to participate has sharpened, studies show that staff find implementing procedures to increase participation to be challenging (Kennan et al., 2018; Van Bijleveld et al., 2015). Some argue that there is a gap between theory and practice.

Studies of residential and foster care find that implementation of children`s participation is limited and that children's voices are often unheard or poorly heard (Cahill et al., 2016; Doek, 2009; Goodkind et al., 2011; Knorth et al., 2008; McCarthy, 2016; Moore et al., 2017; Ten Brummelaar et al., 2018; Van Bijleveld et al., 2015; Vis & Thomas, 2009). Suggested explanations include a lack of agreement among staff as to what participation

entails, and the perception by some staff that children are vulnerable, not always capable of knowing what is best for them (Van Bijleveld et al., 2015), or irresponsible.

Whether and how staff implement participation depends on how they view children's participation (Van Bijleveld et al., 2015). When staff see children as vulnerable and in need of protection, children's opportunities to participate decrease (Sanders & Mace, 2006; Vis et al., 2012; Vis et al., 2011; Vis & Thomas, 2009). Although several studies show that staff view children as needing protection and as being vulnerable and irresponsible, Reime (2018) found that most youths see themselves as autonomous and responsible subjects, not as vulnerable or at risk. This self-construction accords well with the idea of children as competent and active, able to influence their own lives and to participate in a meaningful way.

Children report that they are not adequately consulted and are not given enough detail to make informed contributions to decision-making (Bessell, 2011; Leeson, 2007). In a scoping review, McPherson et al. (2021) reported that several studies show that youth experience the residential-care setting and space as well as the bureaucratized care-planning process as constraints on their effective participation. Tjelflaat and Ulset (2007) found that some of the youth believe that the smartest thing to do is to be quiet and not voice their opinions, since, if they express incorrect opinions (in the view of the staff), they would get a deduction in their weekly allowance. This contrasts with another study in which children reported having a safe relationship, usually with a residential care worker, and indicated that they felt able to voice their opinions (McCarthy, 2016).

Several authors argue that children's participation should become a standard aspect of formal group processes (Bessell & Gal, 2009; Blakemore et al., 2017; Cashmore, 2002; Daly, 2009; Gal, 2017; Jamieson, 2017; Van der Helm et al., 2018). For example, an evaluation by Strijbosch et al. (2019) of the "You Matter" project over a two-year period found that feedback from the children led to a reduction in aspects of negative group climate. A recent literature review concluded that most research on participation focuses on the results rather than on the *process* of participation (Skauge et al., 2021).

Some studies have investigated how routines and rules can challenge the ideas and the possibilities of children participating in their everyday lives and receiving individually adapted care (Egelund, 2009; Ulset, 2014). Rambøll (2016) reports that two out of three children placed in residential facilities confirmed that they could make decisions about their day-to-day lives. Yet, two out of three reported that they could not influence the rules at their care facilities. Some Norwegian studies have pointed out that regulations, routines, and other organizational aspects challenge the flexibility of the social work at residential facilities

(Tjelflaat & Ulset, 2007; Tjelflaat & Ulset, 2008; Ulset, 2014; Ulset, 2018; Ulset & Tjelflaat, 2013). They also found that the residential facilities create challenges to the possibilities for good interactions and real participation.

Ulset and Tjelflaat (2013) showed that the routines influenced whether the youth saw the facility where they lived as an institution or as a home. The relationship between a home for youth and a workplace for staff has been discussed in research on residential facilities (McIntosh et al., 2016). Both children and staff prefer a facility that has the qualities of a home. Challenges to achieving this include staff turnover and work hours, turnover among residents, and institutional frameworks.

Limited opportunities for participation can negatively affect children's sense of dignity and self-worth (Bessell, 2011). Consequently, children may try to participate or exercise control in negative ways, such as by rebelling or withdrawing (Leeson, 2007; Van Bijleveld et al., 2015). Lack of participation can lead to powerlessness and lack of control over one's life. An atmosphere that does not allow the child to participate can also lead to aggression and further violence on the part of the child.

Some youths have experienced participation as a collaborative practice through which they can influence and even establish guidelines for making decisions and assessments (Lansdown, 2010; Paulsen & Berg, 2016; Van Bijleveld et al., 2015; Vis et al., 2012). Such a collaborative process requires adults to show respect for and a genuine interest in the views of youth. It does not mean that youth have the right to decide, but rather that the opinions of youth are given due weight in decision-making. To be listened to, taken seriously, and respected are important to youth, even if the ultimate decision differs from what the youth wanted (Thomas, 2002). Youth participation means also allowing youth to exercise influence over the entire process of participation. Merely holding meetings and conversations with youth is inadequate.

2.6.1 Reasons for youth participation

Previous research has emphasized that youth participation is essential because there is a right to participate. However, some studies do not stress the rights of youth but instead emphasize the benefits to youth of participation. Among these are youth well-being, self-esteem, self-value, self-efficacy, and self-confidence (Bessell, 2011; Horwath et al., 2012; Skauge et al., 2021; Thomas, 2002). If afforded opportunities to participate, youth can experience greater predictability and gain better control and oversight of their lives, and increase their resilience (Van Bijleveld et al., 2014), autonomy, and agency (Križ &

Roundtree-Swain, 2017; Rap et al., 2019). It promotes good health, and potentially protects them from abuse (Cossar et al., 2016; Dillon et al., 2016; Heimer et al., 2018; Kosher & Ben-Arieh, 2020; Križ & Skivenes, 2017; Sæbjørnsen & Willumsen, 2017; Vis et al., 2012). Communication with and participation by youth are essential measures that reduce the need to use restraint, according to Ulset and Melheim (2013). When a youth is fully participating—meaning that the youth is being fully heard—better decisions can be made (Thomas, 2002). When a youth has participated in decision-making processes, staff have a better understanding of the youth's situation and needs, and they can then adapt rules and actions to be most effective with that youth (Vis et al., 2012). Evidence suggests that interventions yield better results when the needs of individual youth are considered in adjusting the interventions (Archard & Skivenes, 2009).

In addition to benefiting the youth involved, youth participation can also enhance the services provided to youth. It thus has instrumental value. Participation may motivate youth to accept and commit to the decisions that are made (Van Bijleveld et al., 2014; Woolfson et al., 2009). Another argument in favor of youth participation is that it can help improve youth's ability to make good decisions and prepare them for their future as adults (Dillon et al., 2016; Mitchell et al., 2010; Van Bijleveld et al., 2014; Van Bijleveld et al., 2015). Recognizing that they can participate in and influence society can contribute to youth's increased trust in societal institutions; it can also help youth become involved in and appreciate democracy.

Participation gives youth an opportunity to exercise influence over their own lives. The more involvement and responsibility assumed by youth in the process, the more motivated youth may become to make changes in their attitudes and behaviors (Woolfson et al., 2009). When participation is perceived as safe, meaningful, and real, youth can develop competence in expressing thoughts and views and making assessments and decisions. Being an active participant in decision-making implies taking part in a reasoning process whereby one learns how to weigh choices, their possible consequences, and their advantages and disadvantages. This skill is useful in life generally and not only with respect to making a specific decision. It is acquired through relational processes whereby youth become involved in and have the possibility to influence decisions and receive support from staff as they consider alternatives and make decisions.

3 Theoretical and conceptual framework

In developing, planning, and designing this project, I was informed and guided by a theoretical and conceptual framework as well as by previous research. Bryman (2016) argues that research is informed and influenced by theory. In turn, research influences theory and concepts as it provides knowledge to which theory relates (Mouton, 2011). Theory consists of concepts, definitions, assumptions, and generalizations (Van der Waldt, 2021), and aims to describe and explain phenomena. Grix (2001) highlights the need for theory that functions as explanation with different levels of abstraction to guide interpretation. Jacard and Jacoby (2010) view conceptual systems as theoretical guides to identify, organize, and explain research outcomes. This dissertation's theoretical and conceptual framework guided the research design and methodology and provided a contextual orientation for the study I conducted (Kelly, 2010). Previous research, which I summarized in Chapter 2 and in Article 1, provided what is already known and pointed to gaps in the existing knowledge. My research drew on the conceptual and theoretical framework connected to social work research. This chapter explains the theoretical perspectives and concepts that inform the dissertation's analysis and shape the interpretations of youth and staff`s perspectives and experiences in residential facilities. I used the presented theory to inform the research process and to guide my analysis of the findings.

3.1 Safety in residential facilities

The literature on safety has evolved from understanding it simply as freedom from physical abuse to recognizing the broader issue of feeling safe (Bath, 2015; Moore & McArthur, 2017; Preisler, 2013). This dissertation relies mainly on the definition of safety in Leipoldt et al. (2019), because it specifically relates to residential youth care. Safety is the degree to which youth are protected from harm, threat, danger, or bullying by fellow residents (Leipoldt et al., 2019). It is also connected to the ability to predict and be prepared and able to control a given course of events and their outcome (Hammer, 2006). To be safe is to have control and to be able to place events within an order that makes them meaningful, expected, and understandable. Additionally, to *feel* safe (also referred to as experiencing psychological safety), one must have an environment in which one can feel secure, calm, and able to attend to normal developmental tasks (Bath, 2015). Feeling safe means feeling assured that one is not in danger and is able to cope; this feeling is closely connected to well-being (Bath, 2015; Furnivall, 2018; Moore et al., 2017) and to the quality of one's interpersonal connections. As

Bath (2015) has noted, only in trusting relationships with others can a person begin to feel safe and to heal. The relationships between children and staff in residential facilities are formed and conditioned by ideologies, political guidelines, and professional perspectives (Sommerfeldt, 2019). In the view of some scholars, “relationship is the intervention” (Stuart, 2009, p. 222).

According to Bowlby (1953), secure and sensitive relationships throughout a child’s life are important to the child’s ability to develop healthy relationships with others; the attachments the child establishes with primary caregivers influence the child’s emotional and social development (Bowlby, 1973, 1988). Bowlby postulated that every child develops an internal working model of relationships, which comprises mental representations for understanding the world, self, and others, and is based on the child’s relationship with a caregiver. This cognitive framework explains the nature of a person’s emotional bonds and relationships with people. Thus, to meet the goal of good quality care and treatment in residential facilities, creating safe and trusting relationships is essential. Staff members are significant figures who respond to children’s needs and promote positive and healthy development (Zegers et al., 2008). According to children, a positive relationship is one in which they are made to feel important and cared for and about, and in which they can place trust (Gharabaghi & Phelan, 2011). These relationships are an important and valuable element of children’s care experience (Gharabaghi & Phelan, 2011). Youth in residential facilities have to deal with a new living environment and new relationships with staff, and may have to make this adjustment more than once. This instability, combined with adverse life experiences, predispose them to present insecure and disorganized attachments. This in turn creates problems with emotional regulation (Bakermans-Kranenburg et al., 2011; Carr et al., 2018; Lionetti et al., 2015; Muzi & Pace, 2021; Van IJzendoorn et al., 2009; Vasileva & Petermann, 2018). An additional contributor to challenges for youth is the lack of stable environment in residential facilities—such as staff turnover and the movement of youth in and out of the facilities—that makes it difficult for youth to establish emotional ties (Gaskell, 2010).

This dissertation understands a conflict-filled situation as one in which two or more youths, workers, or third parties have differing opinions, wishes, or needs and assert their viewpoints at the expense of others. Additionally, one or more people in this situation is frustrated, angry, and/or aggressive (Lillevik et al., 2016). There is a risk that conflict-filled situations may escalate, with adverse consequences. Children placed in a residential facility whose staff are new to them are likely safe physically, but they may not *feel* safe. This can

lead to frustration and to an escalation of conflicts. If children are feeling unsafe, connection to safe people in their lives can help promote feelings of safety (Bath, 2015). Such a person may not always be available in residential facilities, but staff are always responsible to help de-escalate conflicts and reduce the risk of unwanted incidents (Lillevik et al., 2016). De-escalation involves employing suitable concrete principles, strategies, actions, and techniques to reduce the frequency of children acting out and exhibiting violent behavior. De-escalation and intervention tools can be effective in helping youth in crisis; they also reduce the chances of physical and mental injury to both youth and staff. Being attuned to nonverbal cues, asking questions, displaying interest, showing honesty, and calmly responding to the feelings expressed by others are all parts of the active-listening toolkit for staff (Bath, 2015).

The experience and feelings of safety, the quality of the relationships between children and staff, and the way that staff communicate and interact with children all influence the extent to which children can meaningfully participate in their own lives.

3.2 Meaningful participation

In recent years, the right of children to participate in a welfare context has received considerable attention from academic researchers. Some scholars have criticized the concept of participation as lacking clarity and precision (Križ & Skivenes, 2017; Lansdown, 2010; Sinclair, 2004). Others believe it is too often used without theoretical and contextual explanation or without a description of the level of involvement needed by a child to constitute true participation (Vis & Thomas, 2009). Van Bijleveld et al. (2015) claim that the lack of clarity about the concept of participation may be a key barrier to actual child participation.

Participation means more than just the legal right to participate. The UN Convention on the Rights of the Child (UNCRC,1989) gives children stronger formal rights than previously existed in most individual countries. This rights treaty, which was ratified within a few years by almost every nation in the world, declares that governments should ensure that children are treated, not as the objects of decisions affecting them, but rather as subjects who should participate in these decisions, increasingly so as they mature. The literature on participation is explicit about considering children to be active and competent human beings, having certain capacities and potentials with specific needs and interests (Masschelein & Quaghebeur, 2005). The capacities that children are assumed to have are seen as essential to their potential to identify and express their own needs.

Although a universal definition of participation is lacking, several different meanings have been offered in the literature. Participation thus needs to be seen, not just as a concept involving rights, but also as a relational concept (Aamodt, 2015; Husby et al., 2019; Husby et al., 2018; Nybell, 2013; Seim & Slettebø, 2017). Researchers generally agree that children have the right to form views, express themselves, be heard, and influence decisions about their lives. In doing so, they often need assistance from adults (Bruce, 2014; Cossar et al., 2016; Jobe & Gorin, 2013; Križ & Skivenes, 2017; Van Bijleveld et al., 2014).

The UNCRC General Comment on Article 12, as well as several researchers, emphasize participation as a dynamic and ongoing process that includes information-sharing and dialogue based on mutual respect and that takes children's views into account and allows them to influence outcomes (Archard & Skivenes, 2009; Chawla, 2001; Gulbrandsen et al., 2012; Križ & Skivenes, 2017; Lansdown, 2010; Rap et al., 2019; Van Bijleveld et al., 2020; Vis et al., 2012). These processes provide the basis for a three-dimensional approach to meaningful participation, as presented in Bouma et al. (2018), with respect to children in out-of-home care settings. These three dimensions are operationalized by Bouma et al. (2018) as informing, hearing, and involving; they inform the analysis carried out in this dissertation (see Article 4).

The first dimension—informing—is a prerequisite to participation (Bessell, 2011; Bouma et al., 2018; UNCRC, 1989; Q-27/2006B). Children need information about their right to and the possibilities for participation, as well as about the aims, potential impact, and consequences of participation. Information can be seen as a two-way process, a dialogue, by which the child gets information and is able to share reflections and context (Sandbæk, 2004). Staff are responsible for ensuring that children understand the information they are given. Only then can the children form views relevant to their circumstances (Cashmore, 2002; UNCRC, 1989). Viewpoints are developed in interaction with other people (Gulbrandsen et al., 2012). The second dimension—hearing—refers to children expressing their views freely and being heard (Bessell, 2011; Bouma et al., 2018; UNCRC, 1989). Children depend on professionals to ensure the safe and supportive relationships and environments that are necessary to facilitate free expression (Archard & Skivenes, 2009; Bell, 2002; Cashmore, 2002; Cossar et al., 2016; Horwath et al., 2012; Pölkki et al., 2012; Van Bijleveld et al., 2015). Children should be assured the opportunity to express their views "freely." The third dimension—involving—means that children's expressed views are listened to and considered before decisions are made and that the children can affect these decisions (Van Bijleveld et al., 2015).

A prerequisite of meaningful participation is the provision of safe, friendly, accessible, culturally safe, and inclusive spaces. In such safe spaces, children are considered an integral part of the participation process and have support to form their own views. Having a safe space to form one's opinion is a necessary precursor to the expression of one's views. Fostering meaningful participation also involves creating environments in which children's voices are not merely perfunctory, but rather are listened to and considered part of a genuine process of facilitation and engagement with their needs. Children are increasingly seen as agents in both their own lives and in society, and agency is viewed as a precondition of participation (Valentine, 2011). Atwool (2006) argues that the focus of social work has been on needs rather than rights and that this has contributed to the disempowerment of the child. Respecting the right of the child to have a viewpoint is a crucial principle of participation. This also involves addressing any barriers and obstacles that may suppress participation. Additionally, meaningful participation means ensuring that children have access to the people who are empowered to make decisions as well as to adults who will actually listen to them and give weight to their opinions. It also entails children witnessing the way in which their views are considered and acted upon by the adults in power. This suggests that decisions and processes about the lives of children should clearly demonstrate to the children the way that their input affected an outcome (Lundy, 2007). Finally, participation is meaningful if the quality of participation is strong; this means that the children involved feel listened to and taken seriously (Dillon et al., 2016; Kennan et al., 2018).

In this dissertation, the term participation is understood as a meaningful process whereby children are sufficiently informed in a way that is appropriate for their age and maturity level. They are heard and listened to in an environment that allows free expression, and their views are taken into account when staff provide them with care and treatment in residential facilities. Further, the staff are aware of the influence of differences in power between themselves and the youth who live there. This understanding of participation is based on UNCRC Article 12, as well as on Norwegian state documents and several researchers' definition of the concept in the field of social work and residential care. This understanding informs the analysis carried out in this dissertation.

3.3 Power, governmentality, and participation

The standards for providing justifiable care and treatment in the best interest of the child involve legal, ethical, and professional judgments. Legal standards are definded by a society's ethical norms, through the power of knowledge (Foucault & Østerberg, 1994).

Power structures in residential facilities, such as staff authority over the children, are juridical, legitimized, and authorized and they are often in tension with the aim of granting youth agency and ensuring youth participation. Participation, understood as discourse, promises a freedom that complies with democratic society and citizenship, endorsing responsibility, tolerance, respect, and equal rights for all in a democracy (Masschelein & Quaghebeur, 2005). However, participation as discourse can also be viewed in the light of Foucault's concept of governmentality. According to this concept, individuals behave, not in response to external oppression, but because they have internalized norms (Foucault, 1991; Rose, 1993). Participation, in this light, is neither clearly liberating nor a guarantor of freedom, but rather a means, using the discourse of freedom and individuality, to teach and reproduce socially desired behaviors.

3.3.1 Power in the context of residential facilities

The concept of power is generally and traditionally understood as something possessed by someone and exercised over others (Christensen, 2023). This understanding considers power as potentially repressive. Power can alternatively be comprehended as the way that society and individuals discipline themselves (Dean, 2012; Foucault, 1980), enforced by the knowledge and norms that make people want to do what society thinks is right (Foucault, 1991). According to this latter understanding, power is exercised rather than possessed. It is conditioned by discourse and is productive (Foucault, 1980; Kelly, 1994), its main product being the human subject (Christensen, 2023). In Foucault`s conception, power is exercised in everyday interactions but not always consciously and intentionally. It is internalized, and thus people become disciplined to discipline themselves. This model of power was developed because Foucault found the juridical model to be insufficient to grasp power relations at the micro-level of society (Christensen, 2023; Kelly, 1994). Power, as understood by Foucault's model as well as the more traditional one, coexists in institutions such as residential facilities.

One of the objectives of residential facilities is to alter the attitudes and behaviors of youth. The goal is to get youth to follow society's norms and rules so that they, in turn, are capable of complying with the normalizing power of society. To achieve this goal, residential facilities deploy the microphysics of power, integrating them into the institutional practices (Foucault & Østerberg, 1994), using rules, structures, and disciplinary tools within the framework of milieu therapy. Staff can force compliance by using the threat of negative consequences. Coercive measures are considered part of the structure and can be used by staff

as they deem necessary (Gelkopf et al., 2009). Staff can impose restrictions on the movement and activities of the youth. The use of coercion is an overt manifestion of power (Souverein et al., 2013). Practices within institutional structures that involve power dynamics and control can inhibit youth's agency (Polvere, 2014). The power relationship between youth and staff is asymmetrical (Chow & Priebe, 2013, Crewe, 2009). This power imbalance has been shown to be one of the causes of youth's experience of repression (De Valk et al., 2016). Staff behavior that is perceived as unfair or excessive is also conceived of as repressive. "Repression" can be defined as "authorities intentionally acting in a way that harms youth, or unlawful or arbitrary deprivation of a youth of liberty or autonomy" (De Valk et al., 2016, p. 758). Repression may also be concealed in staff behavior and institutional structures. This threatens rehabilitative goals, worsens youth's problems, and may even violate youth's rights (De Valk, 2019). This could challenge and hinder youth experiences of freedom and of having influence over their lives. According to Foucault, resistance is inseparable from power (Kelly, 1994).

If the predominant professional perspective is that children are vulnerable and irresponsible (Goodyer, 2013; Reime, 2017; Van Bijleveld et al., 2015), a facility's general routines, rules, and interventions may work at cross-purposes to the goal of ensuring children's rights (Reime, 2017). Arbitrary use of power may result in youth experiencing staff behavior as unpredictable and unsafe, which may then cause youth reactance, demotivation, or even aggression (De Valk et al, 2016; Heynen et al., 2017). Staff may then respond to such behavior by intensifying repression, which can contribute to youth feeling a loss of control and autonomy, which can, in turn, provoke new aggressive behavior (Van der Helm et al., 2011). Many theories have sought to explain human aggression, which is often defined as behavior intended to harm someone physically or psychologically (Berkowitz, 1993; Bushman & Anderson, 2001; DeWall et al., 2013). This dissertation understands aggression as encompassing various forms of assertive behavior. Following Lochman et al. (2009), aggression can be defined as any behavioral act that includes verbal, physical or relational violence against others, the destruction of objects and/or self-harm. Aggression is believed to result from complex interaction among personal, interpersonal, and circumstantial variables (Allen et al., 2018). It is closely connected to feelings of powerlessness; such feelings may become overwhelming and lead people to behave aggressively if they cannot find ways to meet important needs.

The concept of powerlessness offers a basic framework for understanding frustration and aggression (Isdal, 2000). Powerlessness is understood here to be a condition in which people feel that their integrity is threatened, or their wishes, needs, and expectations are not

being met. The experience of powerless can feel both degrading and unsafe and as a condition of deficiency. It can result when important needs—for predictability, overview, control, and safety, and to participate and be seen, heard, understood, recognized—are not met (Isdal, 2000). A person experiences powerlessness, according to Seeman and Evans (1962), when they expect their behavior to have no effect on the outcome. Powerlessness occurs when an individual believes that, regardless of what they do, nothing will change. Assuming that youth may resort to violence when they experience powerlessness, acting to reduce youth's feelings of powerlessness may prevent aggression and violence (Lillevik & Øien, 2010).

3.3.2 Participation through the lens of governmentality

The discourse of participation promises a kind of freedom that complies with democratic society and citizenship; it endorses responsibility, tolerance, respect, and equal rights for all in a democracy (Masschelein & Quaghebeur, 2005). However, viewed through the lens of governmentality, participation appears to be neither clearly liberating nor a guarantor of freedom. During the past decades, several governmentality-inspired contributions have influenced research on children that is relevant to the concept of participation (Haldar & Engebretsen, 2014; Hultqvist & Dahlberg, 2001). Participation can be seen as a governmental strategy and a form of governing power. It governs the individuals from within by guiding their self-management, which leads to reproducing the normative standards according to which they are governed (Dean, 2009; Rose, 1993). The aim is to get the individual to act in the individual's own interest, as an autonomous, self-determining person. This involves a learning process. Participation then, is a form of governmentality; power is exercised through persuasion, not threats (Masschelein & Quaghebeur, 2005; Rose, 1996).

The experience of growing up in a residential facility can seem incongruous; children are surrounded by staff and rules intended to protect and to some degree control them. But at the same time, they are encouraged to see themselves as autonomous individuals with their own rights. Children are invited, according to institutional routines and legislation, to behave and present themselves as active participants in and experts about their own lives, to express their opinions and participate. Participation is voluntary on the part of the child; it derives authority by claiming to offer freedom for the individuals by presenting participation as a way for the children to become independent and empowered. However, it also requires that the children submit themselves to certain norms and follow guidelines inscribed in the discourses and techniques of participation (Masschelein & Quaghebeur, 2005).

4 Methods

The primary components of this chapter are the research and analysis methods and selection of participants (See Tables 1 and 2). This chapter also includes reflections on my positionality, the research's limitations and quality, and ethical issues. The methods used in this reserch project were a systematic mapping review, followed by qualitative interviews, which comprised both focus-group and individual interviews (Table 1). The mapping review was necessary to gain an overview of the research on children and youth inpatient and residential facilities and to provide a foundation on which to build this study. A qualitative approach, which has the potential to capture the unique complexities within residential settings, was chosen rather than a quantitative one, which explores the relationships among variables (Creswell, 2014). This was considered the appropriate choice since the purpose of this research was to produce rich and meaningful data through an examination of the experiences and perceptions of staff and children working and living in residential facilities.

Table 1. Overview of the three sub-studies, their methods, and the analytic approach

Study (Article)	Method	Data source	Analytic approach
One (1)	Systematic mapping review	14 studies included in the analysis	Descriptive categorization
Two (2)	Focus group interviews	Audio recordings from 3 focus groups at 3 different facilities with a total of 18 staff members	Stepwise-Deductive Induction
Three (3)	Individual interviews Group interview	Audio recordings from group interview with 3 youths, and individual interviews with 5 youths	Stepwise-Deductive Induction
Two and Three (4)	Focus group interviews Individual interviews Group interview	Audio recordings of both youth and staff	The framework of meaningful participation

It is relevant to the project to acknowledge the perspective of social constructivism, which is essentially an anti-realist, relativist stance (Hammersley, 1992) that has influenced grounded theory (Charmaz, 2000). This perspective includes people's understanding of reality as formed by their experiences, the situations they have been in and been connected to, and the people with whom they have communicated. An important contribution from social

constructivistic sociology is the recognition that a society's institutions, such as residential facilitites, are formed by the society in which they are situated. Elements of Foucault`s insights, such as that truth is historically contingent and entwined with power, can be found in social constructionist analyses (Christensen, 2023). Knowledge and meaning are constructed jointly, and a theory or "truth" acquires meaning by virtue of its usefulness in a social system, such as an institution. In line with this, a person's understanding of reality is socially constructed, and a researcher's focus is shaped by the theories subscribed to in planning, conducting, and analyzing the material. This dissertation seeks to uncover the meaning that people attach to their actions and life situations and to determine how this construction of meaning creates possibilities for new understanding and change. This perspective has been criticized as relativistic, as perceiving everything as socially constructed, and as ignoring objective reality (Bury 1986; Burr 1995; Craib 1997; Schwandt, 2003; Sismondo 1993). One rejoinder to this criticism is that social constructivism does not reject the existence of objective realities and facts; rather it seeks to assign importance to the *interpretation* of these realities and facts. For this dissertation, the so-called mild variant of social constructivism provides the foundation.

4.1 Systematic mapping review (Article 1)

To obtain an overview of the literature on conflict management and the use of R&S in different youth inpatient and residential facilities, a systematic mapping review was conducted. A literature review can enhance and consolidate the theoretical basis of the research area and guide the interpretation of research findings (Kumar, 2014). Given the diversity of the literature on this research topic, a mapping review offered the best design as it would help identify what remains unknown or poorly understood about the subject. A mapping review "is a transparent, rigorous, and systematic approach to identifying, describing, and cataloging evidence and evidence gaps in a broader topic area." (Campell et al., 2023, p.5). A mapping review typically extracts only descriptive information about the studies; in this case, it drew on studies of considerable heterogeneity with respect to samples, facilities, measures, designs, and programs. This wide assortment meant that I could neither perform a meta-analysis nor make comparisons among the studies.

I also considered conducting a systematic literature review, but decided that such a review was not suitable for this study. A systematic review should synthesize findings from previous studies in a more narrow way than was considered needed in this field, and compare and evaluate them. Because research on the subject of interest is limited, and required

drawing on multiple fields of research, a systematic review was not a good choice for this study.

In conducting the mapping review, the aims established by Lillevik et al. (2016) were replicated. They were 1) to describe and review the literature on the effectiveness of interventions in preventing and managing aggression and violence in inpatient and residential youth facilities; 2) to describe and review the literature on the effects of R&S and on youth and staff experiences of youth violence and R&S; and 3) to identify potential gaps in knowledge about these issues. A search protocol was developed in consultation with an Oslo Metropolitan University research librarian to enable systematic identification of relevant studies. Seven databases were searched: Cinahl, Medline, PsycINFO, Web of Science, Cochrane Library, Social Care Online, and NCJRS. The search terms can be found in Article 1. The inclusion criteria comprised full-text articles published in scholarly journals between 2015–2020 in English, Norwegian, Swedish, or Danish that are relevant to residential care. The initial search identified 4,698 scholarly, peer-reviewed studies. Once duplicates were removed as well as studies that, based on their titles, were clearly not relevant, 320 publications remained. In accordance with the inclusion and exclusion criteria, two researchers then vetted the abstracts, which excluded a further 260 studies. The remaining 60 publications were then screened, with two researchers reviewing each full-text publication for adherence to the inclusion/exclusion criteria and relevance to the research questions. In cases where the two researchers disagreed about the relevance of a particular publication, a third researcher was consulted, and a decision made by a majority of the three. This entire process yielded 14 studies for inclusion in the analysis. The analysis of these 14 studies is presented in Article 1, which included information on the type, the author, and the location, findings, methodology, key implications, and recommendations of each study.

The 46 papers eliminated in the last screening were excluded for several reasons. Two of the papers turned up by our search dealt with institutions—a hospital emergency room and a child daycare center—that were not relevant to our topic. One paper was written in German and thus did not meet our language criteria. Twelve papers were excluded because the residents were adults rather than children. Six were excluded because they were reports or commentaries or did not fit the included design. The remaining 25 were excluded based on their subjects, for example evaluation of the use of a sensory room, and reduction in medication use. Even though these studies did not fulfill the inclusion criteria of the mapping review, several of the studies and reviews are discussed in Chapter 2 of this dissertation, as they provide a complement to information on the social and residential work field.

4.1.1 Limitations

The systematic mapping review has potential limitations. First, the review may reflect selective reporting bias (Higgins et al., 2019). To minimize the possibility of unintentional, skewed article selection, we searched seven different databases. Nevertheless, we must acknowledge that some important articles may have been missed because, for example, they did not include all relevant search terms in headlines and abstracts. Additionally, we excluded gray literature—that is, articles published without a rigorous review process. This may also have led to selection bias. Second, data may have been inaccurately extracted and/or misclassified due to human error. Ninety percent of the initial screening was done by the first author, which could have led to some studies being incorrectly excluded. This risk was reduced by first setting clear exclusion criteria and double screening ten percent of the studies. To diminish familiarity bias, we included studies from several contexts. These potential limitations were diminished further by the strength of the review, which had a broad focus and included several different samples and facilities. To ensure coverage of the subject from different perspectives, we included qualitative, quantitative, and mixed design studies.

4.1.2 Quality assessment and risk-of-bias assessment

To assess and ensure quality, I took the following steps. A co-author from outside of the field of youth inpatient and residential care was included to maximize objectivity in the review process. All quality assessments were rated by two authors independently of each other. The systematic reviews were quality-rated using AMSTAR quality assessment. Despite the limitations of the reviews based on AMSTAR's quality assessment checklist (Shea et al., 2007), we included them because the findings contribute to the field of inpatient and residential youth facilities and because the literature in the field is limited. Another reason is that the AMSTAR tool was not suitable as several questions were not relevant. Qualitative research and cross-sectional studies were quality-rated using the Norwegian National Knowledge Center's checklist for qualitative and cross-sectional studies (*National knowledge center handbook for health services*, 2014). Risk of bias in effect studies was assessed using the Effective Practice and Organization of Care (EPOC) risk-of-bias tool (EPOC, 2015). The assessment suggested that the effect studies that we included were, for the most part, at low risk of bias. Five of the studies noted that certain measures, such as blinding of personnel, could not easily be achieved because, for example, intervention practitioners were aware of the program they were implementing. EPOC yielded a significant number of determinations that bias risk was "not applicable." This may indicate that the EPOC tool is not adjusted to

these types of studies. All of the effect studies included in our review failed to report or reported unclear information on domains crucial to internal validity, such as the use of a randomization procedure. In several of the effect studies, the risk of blinding of outcome assessment was unclear or information was lacking, suggesting that the results of these studies should be interpreted with caution. Performing quality assessments of the studies included in the review (Article 1) was challenging because of the variety of methods used in these studies and because the checklists and quality assessments did not always fit the designs of the studies. Even if the checklists did not fit all the studies, resulting in a low score, the findings made a contribution to the field as they revealed different perspectives.

4.2 Interviews (Articles 2, 3, and 4)

In the qualitative part of the project, I explored staff and youth experiences and perceptions. The objective of the interviews with staff was to investigate their perceptions of safety and youth participation and their experiences with the Basic Training Program for Safety and Security. The objective of the interviews with youth was to determine what they think about their own safety at the institution in which they live, how they experience staff behavior and attitudes, and the extent of their influence and participation, as they perceive them, in decisions about their own lives. Articles 2, 3, and 4 are based on focus-group interviews with staff and a combination of group interview and individual interviews with youth at different residential facilities (see table 1). I consider it a strength of the study that the staff and youth who were interviewed were living and working at the same facilitites. This afforded a unique opportunity to view their perspectives and experiences as part of the same context.

Other methods or supplementary methods, such as observation studies and surveys, could have been chosen. A survey that maintains the anonymity of the responders could have been helpful in meeting the concerns that the responses of those participating in group interviews, for example, could have been influenced by others in the group. However, the qualitative interview method offered several advantages. For example, it ensured that the gathered data would capture details and nuances that a survey method would be unlikely to. Because access to youth in residential facilities is often quite limited and, therefore, youth voices are rarely reflected in research studies, the chosen interview method was appropriate to this study’s goals. It was also suitable given the time-limited nature of the project. Additionally, follow-up interviews could have been useful and might have contributed to a better and more in-depth understanding of the topics.

4.2.1 Focus-group interview

A focus group is defined as a focused group discussion among typically 5 to 8 people about a topic under the guidance of a group moderator (Krueger, 2014; Stewart & Shamdasani, 2014; Tjora, 2021). The purpose of a focus group is to gather opinions and better understand how people think about an issue, idea, or service. It provides qualitative data to help understand the topic under discussion. The researcher should create a permissive environment that encourages participants to share points of view without feeling pressured to reach consensus. These processes can contribute to clarification and exploration of views and discussions that are less accessible via other methods (Carey, 2016). The researcher must pay attention and show interest in what the participants have to say. The participants are able to supplement, comment, complement, and challenge each other. This interaction among the participants provides the opportunity to clarify opinions and facilitate spontaneous answers, and in this way generate data that cannot readily be produced in individual interviews. I considered such a group to be the best size to ensure both that several opinions and perspectives would be represented and that the group felt like a safe space for sharing viewpoints. The possible benefit of a group dynamic was a key reason for my decision to use this method. We also discussed whether this method is suitable for youth participants. Focus groups work best when participants feel comfortable, respected, and free to share their opinions without being judged (Krueger, 2014). This was one of the concerns about using this method with youth participants who live in an environment they usually have not chosen for themselves. However, we concluded with that the potential benefits, such as the comfort that the youths might derive from being in a group with each other, outweighed the possible disadvantages, such as youths feeling reluctant to discuss personal, sensitive issues in front of others or their feeling insecure and vulnerable in a group. I as well as staff provided the youths with information explaining that participation was voluntary and could be ended at any time; we trusted that this was sufficient to ensure that the youths felt safe to withdraw from the interview if that was their wish. Ultimately, we decided that the benefits to youth of creating a group discussion outweighed the possible risks.

4.2.2 Limitations

Focus groups present some limitations and ethical challenges. Both informants and researchers are influenced by personal experiences, subjective positions, and by each other. Group dynamics can influence focus-group responses and thereby potentially introduce bias. Focus-group context may create a sense of vulnerability (Sim & Waterfield, 2019). The

spontaneous and unpredictable nature of the discussion among participants may give rise to problems with respect to social and psychological harm, anonymity, or confidentiality that can be difficult to predict (Sim & Waterfield, 2019). There is a risk that opinions shared may lead to shame, stigma, distress, discrimination, and other social negative consequences (Warwick, 1982). What causes distress to one participant may provide a sense of validation to another participant. In a focus-group interview, respondents may feel under pressure to perform and/or conform (Ransome, 2013). The dynamic context of the focus group demands that the moderator be prepared to intervene if some participants are at risk of harm during the discussion, but this intervention should be done in such a way that it does not deprive participants of their voice. It is also the moderator's task to balance and lead the group so that all participants have the possibility to express their views. In such situations, the moderator should intervene and help direct attention to the participants who have not yet expressed their views. Although conducting focus-group interviews carries risks, the resulting discussions can be beneficial, providing a supportive forum in which participants can share and discuss their views and perceptions (Sim & Waterfield, 2019). I acknowledge the possible concerns and limitations and took them into consideration when planning this study.

4.2.3 Individual interview

Due to COVID-19 restrictions, we decided to conduct remote individual semi-structured interviews with the youths belonging to the facility that had not yet been the locus of the focus-group interview. We chose remote individual rather than group interviews because of the complex logistics of gathering several people in one room during the pandemic, and because holding a group interview online was likely to affect group dynamics in ways that we could not easily anticipate. We decided that telephone interviews with youth were a better option than not talking to youth at all. Individual interviews have some advantages. For example, they are more private and confidential than group interviews, and personal information is not shared with other participants. Rather than formal interviews, we sought to establish a dialogue between the interviewer and each youth participant. The conducted individual interviews were semi-structured and based on an open interview guide (see interview guide) to create space and the possibility for youth to talk about what was important to them within the three main areas of this study's interest: safety, staff behavior, and participation.

4.2.4 Recruitment of participants

A convenience sample of facilities was chosen to achieve variety in both size and location. This method is a type of nonprobability or nonrandom sampling (Etikan et al., 2016). Members of the target population who meet certain practical criteria, such as being easily accessible, geographically proximate, available at a given time, or willing to participate, are included. This method can be valuable and cost-effective. However, this sampling technique does have limitations and inherent biases that can potentially reduce the reliability and validity of research findings. For example, when participants are not chosen at random from a larger population, the sample may be atypical of the greater population, and the findings may not apply to other groups. Convenience sampling may also result in a sample lacking variety. This can potentially narrow the spectrum of opinions and experiences represented. To address this limitation, I selected facilities that differ in their size and in the number of staff, that were at different stages in their implementation of the Basic Training Program in Safety and Security, and that serve different youth populations. To recruit participants, I approached the managers of five residential facilities in three different regions of Norway, offering them written information about the planned study and requesting permission to recruit participants. Three of the five facilities agreed to participate (see Table 2). One is a therapeutic residential facility that provides treatment for drug and behavior problems, and the other two are care facilitites.

Table 2. Overview of the participants

Facility	Staff participants	Youth participants
Care	6 staff members (including 2 teamleaders) Employed at the care facility from 2 months to 13 years	None
Care	7 staff members Employed at the care facility from 8 months to 7 years	3 out of 10 youths Group interview
Treatment	5 staff members (including 1 teamleader) Employed at the treatment facility from 1 to 18 years	5 youths (3 out of 6 youths, 2 out of 6 youths, ten months later) Individual interviews

We relied on managers to communicate with potential participants and on the willingness of staff and youth to participate. To minimize the likelihood that youth who fit the inclusion criteria would be intimidated by researchers whom they did not know, we had staff they did know invite them to participate and provide them with written information about the

project and our request for their consent to participate. We thus cannot be sure that every youth who fit our selection criteria received precise information. Staff reported that they assisted with reading and explaining as needed. The youths were asked to participate in a focus-group interview, but were also offered the possibility of being interviewed individually instead. Recruiting a sufficient number of youths for focus groups to be held at a fixed time and place proved difficult. The three participating youths were recruited by staff at a care facility that housed 10 youths. Two were male and one, female; one was 16, one, 17, and one, 18 years of age. The girl and one of the boys knew each other well; both were acquaintanced with the other boy. All three lived at the same care facility, but belonged to different houses, and their residential care experience varied from a few months to several years. One of them had lived in other residential facilities previously. These three youths were interviewed in a group (see Table 2).

The treatment facility was able to recruit three out of six qualified youths, and after 10 months, it recruited two more out of six new youths. These five youths were either 16 and 17 years old; one was female and the others, male. All had between a few months' to one year's experience at the treatment facility. Some of the interviewed youths had been placed at the residential facility against their will.

After one group interview with the youths at the care facility, the COVID-19 pandemic was declared, limiting possibilities for further face-to-face interaction. After discussions with my supervisors and with the staff at the facility where the youths not yet interviewed lived, the most feasible way to proceed was determined to be by interviewing each youth individually over the phone.

None of the staff or youth participants had a direct or indirect relationship with any member of the research team that could be said to represent a conflict of interest or to have imparted bias to the research study.

4.2.5 Limitations

The staff members who took part in the study may have felt obliged to participate because their facility manager presented the invitation to them. To avert this bias, participants were told to contact the researchers directly if they wished to participate.

A limitation regarding the selection of youth was that we could not ensure that every youth who met the inclusion criteria was actually invited to participate by staff. Our sample may be skewed toward youths with more confidence and thus greater willingness to participate in an interview or toward those who are more willing to contribute without being

paid. These sample aspects may have affected the findings of this study. Those who did not participate may have opinions other than those that were uncovered, and a different sample might thereby have generated other codes and results.

The limitations of small sample size were outweighed, in my estimation, by the importance and value of conveying the thoughts of these youths. To increase the number of youth participants would have required me to expand the number of residential facilities. I chose not to do this in order to gather information from both staff and youth participants in the same facilities. Had I included more facilities to expand the number of youth participants without also inviting staff from those facilities to participate as well, the analysis would have been affected. Such an expansion was not possible, however, given the time limits placed on the project.

4.2.6 Conducting the interviews

Most of the interviews were conducted between February 2020 and September 2020, inclusive, with two individual interviews with youth done in January 2022. The in-person group interview and the focus-group interviews were conducted in offices or meeting rooms at the residential facilities. All interviews were audio-recorded on an app after obtaining consent from the participants; the recordings were sent directly to an encrypted database, “Tjeneste for sensitive data” (TSD), which is owned by the University of Oslo. The interviews were transcribed and anonymized by me shortly after they were conducted.

I was prepared to address some of the aforementioned challenges by being verbally clear about the consent process, and ensuring that appropriate expectations were expressed and heard. In addition to written information and consent, we verbally informed participations about the method and content immediately prior to the discussion and also after the interviews were completed. In this part of the research process, the researchers inevitably influenced the participants, both by their presence and because we chose the general topics to be discussed, in what manner, and for how long. There is also a risk that participants may have offered comments that they believed the interviewers wanted to hear.

Staff interviews

I organized the interviews in meeting rooms and in a living room at the different facilities. I introduced the project, the researchers, and the themes to be discussed. Even though we succeeded in engaging staff in discussions with one another in the staff focus groups, the participants presumably were influenced by the presence of researchers, the recording device, and each other. Additionally, the complexity of the issues under discussion

may have conditioned the responses of staff members and team leaders, keeping them from fully disclosing the actual practices in the residential facilities. Power dynamics within the group may have affected the participants' answers, as two of the focus groups included both staff members and team leaders. We raised the matter in the interview setting and the participants described the team leaders as equal members of the team who work the same hours under the same conditions as they do. We did not perceive any reluctance or hesitation among the participants with respect to this issue, but acknowledge that the differences in power between staff and team leaders may have influenced what the participants chose to talk about and wanted to share.

Most of the staff who participated spoke positively about the Basic Training Program in Safety and Security and focused on positive outcomes. A few raised concerns about the likelihood of improvements resulting in response to the training. Although they may have accurately reported their perceptions and experiences, they may also have perceived the interview as similar to an evaluation and therefore wanted to present themselves as competent and successful in implementing the training program. This could have led them to downplay difficulties and challenges. They may also have been reluctant to talk or felt defensive about their work practices and how they handle conflicts, believing that they would be judged negatively if they had not, for example, completed the training hours specified in the training program. We emphasized that we are not experts and that our aim was not to investigate how successfully they were following the program. The focus-group interviews we conducted with staff worked as intended and contributed to rich data material relevant to all themes discussed in the interviews. This is one of the strengths of this part of the projcet.

Youth interviews

To establish contact and make the environment as relaxed and informal as possible, we invited the youth in the focus group to have pizza, soda, and candy in a large meeting room located at the end of the office section of the residential facility. This allowed us to have a so-called soft start, to engage in small talk and share information about who we are. I then presented the main themes for discussion and we started off with benign questions such as "What does a regular day look like?" We then continued with other questions and approaches that would not expose the youths' histories or private characteristics. Although we strove to create a informal ambience and show that we were sincerely interested in their opinions and experiences, we cannot assume that the youths trusted us or that a safe relationship was initiated. During all the interviews, I sought to include several themes, but the order in which they were raised was flexible and varied, depending on the dialogue and what the participants

said. I also chose not to push for more answers than the youths seemed comfortable providing. I used open-ended questions and tried to encourage the youth to talk freely.

When interviewing youths individually, I did not ask every question to each youth, as some of them talked more freely than others. The shortest interview had a duration of 13 minutes, with a youth who barely answered yes or no, even if the questions were not formulated as yes/no questions. Possibly the youth was not able to develop answers or was naturally not very talkative or I did not succeed in creating a safe space to talk. The other interviews were richer in content, lasting an average of 37 minutes. Interviews in person with youth are often around 40–70 minutes (see, for example, Sommerfeldt, 2023; Gundersen et al., 2023; Gundersen et al., 2024), so phone interviews can be expected to be a bit shorter. Establishing contact and trust through relatively short phone interviews was challenging and probably resulted in less-rich data material. Other researchers have also experienced challenges in conducting interviews with children and youth, especially if the researchers have not established contact with the youth beforehand (e.g., Hagen & Lyng, 2019).

4.2.7 Limitations

There were some shortcomings to our approach. With respect to the youth focus group, I did not succeed in fostering a discussion among the youth participants. Youth participants responded to questions by directly addressing me; they did not talk among themselves. I thus determined it was more appropriate to conduct the session as a group interview. The individual interviews and the one group interview mean that we did not capture the interactional aspect or group effect which can often be obtained through the focus-group method. It is possible that the focus-group interview would have succeeded had I considered more fully in advance different techniques for fostering an atmosphere conducive to discussion, such as showing the youths a short film that offered them opportunities to discuss themes of interest in less personal ways. Evaluating the interview in hindsight, it probably would have been better to meet the youths in advance, to acquaint them with me, the focus-group moderator. There were fewer participants than the minimum recommended number for a focus group, so that too may have been a factor in the lack of discussion among the youth.

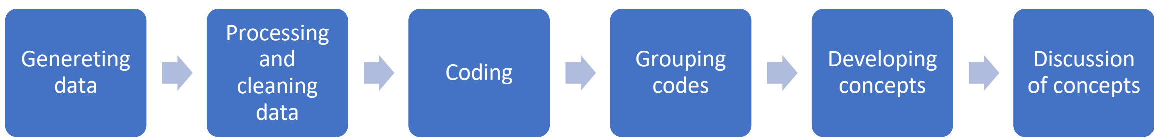
Even though there were few interviews with youth and some of the youths did not talk much, the information the youths provided is important and obtaining it was worth the possible discomfort the interviews may have caused. I made sure the youths had staff to talk

to after the interviews. They were also free to contact me with any questions or to withdraw their participation at any time.

4.2.8 Data analysis

The theoretical and conceptual framework of the dissertation influenced parts of the analysis. My goal was to describe and provide a theoretically and conceptually informed interpretation of the data. To analyze the empirical material, I used an approach that was inspired by parts of the Stepwise-Deductive Induction (SDI) method (Tjora, 2019), which fit well with the aim of the interview analysis. The approach combines an open inductive approach, which lets the conclusions arise from empiricism, and a deductive approach, which was influenced by the theoretical and conceptual framework and by the background of the predefined themes of the dissertation. This combined approach could be described as an analysis with an emphasis on empiricism but with necessary influence by previous research and knowledge. It increases the possibility that the conclusions have validity beyond the collected data (Tjora, 2019). The reliability of findings requires internal logic or consistency throughout the entire research project. The SDI approach is well suited to ensure reliability, and it provides the foundation for analyzing the empirical data (Tjora, 2019). One of the objectives of the SDI model is to trigger a stronger commitment to empirical anchoring and systematization in order to make explicit how research takes shape empirically, analytically, and theoretically. The SDI method emphasizes progressing in stages. It supported the generation and systematization of data, including the process of encoding information, seeking patterns, and developing codes. This method's first steps were followed for Articles 2 and 3 of this dissertation.

Figure 1. Illustration of the steps of the SDI model by Tjora (2019).



Processing and coding were the first steps in the analysis of the data; this was appropriate given that this dissertation focuses on the participants' perceptions and experiences of working and living in residential facilitites. I considered an open and closeness to data approach (Tjora, 2018) to be relevant. The first stages of the SDI approach involve rigorous, systematic analysis, with an emphasis on interpretation and reflexivity and a concern for transparency.

The analysis of the interviews began with inductive coding using a computer softwared program, Nvivo. I also organized quotes from interviews using pen and paper and a marker and whiteboard to ensure that we grasped the overall picture. According to Tjora (2018), an empirical coding process, done line by line, is better suited for handling empirical content than are predefined categories or codes. Using open coding to capture the essence of the material can lead to mulitiple codes and code groups. We carried out the analysis moving backward and forward between the data and codes. Our aim was to generate codes that corresponded closely to statements made by those we interviewed and that encapsulated the specific nature of the material. We sought to extract the essence from material and reduce the volume. From the interview transcripts, we derived numerous codes. To ensure quality, we asked two questions of each code: “Could the code be produced prior to the coding process?” and “What does the code itself tell us?” (Tjora, 2019). The answer to the first question should be that the code could not have been produced before the coding was done; the codes—which are text strings—should provide wording very close to that in the transcribed interviews. This makes it possible to thematize the quotes. The list of produced codes (the codebook) helped us stay close to the data and organize the codes and emerging themes. The next step—code grouping—involved generating three to six code groups, each of which had its own internal consistency and was also thematically distinct from the other groups. An additional aim was to sift out irrelevant codes (Tjora, 2019). We concede that a different sample of both staff and youth participants might have generated different or additional codes and code groups.

The stages of the SDI method that were used in the qualitative analysis were inspired by grounded theory. This theory lets empiricism be the starting point and it develops general conclusions from the empircal data (Glaser & Strauss, 1967; Tjora, 2019). As originally proposed by Glaser and Strauss, the validity of the conclusions depend on the researchers’ ability to be neutral and objective (Glaser & Strauss, 1967). As the grounded theory has developed, there has been an increased emphasis on social construction and on an inductive, open approach (Charmaz, 2014). Although various versions of grounded theory have different theoretical underpinnings, they differ very little in terms of the analytic processes (Braun & Clarke, 2020). The analysis process generally involves different stages of coding, beginning with initial or open coding and moving on to more focused, selective, and conceptually oriented coding (Birks & Mills, 2015).

An abbreviated version of grounded theory is now often applied for smaller and more homogenous samples, rather than the large number of samples typically associated with grounded theory (Braun & Clarke, 2006). It often produces an analysis that is

indistinguishable from that of thematic analysis (Braun & Clarke, 2020). Thematic analysis is often understood as belonging to the qualitative research tradition, which is centered on exploring participants' subjective experiences and sense-making (Braun & Clarke, 2013; Willig, 2013). However, some note the connection between thematic analysis and the critical qualitative research tradition, which is often associated with poststructuralism and constructionism and focuses on social patterns of meaning and their implications (Braun & Clarke, 2020; Clarke & Braun, 2014).

In constructivist and inductive approaches, coding is a tool for carving out blocks of code groups or themes. As Braun & Clarke (2021) suggest, thematic analysis is a spectrum of methods, from those that prioritize coding accuracy to those that are more reflexive and emphasize the subjectivity of data interpretation. Even when the analysis is conducted in a more rigorous way, the positionality and subjectivity of the researchers influence the process. According to Braun & Clarke (2020), thematic analysis is theoretically flexible, which means that theory cannot be avoided.

Other approaches and methods were available to us for analyzing the data. For example, we could have chosen a more reflexive, thematic analysis (Braun & Clarke, 2021), which might have produced similar results, given that the coding process is similar, or might have presented other focus areas, given that thematic analysis is more subjective and interpretative.

Qualitative content analysis offered another possible analysis method. This method is often described as useful for identifying themes in qualitative data (Braun & Clarke, 2021). It can be defined as "a method for the subjective interpretation of the content of text data through the process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p. 1278). This method is similar to and overlaps with both the codebook approach of thematic analysis and parts of the SDI method, and it could have been used to analyze the transcribed interviews. However, I considered this method to be too limited for analyzing the communication processes in a focus-group interview. It has also been implicitly criticized as atheoretical and lacking in theoretically flexible (Forman & Damschroder, 2008). The method is often used for producing descriptive analyses; it is less interpretative than other qualitative methods.

For Article 4, I used a more deductive approach, which took the framework of meaningful participation (Bouma et al., 2018) as a starting point and as an analytical tool to structure and analyze the interview material. The theoretical framework of meaningful participation—informing, hearing, and involving (Bouma et al., 2018)—was discovered

during the project, and I found it useful to structure, analyze, and present the findings in Article 4. MacFarlane and O'Reilly-de Brún (2012) point out that preexisting concepts or theories in qualitative analyses can provide a powerful lens through which to study data. At this stage of our study, we derived the coding scheme from the three dimensions of meaningful participation. The theoretical framework of meaningful participation theory provided answers to the "what should be?" question. The study reflects participants' experiences and perceptions in response to the "what is?" question. Testing or verifying the extent of the discrepancies between the "what is" and the "what should be" then follows (Van der Waldt, 2021). By analyzing the data using the framework of predefined dimensions of participation, I may have missed some perspectives that might have emerged from an inductive analysis.

4.3 Ethical Concerns

Ethics were a priority throughout the study. I ensured that the formal requirements of a scientific study based on interviews were met. My research project was approved by the Research Council of Norway (award number 339013) and by the Norsk senter for forskningsdata (NSD), now the Norwegian Agency for Shared Services in Education and Research (SIKT). The project has followed the ethical guidelines for social sciences and humanities research (NESH, 2021). All youth and staff participants were informed that participation was entirely voluntary and that they could leave the study at any time. Confidentiality was a topic of considerable importance in this study, particularly since all the interviews were conducted at the residential facilities or by phone with the participants at the facility. In keeping with the legislation on protecting personal integrity and research ethics practice, I have anonymized all directly and indirectly identifiable data to ensure confidentiality. The participants were given information explaining that the researcher would ensure their anonymity when reporting and discussing the data by excluding names, places, geographical characteristics, details about the facilities, working hours, and any other information that could expose the identity or affiliation of the participants, particularly to those who are familiar with the facilities. For this reason, further information about the participants' characteristics and experiences are not presented in any detail. The gender of the speaker is not stated in connection to any of the quotes. I chose to not give the participants fictitious names, as this would link all the quotes from one person and elevate the possibility that the person could be identified, despite the name fabrication. The quotes are presented to highlight analytical points. I have also avoided connecting the quotes to any particular

facility, also to ensure anonymity. Any quotes that contained details that could expose the identity of the speaker have been modified. All recorded materials will be erased after five years to minimize any risks related to confidentiality.

4.3.1 Children and youth as participants

Children and youth have the right to participate in research and their perspectives are important. Including them in research can yield valuable information about how they view their lives and futures that could favorably influence residential care practice. In contrast to adults, they often need more time to feel safe and be invited into a dialogue that is perceived as caring, safe and relevant to their situations (Hagen & Lyng, 2019). They should be given sufficient and relevant information in a way they understand, that makes sense, and has meaning to them (Bredal et al., 2022). I did my best to show interest and stress that the youths have important and unique experiences, that they are the experts in the interview setting, and that we, as researchers, want to learn from them about their experiences living in the facilities. By participating in the study, they have the opportunity to influence the results and hopefully, their lives in residential faciltities. However, children are considered a vulnerable group, especially those living in residential care settings (NESH, 2021). We raised several concerns, among them that youth in residential facilitites are vulnerable in several ways and can have difficulty trusting adults. When children are asked to participate in research, their vulnerability should be taken into account. All participants in this study were over 16 years of age and were considered by staff and in the interview session to understand what they agreed to. We trusted that staff made the necessary assessment that the research setting would not harm the participating youths.

The youth received both the written and oral information from staff before the interviews were conducted. The participants of the group interview also received information about the project directly from me to ensure that they had all the necessary information before deciding whether or not to participate. Those that agreed to participate signed the consent form at the beginning of the interview. The youths who were interviewed by phone signed the consent form prior to the interview with the help of staff. The information about the project was provided before the interview began and at the beginning of the phone interviews. Each youth decided where and when the phone interview would be carried out.

I stressed to the youth participants the importance of their voices and experiences. Although we indicated clearly that participation was voluntarily and anonymity was

guaranteed, we cannot be sure that the youths perceived it as such. Staff may have spoken to the youths in a way that made them feel pressured to participate or the youths may have chosen to participate for the sake of others rather than themselves. When I interviewed the youths, I made sure that they received information that participation was entirely voluntary. However, due to the obvious power imbalance that exists in residential facilities, we cannot guarantee that the youths did not feel obligated to participate or chose to hold back information out of fear of negative consequences. Being asked to talk about their experiences in the residential facility and with staff may have made them feel vulnerable and at risk of sanctions if their comments were not kept confidential. There is a possibility that the youths' responses were skewed by their recognition of the power inequality between staff and themselves, and fear of negative consequences if they criticized staff practices. However, despite the possibility that the youths were not fully transparent with us, the information they did share raises important issues regarding residential care and treatment. I tried to reduce the likelihood that any of the youth participants would shape their answers or hold back opinions by explicitly and clearly telling them that no answers were wrong and that staff would not be told what they had said.

I tried to ensure that neither the in-person interview nor the phone interviews were too emotional demanding. The youth were being asked to talk to a researcher about themes that they might not have talked about often or which they perceived to be sensitive and personal. I avoided several questions that I considered too personal and invasive, such as whether their placement had been voluntary or not. Knowing that voluntary placement often is approved by a youth because non-voluntary placement will occur otherwise, I determined the question to be irrelevant and that there was no reason to ask the youths to discuss such details that could have provoked discomfort. Other details about their lives and child-care history were omitted out of the same consideration. This means that the researchers and hence the readers of this dissertation do not have extensive information about each participating child. This limits a full understanding of each child's history and context.

4.4 The researcher's positionality

All researchers have their own preconceptions and assumptions, which are shaped by their experiences, including their professional background, life circumstances, and academic education (Neumann & Neumann, 2012). Researchers need to be cognizant of this as they embark on a project, to ensure the quality and trustworthiness of their research. It is essential that researchers examine how they arrived at their interpretations and which factors

influenced them. This reflexivity is often referred to as a quality indicator, linked to the reliability and validity of research (Alvesson & Skoldberg, 2009).

My formal education was in Child Protection and Social Studies (bachelor's degrees) and Value-Based Leadership (master's degree). From my studies and working experience, I knew before embarking on this project that aggression and violence are challenges that residential facilities face, and that working and living in an unsafe environment can significantly affect staff and youth. I was also aware of the Basic Training Program in Safety and Security and its goal of improving both the living environment for youth and the working environment for staff. Further, I knew that international and national laws give youth the right to participate and that research indicates that this right is not ensured in practice.

My preconception of residential care and the jobs of those who work in residential facilities was also shaped by my 15 years of employment in the areas of social protection and residential care and treatment. As a former youth care worker, I possess job experience and education similar to that of the staff participants in this study. It is likely that I also share some of the staff participants' values and biases in relation to the professional work itself. Moreover, I work for the same organization, Bufetat, as do the staff who participated in this study. In addition to possibly introducing bias, my position within Bufetat gave me an advantage in gaining access to potential study participants. My experience and knowledge as well as employment were useful to my ability to talk to staff and youth in residential care, and thus, to obtain data. They also allowed me to ensure that the interview guides and questionnaires employed terminology that was precise and meaningful to staff participants. In this way, personal experience can be beneficial; for example, it can lead to adjustments in the interview guides and questionnaires to make them more terminologically precise and relevant (Tjora, 2019). These factors, while helping me gain access to needed data, may have introduced bias into this study.

Conscious of this possibility, I took several steps to counteract potential bias. First, none of my research co-workers had prior knowledge of or experience with any of the participating residential care units or staff members who participated in the study. This reduced the significance of my employment with Bufetat. Second, Bufetat is a large public organization with thousands of employees, and I made sure that I had no prior knowledge of the facilities or familiarity with any of the participants in this study. Third, I and my supervisors reflected critically on these factors throughout the course of the project, including on their possible effect on our interpretations and conclusions and on the ways that my past involvement in youth residential care could bias the research. Fourth, to limit the bias

potentially introduced by my personal experience and commitments, researchers not affiliated with Bufetat or residential work attended all interviews. These researchers had limited knowledge of the Basic Training Program in Safety and Security and of how child welfare institutions are organized and run. Over the course of the research project, I presented preliminary findings to colleagues in Bufetat and at international and national conferences. Colleagues in Bufetat provided feedback on the findings and contributed to reflections on the ways that the research could be useful in practice.

4.5 Validity and quality of the study

The quality of the research depends on its success in presenting persuasive analyses that seem relevant and credible (Justesen & Mik-Meyer, 2012; Kvale et al., 2015). In addition to meeting the criterion of quality, this dissertation must present valid research. Important to establishing validity is providing information that is credible, transferable, dependable, and confirmable (Lincoln & Guba, 1986). In the course of the project, I strove to maximize the validity of the research. To gather data, I chose to do interviews, a method that provides the greatest access to participants' experiences and perceptions. To gain the deepest understanding of the content of interviews and the fullest sense of participants' thoughts and meanings, I transcribed every interview in its entirety and with the greatest accuracy possible. Two independent researchers,—myself and one of the other authors—then coded each interview manually. This method was chosen to minimize possible bias and to obtain an interpretation of the data that was as accurate as possible and that the researchers recognized and agreed on, thereby ensuring reliability and validity (Andenæs, 2000). Anonymized project data will be unavailable five years after the project is completed. Thereafter, all transcripts and recordings will be disposed of as required by storage policy.

The generalizability of qualitative analysis is not comparable to that of quantitative results. Due to the qualitative nature of this study, it was not our goal to generalize to youth and staff in the population or to other populations or settings. Rather, the power of the qualitative analysis lies in the researchers' evolving engagement with the data in a systematic way. According to Tjora (2021), two types of generalizations are possible with qualitative research. One is moderate generalization, which is relevant when the researcher describes the context and situations in which the data are relevant. The other is conceptual generalization, which recognizes that concepts and theories are produced and could have relevance outside that which is being studied (Tjora, 2021). The latter type of generalization is the goal of the SDI method that inspired this dissertation's analysis. My aim has been to make the analysis

and results relevant outside the three facilities we studied. I also argue that the findings contribute meaningfully and richly to research concepts related to youth and staff perspectives and experiences of living and working in residential facilities.

The validity and reliability of the themes extracted from our codes and code groups are dependent on the coders' thoroughness and qualifications. The results of the analytic process are a synthesis of the data and our preconceptions. The analytical process depended on our interpretation, and the themes were a result of a process in which data collection, interpretation, and analysis are inherently merged (Cohen et al., 2011). Categories and codes were based on participants' descriptions of practice and therefore were not tested empirically. We cannot determine if the descriptions provided by the participants correspond to actual practice. For example, we do not know whether staff participation in the Basic Training Program in fact has led to a reduction in incidents of conflict or has improved youth safety and care.

5 Results and discussion

The purpose of this dissertation has been to develop knowledge about the perceptions and experiences of the staff who work and the youth who live in residential facilities in Norway. The knowledge generated by my research illuminates ways that safety can be increased and identifies factors that create a lack of safety for both youth and staff. It also expands knowledge about how youth participation is understood and experienced by both staff and youth. The dissertation's theoretical aspects illustrate how aggression, conflict, and powerlessness can be understood and how they can affect staff and their work with youth.

Research demonstrates the importance of youth's voices in promoting safety and well-being in residential treatment (Chama & Ramirez, 2014; Green & Ellis, 2008; Jolivette et al., 2015; Moore et al., 2017; Sellers et al., 2020). This dissertation responds to and echoes the call to address concerns about safety and youth participation. It offers new empirical evidence of the importance of listening to youth voices as part of the continued effort to improve residential care (Côté & Clément, 2022; Moore et al., 2018; Trawick et al., 2019), and it shows that youth's perspectives can contribute to a wider understanding of both safety and youth participation. A possible limitation of this dissertation is that it rests on an empirical foundation laid by previous research and discussions, which is based on research from different types of inpatient and residential children and youth facilities. The wide foundation was chosen mainly because of the dearth of research on safety, aggression, and participation

in comparable residential facilities, and due to the significant similarities between inpatient psychiatric wards and residential facilities.

5.1 Prevention of conflicts, aggression, and use of R&S

As noted in Chapter 2 of this dissertation, aggression and violence are well known problems in youth inpatient and residential facilities and they frequently affect both the quality of youth care and the well-being of staff. Responses to aggression and violence, such as R&S, pose challenges and can threaten the sense of safety of both staff and youth. The literature review (Article 1) conducted as part of this dissertation described studies published after 2015 related to interventions to prevent aggression and violence in inpatient and residential youth facilities and sought to achieve an overview of the effects and experiences of R&S. Our review discovered a limited but growing number of studies conducted in inpatient and residential youth facilities compared to a review conducted in 2015 (Lillevik et al., 2016). In contrast to that review, Article 1 found fewer qualitative studies and more effect studies that evaluated interventions of different types, including education and training programs. Article 1 shows that various educational and training programs have been implemented in different countries to improve practice and create safer places for youth to live and for staff to work. The interview study conducted for this dissertation (Article 2) supports these findings. Five of the eight effect studies included in the review were conducted in the USA, as were the two reviews of intervention studies. Due to the distinctiveness of systems and contexts, generalizing results from the USA to other countries is difficult. This area of research remains underdeveloped, especially outside of the USA. However, the findings in Article 1 indicate that, overall, reports of conflicts/aggressive incidents as well as the use of R&S can be reduced by implementing various education and training programs. The findings also indicate that these interventions assist staff in preventing and managing aggression, conflict, and unwanted situations. Overall, the studies of the different interventions found several indicators of positive outcomes. These included improvements in staff ability to de-escalate conflicts (Forbat et al., 2017), reduction in number of conflicts reported (Forbat & Barclay, 2019), decline in youth aggression towards staff (Goldstein et al., 2018; Izzo et al., 2016); fewer injuries (Bryson et al., 2017), and lower rates of R&S use (Azeem et al., 2017; Black et al., 2020; Bryson et al., 2017; Magnowski & Cleveland, 2019; Roy et al., 2019). Findings also indicate that both youth and staff report negative experiences with physical restraint (Article 1). However, few of the studies included in the literature review can be considered methodologically rigorous. Although education and training programs can improve staff

knowledge and attitudes, whether or not they positively influence the way youth experience staff communication and behavior is not clear. Moreover, to my knowledge, no research has been conducted to ascertain which aspects of the interventions brought about the desired changes.

5.2 Safety for youth in residential facilities

The youth who participated in this study identified two key factors important to their sense of safety: the physical environment and their relationships with staff and other youth (Article 3).

5.2.1 The physical environment and relationships affecting safety

Several of the youths who participated in this study reported that they felt safe in their private rooms (Article 3). According to Nolbeck et al. (2020), the private bedroom can be both a safe space for someone wishing to have some time alone and a confining place where someone experiencing depression or anxiety may feel trapped and left behind.

Youths also reported that their relationships to other people, both staff and other youths, affect their sense of safety. The importance of relational care in residential settings is well recognized (Bath, 2015; Harder et al., 2013; Holden, 2009; Trieschman et al., 1969). The findings of Ballentine et al. (2023) imply that building trusting, safe relationships with youth should be a top priority and suggest that youth perspectives are valuable and should be included in assessments. According to Sellers et al. (2020), there is a strong association between children's perceptions of a relationship's quality and children feeling safe. Children were more likely to report feeling safe when they also perceived the quality of their relationship with staff to be good. This strong association supports recent qualitative research documenting that staff who were available, caring, and tenacious in building relationships with the children in care enhanced the sense of safety experienced by children (Moore et al., 2017; Nolbeck, 2020). Engström et al. (2023) found that caring treatment from staff created experiences of participation and that young people's responses were characterized by mutual trust and emotional closeness. Safe relationships with staff may increase children's feelings of safety and thus their capacity to gain the greatest benefit that residential care offers (Nolbeck, 2020).

A residential care facility is both a home and a workplace, and this duality can present challenges to both youth and staff (Garsjø, 2008). Staff's efforts to create safety for youth can be perceived by the youth as undercut by staff's work hours and their coming and going. Staff

working hours are regulated by law; children in residential facilities must thus adapt to a large number of staff members (Sommerfeldt, 2019). Also, the knowledge that staff are paid and "being professional" can affect trust and relational aspects, and thereby, safety, as well as create distance between staff and youth (see Article 3). The institutional context may limit the opportunity to develop and maintain close relationships (Sommerfeldt, 2022). The legal framework guides staff to act in accordance with good practice and may thus limit their room for action. This limitation is intended to prevent unhealthy, limitless, offensive relationships from developing between youth and staff and to thereby take care of the child's best interest (Sommerfeldt, 2019). At the same time, the legal framework restricts the possibilities for relational practices and sets certain limits regarding personal, spontaneous, and intuitive meetings between children and staff. Given current demands for evidence-based treatment, the room for action for professionals has been shrunk. As a consequence, there is less room for a child and a staff member to develop a mutual, reciprocal relationship. According to Sommerfeldt (2019), the professionalization of the social work field seems to be closely connected to the idea of the child as injured and in need of professional attention and care. One risk is that the care provider will lean on the methods and structures of their profession, out of fear of doing something wrong, and then not make their own context-sensitive assessments. Youth may then perceive staff as distant and may experience well-intentioned interventions as violations (Høilund & Juul, 2015). To ensure ethical, sound practice, professionals must be reflexive and take responsibility for creating trusting and safe relationships with youth. The study by Sommerfeldt (2022) shows that relationships of reciprocity are possible, and it indicates that staff need to work at building relationships with children.

Residential care facilities are staffed by people and people have a variety of personalities. There is thus potential for conflict between youth and staff and among various staff members. Some of the youth in this study reported that the way that staff acted and responded to them depended on who the staff member was. Youth pointed out that the care and treatment they receive from staff are person-dependent (Article 3). When asked about how they perceive and experience communication and contact with staff, several of the youths responded, "it depends who…." Consistency in staff relationships with children is critical to support the therapeutic impact of these relationships (Anglin, 2002; Whittaker et al., 2016). Ulset (2014) points out that a lack of consistency in employee practices creates insecurity and a lack of predictability. However, Sommerfeldt (2022) notes that youths often appreciate differences among staff members because, for example, these differences make them human

and knowable. The youths who participated in this dissertation research as well as those in the study by Sommerfeldt (2022) stressed the importance of reciprocity and of staff sharing information about their personal lives and showing genuine interest in them. When staff conceal their private lives, it creates a distance in their relationships with youth and implies a lack of reciprocity (Sommerfeldt, 2022). Throughout the interviews, youth described staff members who care and appear to enjoy spending time with them, and those who do not seem to care, do not share information about themselves, and act "professional" (Article 3). The difference between the behavior youth appreciate and the behavior that some staff exhibit may reflect the dual role of the residential facility as a home for youth and a workplace for staff.

Achieving a safe environment in residential facilities is a challenge. Although the youths in this study did not talk much about safety in connection to peer relationships, some did relate experiences both of being threatened by peers and of witnessing or hearing distressing conflicts between peers and staff members (Article 3). Research shows that victimization by peers is a common experience in residential youth care facilities (Attar-Schwartz & Khoury-Kassabri, 2015; Eltink, 2020; Freundlich et al., 2007; Sekol, 2013; Sekol & Farrington, 2016). Research has also linked children's perceptions of staff members as strict to their experiences of physical and verbal maltreatment by staff and to physical victimization by peers (Attar-Schwartz, 2017; Mazzone et al., 2018). Aggression from peers or staff may decrease children's perceived sense of safety (Attar-Schwartz, 2017; Mazzone et al., 2018). When children first experience trauma in their original home, and then experience trauma in the residential facility intended to keep them safe, they can exhibit difficulties, such as showing heightened vigilance to threats, and difficulty regulating emotions and forming positive relationships (Bath, 2015; Eltink, 2020; McCrory et al., 2010). These symptoms can hinder their ability to gain the therapeutic benefits of out-of-home placement (Bath, 2015; O'Hara, 2019).

The study by Sellers et al. (2020) reports that one-third of 715 children in residential care never, rarely, or only sometimes felt safe. The absence of a feeling of safety can inhibit children's opportunities for recovery and development (Bath, 2015). As shown in several studies, good quality relationships between children and staff may enhance children's feelings of safety and increase their capacity to receive care and treatment (Sellers et al., 2020).

To understand residential care not as an idea but in reality, the voices of children have to be considered. Staff are responsible for children feeling safe, and their understanding of children's perceptions of safety is essential to create an environment that ensures children's

safety. According to Sellers et al. (2020), staff estimates of children's feelings of safety were consistently higher than were the children's perceptions of their own safety. This discrepancy may simply reflect that adult perceptions of what children experience is often out of sync with children's reports of their own experience (De Los Reyes & Kazdin, 2005). These findings raise questions about how staff understand and recognize children's sense of their physical and psychological safety.

5.2.2 Youth waiting for life to start

Analysis of our interviews revealed an unexpected finding about youths' perceptions of their everyday life (Article 3). This finding emerged when, to initiate conversation with the youths, we asked the question, "What does a regular day in your life look like?" Only half of those interviewed reported engaging in any organized daily activities, such as school, or following a weekly planned schedule. The other half described days of staying mainly in their rooms, sleeping and gaming, waiting for their lives to resume. They expressed feeling as if their lives were on hold, that they were just waiting, not knowing how to occupy their time or where they would be going next. These expressions of aimlessness reflect feelings of insecurity and of not being in control of the future. They are similar to the findings of Nolbeck et al. (2020), who studied youth placed in involuntarily institutional care. Some of the youths who participated in this study also expressed feeling that no one needs them, they have no purpose, they do not need anyone or anything, and thus they have nothing to get up for in the morning (Article 3). These expressions could indicate that these youths feel powerless and that they do not matter. That youth express the feeling that they do not matter when they are in an environment that they experience as unpredictable and that they cannot influence is a concern. Such feelings can lead to passivity (Fudge Schormans & Rooke, 2008), feelings of powerlessness (Young, 2011), learned helplessness (Maier & Seligman, 2016; Seligman, 1974), and a loss of self-confidence, self-value, self-efficacy, and the ability to solve their problems (Bessell, 2011; Horwath et al., 2012; Skauge et al., 2021).

5.3 Meaningful youth participation in practice

Staff have the responsibility to facilitate and ensure children's right to participation. To fulfill this responsibility, staff first need sufficient knowledge both about children's right to participate and about what constitutes participation. Included in this understanding should be knowledge of why and how participation can contribute to better residential care and treatment decisions and systems. Youth often bring to residential facilities their experiences of abusive relationships, which have affected them deeply and present them with various

challenges. It is essential that staff contribute to repairing these wounds and help youth develop in a healthy way, through meaningful participation in a safe environment.

5.3.1 Sufficient and adjusted information

To facilitate participation, staff are required to present to children information about their rights in an age-adjusted way so that they can understand (UNCRC, 1989). If children are properly informed, they are more likely to participate and provide important information about their needs. There may be occasions when youth do not want to participate (Lundy, 2007). However, they must receive sufficient and appropriate information before they can conclude whether or not they want to participate. Both staff and children who participated in this study reported that children receive information both when they move into a facility and after the use of R&S (Article 4). Tjelflaat and Ulset (2007) found that most youth participants in their study knew little or nothing about their rights. They believe that providing a brochure and information to youth when they arrive at a residential care facility is insufficient to inform them of their rights.

Reime (2017) underlines the importance of staff giving youth sufficient and clear information about their rights, and that doing so can give youth increased feelings of safety and security. Staff participants in this study reported that the residential facility is responsible for providing information about youth rights, but that the facility puts the responsibility on the youths to contact the state administrator (Statsforvalteren) if they feel that their rights have not been respected. Both youth and staff participants reported that it was up to the youth to ask staff for more information about their rights (Article 4). In other words, the responsibility for acquiring information about rights lies with the youth. This can be interpreted to mean that the facility and staff regard youth as highly competent and responsible, but it can also mean that children are being burdened with a responsibility that formally belongs elsewhere. Youth participants in the study by Moore (2017) felt that adults in institutions needed to proactively and explicitly ask them about their feelings of safety and vulnerability, rather than wait for them to initiate such discussions. The same can be said about discussions of children's rights and the entire process of meaningful participation. Staff members or other responsible adults bear the responsibility for initiating these discussions to help the youth be sufficiently informed. Youth should also be given information about the extent to which their views were considered in making decisions about their lives and if they were not, why not.

According to Reime (2017), staff reported that they do not provide information to youths because they reasoned that the youths either are capable of gaining this information

themselves or know more about their rights than the staff do. This suggests that staff find it challenging to understand and protect youth's rights. Another possible reason that staff fail to properly inform youth about their rights is that they think it is better for youth not to receive the information because they think that youth cannot handle their rights or make good decisions for themselves. According to Reime (2017), who studied staff in residential facilities, several participants reported that the exercise of the rights of children who were undergoing treatment conflicts with what they consider to be good quality treatment. These staff members regard the children as at risk, and thus in need of limits and to be controlled. Most of the youths in the study by Tjelflaat and Ulset (2007) reported that they knew little about their rights; one of them suspected that staff did not want youth to know about their rights, and that the facility avoided some problems if the youths were left ignorant.

All the youths in the study by Tjelflaat and Ulset (2007) knew that they could contact the state administrator, but several did not know how to. Some youths interviewed for this dissertation (Article 4) reported feeling that there was no point in complaining to the state administrator because they thought, or knew from experience, that nothing would be done in response to a complaint. Participants in the research study of Moore (2017), who represented schools and out-of-home care, were generally skeptical about making a complaint. They believed that most mechanisms were not child-centered as they required adults to initiate the complaint process, to decide if a complaint was justified, and, if so, to determine what action should be taken and how and if the child would be informed of the outcome. Participants who had made complaints reported that they were rarely taken seriously and that they had no power in the process (Moore, 2017). The children believed that the institutions should be transparent in their responses to the complaints.

Youth participants in the study of Tjelflaat and Ulset (2007) reported that when staff took the time to explain, the youths felt that they had been involved and taken seriously, in contrast to how they felt when staff just said, "This is the way it is." The youths stated that they found it easier to understand and accept rules and routines if the rationale for them was explained (Tjelflaat & Ulset, 2007). These findings are supported by the opinions expressed by the youths studied for this dissertation.

5.3.2 Expressing views freely

The residential staff has a responsibility to ensure a safe and open environment that facilitates children's right of free expression. Nybell (2013) emphasizes the importance of context and power relations in exploring youth voices. Within residential facilities, the power

relations between staff and children are asymmetrical, which can make eliciting children's views challenging. The comment of one youth, noted in Article 3, that he tries to behave professionally since the staff are professionals suggests that the rights and needs of youth to freely express themselves and to engage in dialogue with staff may not be being achieved.

Some youths reported not knowing how to contact the state administrator (Article 4). This lack of knowledge limits their right to free expression, making them dependent on staff. The fact that the state administrator can tell the residential staff about complaints further limits youth's free expression as youth may censor themselves out of fear that staff will punish them for complaining (Tjelflaat & Ulset, 2007). Some of the youth in the study by Tjelflaat and Ulset (2007) said that the smartest thing to do was to keep their opinions to themselves because, if they did express incorrect opinions (in the view of the staff) or ones not in line with rules and routines, they would lose a portion of their weekly allowance. In other words, these youths may have chosen not to exercise their right to free expression to avoid negative consequences. This violates children's right to participate. One could argue that these youths *chose* to suppress their opinions. However, if the consequences of expressing these opinions is, in the children's view, so punitive that they chose to withhold them, then their choice was coerced and not freely made. Children need to be supported by adults who can help them voice their needs and wishes and protect them from any negative consequences as a result of their raising concerns (Moore, 2017). The youth interviewed for this dissertation said they saw no point to expressing their views because staff members would not change their minds in any case (Articles 3 and 4).

In any discussion with children about their interests, substantial weight should be given to children's views. This involves doing more than just asking children for their opinions of a situation or for their decisions; it requires subtle work to elicit children's wishes and feelings in an adjusted context. This dissertation emphasizes the inadequacy of simply asking children for their views and calls for developing a process that provides and explains information to children and engages them in dialogue to help them gain competence in forming opinions.

5.3.3 Hearing and involving

According to Article 12 of the UN Convention on the Rights of the Child, the views of the child must be "given due weight in accordance with the age and maturity of the child." Youth thus have the right to have their views listened to by those who care for them and to make decisions about their lives. This may seem straightforward but the wording of Article 12

creates complexity. “Due weight” is subject to interpretation; for example, staff who view children as needing protection and limits can interpret it differently from staff who view children in another way. Further, it is the caregivers, including staff, who determine what is appropriate given the child’s “age and maturity.” What they decide can influence what children then offer as their opinions. Often youth are asked for their views and then never learn whether or not their opinions influenced the decisions that were made (Lundy, 2007).

Both Article 4 and Tjelflaat and Ulset (2007) found that youths reported that they talked to staff but did not always feel that they have been really listened to. These findings suggest that these youths’ agency, which is considered a precondition for participation (Valentine, 2011), was being undermined.

The use of routines, rules, and plans is common and an expected dimension of social work at residential facilities. The framework and methods of a facility, which are expressed in formal documents, provide direction to staff as to how to go about their work, and contribute to a less person-dependent practice. However, there is a risk that procedures and rules are contraindicated by contextual assessments made by staff members; thus permitting individually adjusted assessments is important (Eide, 2016). Several youths who participated in the study for this dissertation reported that rules and routines were, in their experience, non-negotiable and impossible to influence (Article 4). Youth in Tjelflaat and Ulset (2007) also experienced a lack of influence over rules and routines. On the one hand, routines can contribute to increased safety. On the other, they can be inflexible and thus limit youth’s participation. The youth studied by Tjelflaat and Ulset (2007) reported that routines limited their ability to choose free-time activities and see their friends who lived outside the residential facility. Most of the youths experienced constraints on their ability to influence their everyday lives and felt that the residential facility largely governed their day-to-day lives and free time. Their feelings could indicate that staff view the youths as vulnerable and irresponsible. Such a view can lead to the use of general routines and means of control that are potentially harmful to youth (Reime, 2017) and reduce youth’s agency (Polvere, 2014). According to Reime (2018), the most dominant aspect of youth’s self-construct is regarding oneself as an autonomous and responsible subject. As discussed in Article 3, one youth reported that it could be difficult for youths to have opinions when they have so many problems. This should also be taken into consideration. The inability to influence or predict the course of one’s own life can create passivity (Fudge Schormans & Rooke, 2008), feelings of powerlessness (Young, 2011), and learned helplessness (Maier & Seligman, 2016; Seligman, 1974). Articles 3 and 4 highlight concerns consistent with these findings. Lack of

ability to influence one's life can also trigger frustration that may escalate over time (Engström et al., 2020). This can lead to a waning of self-confidence and a weakening of resilience and ability to solve their own problems. It is thus essential to offer youth opportunities to understand their relationship to others and the world, to give them a clear sense that they matter, and to strengthen their self-confidence (Gharabaghi, 2019). Achieving a sense of belonging in residential settings is hampered by the fact that these facilities are characterized by rules and routines (McIntosh et al., 2016).

5.3.4 Participation as real and meaningful?

To a large extent, the literature on participation has emphasized the juridical understanding of the term. For participation to be real and meaningful, it must be understood as necessary to making good decisions in the child's best interest and important in the development of the self-esteem and self-worth of the child. According to Moore (2017), many of the participation practices are adult-driven. Adults control the process for eliciting children's opinions, determining when, where, and what they are asked and how the organization will respond. According to Jensen (2014), many youths experience symbolic rather than real and meaningful participation; for example, they are invited to a meeting because protocol requires that they be invited. These findings coincide with those of Article 3. Both youth and staff reported that youths are informed of their right to participation during their move-in meeting and after the use of coercion. As Warming (2015, 2017) points out, demands for documentation can work against children's need for emotional and legal recognition. There is a risk that the discourse of participation leads, not to expanded freedom and empowerment of youth, but rather to a particular mode of government or power (Masschelein & Quaghebeur, 2005). In this sense, the plea for participatory practices may be an interpellation, defining the way children behave and encouraging them to think of themselves in a specific way.

Barriers to meaningful participation may include staff's lack of competence and training in how to talk about difficult and sensitive issues with youth (Skivenes, 2018; Strandbu, 2010), organizational factors, and bureaucratic case management rules (Ormstad et al., 2020). Over time, the residential care and treatment system has become more standardized, new systems have been implemented, and the demands for documentation are increasing. According to the National Association for Children's Welfare (Landsforeningen for barnevernsbarn), an organization for those formerly in residential care, the focus on documentation can be limiting and prevent participation adjusted to youth

(https://barnevernsbarna.no/om-oss/politisk-plattform/medvirkning/). Real and meaningful participation should include spontaneous everyday participation that can be initiated by the children themselves (Tjelflaat & Ulset, 2007). This can be different from the kind of participation that is fostered through routines and bureaucratic standards to meet the letter of the law.

Children's participation is a prerequisite for assessing the best interest of the child. The possibility for tension between the best-interest principle and a child's wishes does not simply reflect a conflict between a child's rights and an adult's duties toward the child. The concept of children's rights, as embodied in the UN Convention on the Rights of the Child, includes both the right to self-determination and the right to protection. Reconciling these two rights in practice—that is, between the adult's duty to promote the child's best interest and the adult's duty to consider the child's wishes and feelings—is essential.

The UN Convention on the Rights of the Child states that taking a child's views into account is essential but may be outweighed by other considerations (Thomas & O'Kane, 1998). Society is inclined to cherish and protect children, but at the same time, children increasingly are encouraged to participate. To balance the child's right to participate with the adult's need to protect the child requires instituting processes that ensure that youth are informed, heard, and involved, but not assigned too much responsibility. If staff see their roles as protecting rather than working in partnership with youth, the ability of youth residents to mobilize power on their own behalf may be stifled or undermined. The unintended result may be to perpetuate, rather than combat, youth's feelings of powerlessness. Several youths expressed feelings of powerlessness (Articles 3 and 4) when they felt that they had no possibility to influence their day-to-day lives and future plans.

Both the state and residential staff are responsible for making well-informed decisions based on the "best interest of the child." Engaging children in meaningful participation does not mean delegating decision-making to them. Making a decision and being responsible for that decision are heavy burdens that youth are not always equipped to bear. According to Thomas and O'Kane (1998), even when youth have a strong desire to participate, they seldom wish to be solely responsible for making decisions. The dual role of social work to provide care to and exercise control over youth has long been recognized and is of new relevance to discussions about governance and the delegation of responsibility (Warming, 2017). These two roles of social work, when enacted in residential care facilities, can create emotional tensions for youth and feelings of uncertainty about their safety (Furnivall, 2018; Moore, 2017). Viewing youth as autonomous may lead to expectations that youth carry heavier

responsibility for their own welfare. Youth then become responsible for acting according to the state's expectations and norms, and if they do not succeed, they are at fault (Mik-Meyer, 2017). In this dissertation, both youth and staff report that youth are responsible for asking for important information about their rights (Article 4), even when it is explicitly clear that adults should bear this responsibility. A child's opinions are likely to be a significant factor in staff's decisions in the child's best interest, but these opinions are only valuable when elicited in an environment that allows children to freely express their thoughts. Several studies have pointed out the power imbalance between children and staff in residential facilities and the obvious risk that the environment is not sufficiently open and free such that youth can express themselves fully. As described in Articles 3 and 4, youths indicated that they do not fully voice their opinions. Possible explanations can be that they perceive their relationships with staff as characterized by professionalism and/or they feel that they cannot influence staff`s decisions no matter what they say. Previous research has also highlighted youths' concerns that negative consequences could result if they express what they want or think (Tjelflaat & Ulset, 2007). Real and meaningful participation within the residential facilities as organized today seems impossible to achieve given the difficulty of creating space for free expression—a basic premise of participation—in facilities in which asymmetric power relations are inevitable. Fulfilling the obligation to act and decide in the best interest of the child is not possible if the real, freely expressed opinion of the child is not taken into account. Opportunities for youth to express their perspectives, identify problems, and catalyze change and improvements are essential (Green & Ellis, 2008). However, a child's views should only be considered if the child has been determined to be competent; that is, the child must have sufficient understanding to be able to comprehend what is being proposed.

Research into children's perspectives may reveal viewpoints that differ from those of staff, practitioners, and policymakers, all of whom often speak on behalf of children (Holland, 2009). There is a limited amount of research that foregrounds children's voices. However, researchers disagree as to how children's participation in research will ensure that children's voices are adequately represented in, and therefore be consequential to, policymaking and decision-making about matters affecting them (Van Bijleveld et al., 2014).

5.4 Safety for staff in residential facilities

The staff who participated in this study reported their perceptions of safety and experiences with the Basic Training Program in Safety and Security (Article 2).

5.4.1 Relationships and organizational support affecting staff safety

Most of the staff participants considered open, honest, and supportive relationships among colleagues and between colleagues and leaders to be the most important element affecting safety at work. Geoffrion et al. (2021) revealed a link between perceived openness and communication among staff members and fewer uses of R&S, which could also mean that strong communication among staff led to fewer conflict-filled situations and positively affected perceptions of safety. A staff group that is stable over time was also perceived as essential to staff safety (Article 2). This finding is supported by Euser et al. (2014), who state that safety can be achieved through predictability, stability, and fewer changes in staff and peer groups. Article 2 of this dissertation shows that organizational structures, stability, and predictability, including shared focus, goals, plans, and expectations, were important to staff members' feelings of safety. This finding supports that of Pelto-Piri et al. (2020), a study which indicates that organizational, situational, and relational factors play key roles in preventing violence. Supportive teams of staff members with beliefs in common are vital to violence prevention (Pelto-Piri et al., 2017).

Staff considered youth aggression to be a challenge that affects their well-being both on the job and when they are off work (Article 2). They stated a desire for clearer leadership and for the implementation of standard routines in the follow-up after unwanted situations; this implies that the current debriefing and staff support routines are insufficient. Pelto-Piri et al. (2020) support these findings, and show that effective violence prevention includes regular management follow-up with staff after violent incidents, along with increased psychological support. Similar to previous international research (Littlechild, 2003; Munobwa et al., 2023; Shier et al., 2019), our findings suggest that staff experience inadequate support from their managers and normalization when dealing with violence at the workplace and they see violence as part of the job. These perceptions may contribute to increased stress.

5.4.2 Education and training contribute to increased safety

Staff believe that the Basic Training Program in Safety and Security improved their safety by enhancing their awareness of conflict situations before and as they occur, stimulating more reflection after they occur, and contributing to more systematic work processes, more coordinated teamwork, and more reflection and prevention efforts (Article 2). As a result, staff reported feeling better prepared for potential undesirable situations. They stressed that receiving sufficient and uniform education and training is important to their sense of safety. This finding corresponds with that of Pelto-Piri et al. (2020), which notes that

improving staff competence in the use of de-escalation techniques can help prevent aggression and violence. Smith et al. (2017) conclude that client violence can be reduced if de-escalation and behavior-management techniques are used properly. The use of R&S in conjunction with handling conflict situations is often perceived by staff as challenging and can create feelings of unsafety. Reviews of strategies for reducing the use of R&S have concluded that clear and predictable leadership, coupled with staff training and preventive interventions, can yield promising outcomes (LeBel et al., 2010; Scanlan, 2010).

Several programs implemented in residential facilities have similar goals to those of the Basic Training Program in Safety and Security (Article 1). One example is the CARE program (Izzo et al., 2016), which has shown a significant decline in different types of behavioral incidents, including youth aggression. Another program is the Non-violence Resistance program (Van Gink et al., 2018), which aims to increase staff confidence, improve team functioning, and decrease the number of aggressive incidents through various measures, including de-escalation and reflection. Multilevel analysis of the program shows significant positive effects on team functioning, team satisfaction, and shared vision and commitment (ibid.). Our findings correspond with those of Van Gink et al. They indicate that teams that are better coordinated and more supportive and stable contribute to enhancing staff perceptions of safety. Our study found that several of the Basic Training Program's aims were reportedly met, among them increased safety in the perception of staff members who attended the program (Article 2). Even if the findings of this study are not generalizable, they suggest that training in prevention and management of conflict and aggression may be important in increasing perceptions of safety of staff who work in youth residential facilities. However, it cannot be concluded that staff member's enhanced perceptions of safety are the result of their having attended this particular training program (Article 2). It is also not possible to say with certainty which particular aspect of the training program or its content may have been responsible for the reported change in staff perceptions. It is possible that staff perceptions were influenced by other programs present in the residential facilities. It may also be that, as indicated by Macdonald and Millen (2012), having a framework, regardless of which model is used, has improved practitioner's knowledge and ability to provide good care and treatment.

5.4.3 Staff perceptions of safety influence care and treatment of youth

Given that aggression is often a response to powerlessness (Isdal, 2000; Lillevik & Øien, 2010), the attitudes and actions of staff can influence outcomes for themselves and for the youth in their care. During periods of emotional exhaustion, staff may mismanage defiant

youth behaviors, triggering the youth and creating tense situations (Geoffrion et al., 2021). Studies of patients in psychiatric settings suggest that when caregivers are perceived as cold or indifferent, the patient's feelings of vulnerability, powerlessness, and fear increase as do the possibilities for violence (Gudde et al., 2015). Staff members indicated that, as a result of the Basic Training Program in Safety and Security, they are more coordinated as a team, more confident at work, and perhaps better able to handle conflict situations without being overwhelmed by their own feelings (Article 2). These findings imply that these staff members may thus be better able to extend recognition to the youth in their care, and thereby reduce youth displays of frustration caused by feelings of powerlessness. Staff reported that they have more confidence in each other that each will act as had been agreed upon in various situations, and that they feel more united as a team (Article 2). As a result, they experienced an increased sense of safety and greater trust in each other; these, in turn, can contribute to ensuring more predictability and stability in their relationships with youth. One negative result of the staff feeling united is that, as the youths reported, they felt that they had no influence over situations and that, no matter what they said, staff had decided and would not changing their minds. This presents a challenge: how to increase safety, predictability, and stability and, at the same time, ensure that staff remain open to altering decisions after seriously considering youth's opinions (Article 4)?

When staff are faced with violence, role conflicts may occur (Munobwa et al., 2023). Staff are normally committed to promoting youth well-being (Barnard et al., 2008). When faced with violence, staff's role as helper is challenged. Yet, despite the violence, staff remain responsible for providing care. Staff's commitment to considering the needs of children seems to supersede their concerns about their own safety when managing situations involving aggression and violence. This professional dilemma highlights a stress moment for social workers (Munobwa et al., 2023), a conclusion affirmed by the staff who participated in this study (Article 2).

Work at residential facilities often involves emotionally charged interactions with youth and puts staff at risk of experiencing violence. Therefore, staff recognize and contemplate the risk of being exposed to violence, and this contributes to their psychological stress. The stress that staff can experience during interactions with youth who show aggression or commit violence can also undermine the cognitive, emotional, and behavioral skills staff need to de-escalate conflicts. Practitioners who participated in the study by Kor et al. (2021) drew attention to the emotional cost of care. They described experiencing anxiety and self-blame for youths' risk-taking behaviors, being affected by the intensity of the work

and recurrent exposure to potentially traumatic events, and having difficulty leaving behind thoughts of work when off the job. The participants of this study also reported bringing work-related worries home with them, spending lots of time before and after work processing stress-related experiences, and worrying about going back to work the next day (Article 2). Several staff participants in our study believe that feeling unsafe at work increases fatigue, stress, and avoidance (Article 2). They reported that they sometimes avoid youths or situations that they find highly stressful. According to Engström et al. (2023) staff`s passive, avoidant behavior can lead to irritation and withdrawal responses from youth.

An alternative to avoidance can be defensiveness. Staff participants reported that, if they feel unsafe or insecure, they may be stricter in the way they communicate with youth (Article 2), which in turn may trigger the youth and lead to increased conflict and aggressive responses as well as to impaired trust in staff (Engström et al., 2023). Our findings that aggression negatively affects staff are supported by other studies (Fraser et al., 2016; Lamothe et al., 2018; Winstanley & Hales, 2014). The consequences, as shown in Chapter 2, can be serious and undesirable, including staff burn-out and turnover (Baugerud et al., 2018; Colton & Roberts, 2007; Conrad & Kellar-Guenther, 2006; Maslach et al., 2001; Parveen et al., 2023; Seti, 2008). According to Kor et al. (2021), as well as to the participants in this study (Article 2), the emotional cost to staff has a direct impact on the quality of care that staff provide to youth.

Accordingly, conscious efforts directed at protecting staff well-being are likely to benefit those for whom they provide care. Interventions that promote staff`s awareness of their emotional state and how their actions affect others could help them recognize when to withdraw from escalating situations and how to communicate and rely on colleagues (Winstanley & Hales, 2014).

6 Conclusion

This dissertation contributes to the growing literature on how practices in residential facilities are experienced, providing new information about both staff and youth perceptions of living and working in these facilities. Staff are confronted with demands from youth and standards set by the government, which are at times in conflict. At the same time, they must provide justifiable and good quality care and treatment. Staff have to balance control, care,

treatment, youth participation, and respect for youth's rights, which creates dilemmas and makes ethical reflection a prerequisite of providing proper care and treatment.

Of particular significance are five findings of this dissertation. First, results suggest that the facilitation and implementation of meaningful participation for youth living in residential facilities is inadequate. The research points to weaknesses with respect to the extent of the information that youth receive and the way that it is presented to them. There are also challenges to meeting the requirement that youths be permitted and encouraged to express their views freely and have their views taken into account. Children have the right to be protected when living in residential facilities, and at the same time, they have the right to participate. This dissertation's findings suggest that, in practice in residential facilities, it is challenging to both fulfill the duty to protect youth and ensure youth's right to participate. They indicate as well that youth in residential facilities feel that they lack an overview of and control and influence over their lives.

A second important finding is that some youths in residential facilities experience aimlessness and powerlessness. Several youths reported feeling that their everyday lives are on hold, and they are just waiting for life to start. Youths reported that they do not see themselves as meaningful to others, and so have no reason to get up in the morning. Youths stated that they feel powerless in voicing their opinions, saying, for example, that there is no use arguing with staff or complaining to the state administrator.

Third, this dissertation finds that youths' private rooms and their locations, as well as their relationships with staff are important to youths' perceptions of safety. This information contributes to deepening understanding of youth's perspectives on what life is like in residential facilities, and it highlights safety as an important concern for youth as well as for staff.

Fourth, this dissertation finds that residential staff members who participated in the Basic Training Program in Safety and Security perceived the program to be helpful and reported that it offered useful guidance for preventing and managing conflict situations with youth. Staff viewed the program as achieving many of its goals, including increasing the conscious thought of staff before applying physical restraint, improving staff communication skills, increasing staff reflection, preventing aggression and conflict, enhancing team coordination and staff unity, and increasing staff awareness of themselves and others. It is hoped that this increased competence will benefit youth living in residential facilities and decrease the number of incidents of aggression and conflict.

Fifth, this dissertation notes that research on the effects of intervention in preventing/managing aggression and violence in residential youth facilities is limited, as is research on the effects and experiences of R&S in these facilities. The main strength of the review conducted as part of this project is its broad focus. It widely informed the qualitative part of this project.

Although this study provides important insights, it also has limitations. Despite the limitations, the findings provide a foundation for understanding perceptions of safety and meaningful participation in residential facilities and the factors that influence them. The chosen method made it possible to uncover information about the lived experiences of the participants. The presence and inclusion of youth voices is one of the project's main strengths and contributed to a wider understanding of the themes the project investigated. It would not have been possible to grasp the dimensions of youth perceptions and experiences without the participation of the youths.

Although the findings are limited to residential facilities in Norway, they are relevant to youth residential care and treatment in general and to professionals working in these settings. Residential facilities can benefit from the dissertation's findings to gain awareness of shortcomings and develop better support systems and resources for their staff and the youth in their care.

7 Applied relevance for care and treatment practice

This study has several implications for practice. Greater awareness is needed of the legally binding obligation to respect children's viewpoints and involve them in all matters concerning them when they live in residential facilities. Achieving a child's best interest is only possible if the child has sufficient information, and if the child's views are expressed freely, listened to, and fully considered. It is essential to recognize the power of staff and the significance of context in potentially influencing what a child expresses. It is possible to implement procedural safeguards to make the process of meaningful participation more transparent and create conditions that make it difficult for adults to solicit but then ignore the opinions of children. If the child's point of view is understood to be formed in the course of meaningful participation, then participation must become more process-oriented.

Children's awareness of their legal right to participate needs to be increased and residential facilities need to do more to ensure that children can actually participate. One way

to do this is to increase staff competence, through additional education and training in the promotion of all dimensions of meaningful participation, and staff awareness of the influence of power and governmentality. This should include training on how to provide children with adjusted and sufficient information so that they can participate in a meaningful way. The education and training of staff should be systematic and ongoing to increase knowledge and understanding of youth's right to participate and the best way to facilitate realization of this right. Implementing meaningful participation will also require that staff create safe spaces and a context that allows children to communicate and express themselves freely. Residential facilities, as organized today, lack youth-adapted arenas in which youth can speak freely with others who do not have the power to respond to their views with negative consequences. Additionally, youth must be able to form trusting relationships with staff if dialogue, listening, and involvement over time are to be achieved. Trusting relationships will also facilitate the process of participation. This study also recommends that the state administrator initiate and have more direct contact with youth, for example, by participating in activities that youth enjoy. The state administrator should be in direct contact with children rather than using staff as intermediaries; this will increase children's opportunities to speak freely to the state administrator. Attention needs to be paid as well to the extent that adults influence children's expression.

On the basis of previous research and this dissertation, it is recommended that children have the right of access to advocates or other competent adults with whom they can build safe and trusting relationships, who can ensure their right to sufficient and adjusted information, and who can facilitate the expression of their views freely without fear of negative consequences. An independent person should be appointed to track children who are placed outside their original homes. It is also important that they have a guaranteed ability to complain if they feel that decisions have been made that do not take their views into account. Youth complaints about staff at a particular facility should not automatically be passed on to the staff.

To ensure good quality care and treatment, there is a need to reflect critically on the connection between actualization of participation and the way that staff members view children. Do they see children as competent and active? Or as vulnerable and irresponsible? Such reflection is essential before determining what a child's limitations are, and which decisions are in a child's best interest. In addition, it is essential that the facility work to help children to live meaningful lives, recognize that they matter to others and that others matter to them, and provide them something to get up for in the morning.

In line with previous research, findings in this dissertation recommend residential facilities strive to create and sustain environments that support healthy development for children and ensure physical and psychological safety for both children and staff. The findings also indicate that equipping and training staff in building trusting and safe relationships with children should be a top priority. Staff must flexibly adapt their professional roles to meet youth's need for mutual, reciprocal relationships. Staff must be aware of how their attitudes and behaviors affect youth and strive to be open, caring and respectful, to provide youth a safe environment that facilitate healthy development. There should be a continuous focus on staff practices, sustained by organizational, collegial, and leadership support, to improve the quality of staff's relationships with youth and to avoid staff turnover and the concomittant disruption in the relationship between youths andcaregivers.

Moreover, when working to increase the quality of care and treatment, children's perspectives of staff and of overall safety should be considered and should inform practice. These perspectives are valuable and should be included in staff and safety assessments. Preventing and reducing the use of R&S is important to prevent damage to the relationships between children and staff and to increase youth and staff perceptions of the institution as a safe place. Given the damage caused by exposure to violence and life in an unsafe environment, acting to increase safety must remain a high priority. Facility structures must be arranged to grant children influence and agency, to foster respect, trust, and mutual relationships, and to ensure continual evaluations of the ethics and practices of control and coercion in these facilities.

The findings of this dissertation, in conjunction with previous research, point to the need to maintain a focus on staff behaviors and attitudes in order to develop effective staff education and training programs as well as organizational policies to achieve the goals of reducing conflict, aggression, violence, and the use of R&S. Further, this dissertation's findings suggest the benefits to staff of education and training in how to improve safety in residential facilities; therefore, all staff members should receive this instruction. The Basic Training Program in Safety and Security appears to have strong potential to furnish staff with enhanced skills and knowledge to identify, prevent, and de-escalate conflict in residential youth facilities. The dissertation's findings suggest that education and training for staff should focus on improving those skills that are perceived as important to meet the needs of children placed in residential facilities and that yield best practice. Underscoring the need for more staff education and training is the fact that the conscious and unconscious misuse of power by staff and the rationalization of this misuse are among the main causes of youth's experience

of repression. More attention also needs to be paid to residential staff's skills in establishing and maintaining positive relationships with children and creating safe spaces for children's meaningful participation.

The dissertation provides relevant data for reflection on future action to improve care and treatment in residential facilities, thereby contributing to policies aimed at consistently implementing education and training program for staff to better provide services to children in residential care facilities. The vulnerability that characterizes children who navigate the protection system intensifies the social and legal responsibility of all entities committed to the safety and well-being of children and to respect for their rights.

8 Future research

This study makes several recommendations for future research. More research is urgently needed about the ways that staff can enhance youth's feelings of safety and meaningfulness and promote youth's healthy development in both their everyday lives and futures. Youth's own perspectives on what they require to lead meaningful lives and experience healthy development are important and fundamental to ensuring that residential care and treatment are of high quality. It is also essential to gain further knowledge of how staff view and understand the youth and how their views affect practice, especially when it comes to the use of power, restrictions, and coercion. To advance knowledge about how to improve the safety and quality of care for youth and the health and safety of staff, investigation is needed into how staff prevent and manage aggression and conflicts in practice and how their actions affect youth. Additional studies are also needed on how to create more work-team stability and establish safe relationships with youth that last over time. Research is lacking on how physical facilities affect feelings of safety. More consideration should also be given to the importance attributed by youth in this study to their rooms and their location within the residential facilities in relation to improving the quality of youth residential care. Further studies might apply observational techniques to investigate the topics discussed here, to map what is actually occurring and compare it to self-reported data from interviews. More research is also needed in countries besides the USA. Due to the small sample size in this study, studies with larger samples are needed to gauge the importance of both staff and youth safety and well-being in residential facilities more generally.

Further studies are needed of the practical implications of education and training programs for preventing and minimizing aggression, violence, and use of R&S, as well as of the effects and experiences of physical restraint. Research has yet to be conducted on the different elements of interventions such as the Basic Training Program in Safety and Security and other similar programs. For example, studies that identify the elements of staff education and training that produce the desired changes in staff behavior and youth responses would be beneficial. Randomized, controlled studies that investigate the effects of interventions are also needed to gain more knowledge about causality. More empirical work is essential to determine if interventions work as intended, which aspects of the interventions work, and if the interventions benefit both youth and staff. Most of the studies and reviews included in our mapping review were based on self-reported data, such as surveys, questionnaires, interviews, and reports (Article 1). Although these studies suggest that guidelines, frameworks, education, and training may increase staff's personal knowledge and change their attitudes and practices, we still need studies that reveal how the prevention and management of aggression and the use of R&S are perceived by youths. More research is needed on the use of various coercion measures as these present challenges related to ethics, jurisdiction, and effectiveness of treatment. In response to the need for further research into the use of coercion, my next project will involve analyzing approximately 2,000 coercion protocols written by staff in ten different residential facilities in 2021 to investigate the documentation and practice of coercive measures and the participation by, and protection of the rights of, children. In conducting this research, I will cooperate with researchers at Research Group for Prevention and Treatment at the Center for Child and Adolescent Mental Health, Eastern and Southern Norway. I also plan to collaborate with researchers who use observation methods inside residential facilities. This research aims to expand knowledge to better ensure that residential facilities protect children's rights. Further studies may lead to enhancement of youth's perceptions of safety, participation, and control and to increased feelings of connectedness and being heard. As such, they could contribute to a reduction in youth's feelings of powerlessness and in incidences of conflict, aggression, and the use of coercion.

Reference list

Aamodt, H. (2015). Brukermedvirkning i barneverntjenesten — en dispositiv analyse. *Tidsskrift for Arbejdsliv*, *17*, 70–86. https://doi.org/10.7146/tfa.v17i2.108993

AbuAlRub, R. F. (2004). Job Stress, Job Performance, and Social Support Among Hospital Nurses. *Journal of Nursing Scholarship*, *36*(1), 73–78 https://doi.org/10.1111/j.1547-5069.2004.04016.x

Ahonen, L., & Degner, J. (2014). Working with complex problem behaviors in juvenile institutional care: staff's competence, organizational conditions and public value. *International journal of prisoner health*, *10*(4), 239–251. https://doi.org/10.1108/IJPH-04-2013-0018

Ainsworth, F., & Thoburn, J. (2014). An exploration of the differential usage of residential childcare across national boundaries. *International Journal of Social Welfare*, *23*(1), 16–24. https://doi.org/10.1111/ijsw.12025

Alink, L. R. A., Euser, S., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (2014). A Challenging Job: Physical and Sexual Violence Towards Group Workers in Youth Residential Care. *Child & Youth Care Forum*, *43*(2), 243–250. https://doi.org/10.1007/s10566-013-9236-8

Allen, J. J., Anderson, C. A., & Bushman, B. J. (2018). The General Aggression Model. *Current Opinion in Psychology*, *19*, 75–80. https://doi.org/10.1016/j.copsyc.2017.03.034

Alvesson, M. & Skoldberg, K. (2009). *Reflexive Methodology.* SAGE

Andenæs, A. (2000). Generalisering: Om ringvirkninger og gjenbruk av resultater fra en kvalitativ undersøkelse. I Haavind, H. (Red.), *Kjønn og fortolkende metode: Metodiske muligheter i kvalitativ forskning.* Gyldendal Akademisk.

Anderson, N. L. R., & Roper, J. M. (1991). The interactional dynamics of violence, part II: Juvenile detention. *Archives of psychiatric nursing*, *5*(4), 216–222. https://doi.org/10.1016/0883-9417(91)90049-B

Andersson, P. (2020). Handling fear among staff: violence and emotion in secure units for adolescents. *Nordic Social Work Research*, *10*(2), 158–172. https://doi.org/10.1080/2156857X.2019.1583598

Andersson, P. (2022). Secure Units as Emotional Sites: Staff Perceptions of Fear and Violence at Secure Units for Young People in Sweden. *Residential treatment for children & youth*, *39*(4), 387–415. https://doi.org/10.1080/0886571X.2022.2041533

Andersson, P., & Överlien, C. (2018). 'If you take it personally you break' Neglected voices on violence in secure units for adolescentssw. *Social Work and Social Sciences Review*, *19*(3), 61–80. https://doi.org/10.1921/swssr.v19i3.1191

Andersson, P., & Överlien, C. (2021). Violence, role reversals, and turning points: work identity at stake at a therapeutic residential institution for adolescents. *Journal of Social Work Practice*, *35*(4), 353–366. https://doi.org/10.1080/02650533.2020.1835848

Anglin, J. P. (2002). *Pain, Normality, and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth* (1 ed.). Routledge. https://doi.org/10.4324/9781315808741

Anglin, J. P. (2004). Creating "Well-Functioning" Residential Care and Defining Its Place in a System of Care. *Child and Youth Care Forum*, *33*(3), 175–192. https://doi.org/10.1023/B:CCAR.0000029689.70611.0f

Aquilina, C. (1991). Violence by Psychiatric In-Patients. *Medicine, Science and the Law*, *31*(4), 306–312. https://doi.org/10.1177/002580249103100406

Arbeidsmiljøloven. (2022). https://lovdata.no/dokument/NL/lov/2005-06-17-62

Archard, D., & Skivenes, M. (2009). Hearing the child. *Child & Family Social Work*, *14*(4), 391–399. https://doi.org/10.1111/j.1365-2206.2008.00606.x

Arsenio, W. F., Adams, E., & Gold, J. (2009). Social information processing, moral reasoning, and emotion attributions: Relations with adolescents reactive and proactive aggression. *Child Development*, *80*(6), 1739–1755. https://doi.org/10.1111/j.1467-8624.2009.01365.x

Attar-Schwartz, S. (2008). Emotional, behavioral and social problems among Israeli children in residential care: A multi-level analysis. *Children and Youth Services Review*, *30*(2), 229–248. https://doi.org/10.1016/j.childyouth.2007.09.009

Attar-Schwartz, S. (2013). Runaway behavior among adolescents in residential care: The role of personal characteristics, victimization experiences while in care, social climate, and institutional factors. *Children and Youth Services Review*, *35*(2), 258–267. https://doi.org/10.1016/j.childyouth.2012.11.005

Attar-Schwartz, S. (2017). Experiences of victimization by peers and staff in residential care for children at risk in Israel from an ecological perspective. *Child maltreatment in residential care: History, research, and current practice*, 269–299. Springer International Publishing/Springer Nature. https://doi.org/10.1007/978-3-319-57990-0_13

Attar-Schwartz, S., & Khoury-Kassabri, M. (2015). Indirect and verbal victimization by peers among at-risk youth in residential care. *Child abuse & neglect*, *42*, 84–98. https://doi.org/10.1016/j.chiabu.2014.12.007

Atwool, N. (2006). Participation in Decision-making: The Experience of New Zealand Children in Care. *Child Care in Practice*, *12*(3), 259–267. https://doi.org/10.1080/13575270600761727

Azeem, M., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2017). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, *30*(4), 170–174. https://doi.org/10.1111/jcap.12190

Backe-Hansen, E. (2011). *Institusjonsplassering - siste utvei?: betydningen av barnevernsreformen fra 2004 for institusjonstilbudet* (Vol. 21/2011). Norsk institutt for forskning om oppvekst, velferd og aldring.

Backe-Hansen, E., Løvgren, M., Neumann, C. B., & Storø, J. (2017). *God omsorg i barnevernsinstitusjoner*.

Baeza, I., Correll, C. U., Saito, E., Amanbekova, D., Ramani, M., Kapoor, S., & Carbon, M. (2013). Frequency, Characteristics and Management of Adolescent Inpatient Aggression. *Journal of child and adolescent psychopharmacology*, *23*(4), 271–281. https://doi.org/10.1089/cap.2012.0116

Bakermans-Kranenburg, M., Dobrova-Krol, N., & van IJzendoorn, M. (2011). Impact of institutional care on attachment disorganization and insecurity of Ukrainian pre-schoolers: Protective effect of the long variant of the serotonin transporter gene (5HTT). *International Journal of Behavioral Development, 36*(1), 11–18. https://doi.org/10.1177/0165025411406858

Bakketeig, Gautun, H. & Backer, A. Grønningsæther (2011). *Institusjonsplassering - siste utvei? Betydningen av barnevernsreformen fra 2004 for institusjonstilbudet.* NOVA – rapport nr 21/11. https://www.bufdir.no/bibliotek/Dokumentside/?docId=120040972

Ballentine, K. L., Huerta, C., Lee, H., & Mz Farmer, E. (2023). The Importance of Youth Perspectives in Understanding Perceptions of Safety and Outcomes in Group Homes. *Children and Youth Services Review*, https://doi.org/10.1016/j.childyouth.2023.107052

Barnard, A., Horner, N., & Wild, J. (2008). *The value base of social work and social care: an active learning handbook*. McGraw-Hill Education.
Barneombudet. (2020). *«De tror vi er shitkids» Rapport om barn som bor på barnevernsinstitusjon*.
Barneombudet. (2015). *Grenseløs omsorg. Om bruk av tvang mot barn i barnevern og psykisk helsevern.*
Barnevernsloven (2021). LOV-2021-06-18-97. https://lovdata.no/dokument/NL/lov/2021-06-18-97
Bath, H. (2015). The three Pillars of Traumawise care: Healing in the other 23hours. *Reclaiming Children & Youth*, *23*(4), 5–11. https://www.traumebevisst.no/kompetanseutvikling/filer/23_4_Bath3pillars.pdf
Baugerud, G. A., Vangbæk, S., & Melinder, A. (2018). Secondary traumatic stress, burnout and compassion satisfaction among Norwegian child protection workers: Protective and risk factors. *British Journal of Social Work*, *48*(1), 215–235.
Bell, M. (2002). Promoting children's rights through the use of relationship. *Child & Family Social Work*, *7*(1), 1–11. https://doi.org/10.1046/j.1365-2206.2002.00225.x
Bellonci, C., Huefner, J. C., Griffith, A. K., Vogel-Rosen, G., Smith, G. L., & Preston, S. (2013). Concurrent reductions in psychotropic medication, assault, and physical restraint in two residential treatment programs for youth. *Children and Youth Services Review*, *35*(10), 1773–1779. https://doi.org/10.1016/j.childyouth.2013.08.007
Bergsund, H., & Nøkleby, H. (2023). *Bruk av tvang og grensesetting I barnevernsinstitusjoner og fosterhjem: systematisk kartleggingsoversikt (oppdatering). (The use of force and limit-setting for children and youth in residential childcare and fostercare: systematic scoping review (update).* https://www.nb.no/items/URN:NBN:no-nb_pliktmonografi_000022150
Berkowitz, L. (1993). *Aggression: Its causes, consequences, and control*. Mcgraw-Hill Book Company.
Bessell, S. (2011). Participation in decision-making in out-of-home care in Australia: What do young people say? *Children and Youth Services Review*, *33*(4), 496–501. https://doi.org/10.1016/j.childyouth.2010.05.006
Bessell, S., & Gal, T. (2009). Forming Partnerships: The Human Rights of Children in Need of Care and Protection. *International Journal of Children's Rights*, *17*(2), 283–298. https://doi.org/10.1163/157181808X358258
Birks, M. & Mills, J. (2015). *Grounded theory: A practical guide,* 2nd. Ed. Sage
Bitton, M. S., & Rajpurkar, S. (2015). Therapeutic crisis intervention system in residential care for children and youth: staff knowledge, attitudes, and coping styles. *Children and Youth Services Review*, *56*, 1–6. http://www.journals.elsevier.com/children-and-youth-services-review/
Black, V., Bobier, C., Thomas, B., Prest, F., Ansley, C., Loomes, B., Eggleston, G., & Mountford, H. (2020). Reducing seclusion and restraint in a child and adolescent inpatient area: implementation of a collaborative problem-solving approach. *Australasian Psychiatry*, *28*(5), 578–584. https://doi.org/10.1177/1039856220917081
Blakemore, T., Herbert, J. L., Arney, F., & Parkinson, S. (2017). The impacts of institutional child sexual abuse: A rapid review of the evidence [Behavior Disorders & Antisocial Behavior 3230]. *Child abuse & neglect*, *74*, 35–48. http://doi.org/10.1016/j.chiabu.2017.08.006
Bogo, M., Shlonsky, A., Lee, B., & Serbinski, S. (2014). Acting Like It Matters: A Scoping Review of Simulation in Child Welfare Training. *Journal of public child welfare*, *8*(1), 70–93. https://doi.org/10.1080/15548732.2013.818610

Bouma, H., López López, M., Knorth, E. J., & Grietens, H. (2018). Meaningful participation for children in the Dutch child protection system: A critical analysis of relevant provisions in policy documents. *Child abuse & neglect*, *79*, 279–292. https://doi.org/10.1016/j.chiabu.2018.02.016

Bower, F. L., McCullough, C. S., & Timmons, M. E. (2003). A Synthesis of What We Know About the Use of Physical Restraints and Seclusion with Patients in Psychiatric and Acute Care Settings: 2003 Update. *Worldviews on Evidence-based Nursing presents the archives of Online Journal of Knowledge Synthesis for Nursing*, *E10*(1), 1–29. https://doi.org/10.1111/j.1524-475X.2003.00001.x

Bowlby, J. (1953). *Child care and the growth of love.* Harmondsworth.

Bowlby, J. (1973). *Attachment and loss: Separation; Anxiety and anger.* Basic books.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory.* Routledge.

Braga, T., Gonçalves, L. C., Basto-Pereira, M., & Maia, Â. (2017). Unraveling the link between maltreatment and juvenile antisocial behavior: A meta-analysis of prospective longitudinal studies. *Aggression and Violent Behavior*, *33*, 37–50. https://doi.org/10.1016/j.avb.2017.01.006

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Quality Research in Psychology,* 3(2). 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* Sage

Braun, V. & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research,* 21(1), 37–47

Bredal, A., Stefansen, K. & Bjørnholt, M. (2022). Why do people participate in research interviews? Participant orientations and ethical contracts in interviews with victims of interpersonal violence. *Qualitive Research, 0* (0). https://doi.org/10.1177/14687941221138409

Brend, D. M. (2020). Residential childcare workers in child welfare and moral distress. *Children and Youth Services Review*, *119*, 105621. https://doi.org/10.1016/j.childyouth.2020.105621

Briggs, E. C., Greeson, J. K. P., Layne, C. M., Fairbank, J. A., Knoverek, A. M., & Pynoos, R. S. (2012). Trauma Exposure, Psychosocial Functioning, and Treatment Needs of Youth in Residential Care: Preliminary Findings from the NCTSN Core Data Set. *Journal of Child & Adolescent Trauma*, *5*(1), 1–15. https://doi.org/10.1080/19361521.2012.646413

Bronsard, G., Alessandrini, M., Fond, G., Loundou, A., Auquier, P., Tordjman, S., & Boyer, L. (2016). The prevalence of mental disorders among children and adolescents in the child welfare system. *Medicine, 95*(7), e2622. https://doi.org/10.1097/MD.0000000000002622

Bruce, M. (2014). The Voice of the Child in Child Protection: Whose Voice? *Social Sciences*, *3*(3), 514–526. https://www.mdpi.com/2076-0760/3/3/514

Bryman A. (2016). *Social research methods*. Oxford University Press

Bryson, S. A., Gauvin, E., Jamieson, A., Rathgeber, M., Faulkner-Gibson, L., Bell, S., Davidson, J., Russel, J., & Burke, S. (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International journal of mental health systems*, *11*, 36. https://doi.org/10.1186/s13033-017-0137-3

Bufdir. (2020). Barneverninstitusjoner. https://bufdir.no/barnevern/Tiltak_i_barnevernet/Barnevernsinstitusjoner

Bufdir. (2022a) *Oppdrag 2 tillegg 3 til TB2022. Helhetlig kunnskapsgrunnlag tvang og rettigheter i institusjon.*
Bufdir. (2022b). *Turnover blant ansatte i barnevernet - hvorfor slutter så mange? En nasjonal omfangsundersøkelse av årsaker og kjennetegn ved tjenester og institusjoner med høy turnover.*
Burr, V. (2003). Social Constructionism (2nd Ed). Routledge.
Bury, M. (1986). Social constructionism and the development of medical sociology. Sociology of Health and Illness 8(2), 137–169
Bushman, B. J., & Anderson, C. A. (2001). Is it time to pull the plug on hostile versus instrumental aggression dichotomy? *Psychological Review*, *108*(1), 273.
Cahill, O., Holt, S., & Kirwan, G. (2016). Keyworking in residential child care: Lessons from research. *Children and Youth Services Review*, *65*, 216–223. https://doi.org/10.1016/j.childyouth.2016.04.014
Clakins, S.D., & Hill, A. (2007). Caregiver influences on emerging emotion regulation: biological and environmental transactions in early development. In J.J. Gross (Ed.), *Handbook of emotion regulation (*pp. 229–248). Guilford.
Campbell, F., Tricco, A.C., Munn, Z. *(*2023) Mapping reviews, scoping reviews, and evidence and gap maps (EGMs): the same but different— the "Big Picture" review family. *Syst Rev* **12**, 45. https://doi.org/10.1186/s13643-023-02178-5
Cantwell, N. (1993). Monitoring the Convention through the Idea of the "3P`s". In *Eurosocial report 45*
Carey, M. A. (2016). Focus Groups—What Is the Same, What Is New, What Is Next? *Qualitative Health Research*, *26*(6), 731–733. https://doi.org/10.1177/1049732316636848
Carr, A., Duff, H., & Craddock, F. (2018). A systematic review of reviews of the outcome of severe neglect in underresourced childcare institutions. *Trauma, Violence & Abuse, 21*(3), 484–497. https://doi.org/10.1177/1524838018777788
Carr, A., Duff, H., & Craddock, F. (2020). A Systematic Review of the Outcome of Child Abuse in Long-Term Care. *Trauma, Violence, & Abuse*, *21*(4), 660–677. https://doi.org/10.1177/1524838018789154
Cashmore, J. (2002). Promoting the participation of children and young people in care. *Child abuse & neglect*, *26*(8), 837–847. https://doi.org/10.1016/S0145-2134(02)00353-8
Chama, S., & Ramirez, O. (2014). Young people's perceptions of a group home's efficacy: A retrospective study. *Residential treatment for children & youth*, *31*(2), 120–134.
Charmaz, K. (2000). Grounded theory objectivist and constructivist method. In Denzin, N. and Lincoln, Y. (Eds.), Handbook of Qualitative Research, 509– 535. Sage
Charmaz, K. (2014). Grounded Theory in Global Perspective: Reviews by International Researchers. *Qualitative Inquiry*, *20*(9), 1074–1084 https://doi.org/10.1177/1077800414545235
Chawla, L. (2001). Evaluating children`s participation: Seeking areas of consensus *PLA Notes*, *42*(october), 9–13.
Chow, W. S., & Priebe, S. (2013). Understanding psychiatric institutionalization: a conceptual review. *BMC psychiatry*, *13*(1), 1–14. https://doi.org/10.1186/1471-244X-13-169
Christensen, G. (2023). Three concepts of power: Foucault, Bourdieu, and Habermas. *Power and Education. 1–14.* https://doi.org/10.1177/17577438231187129
Cohen, Manion, L. and Morrison, K. (2011). *Research Methods in Education*. 7th ed. Routledge
Collin-Vézina, D., Coleman, K., Milne, L., Sell, J., & Daigneault, I. (2011). Trauma Experiences, Maltreatment-Related Impairments, and Resilience Among Child

Welfare Youth in Residential Care. *International Journal of Mental Health and Addiction*, *9*(5), 577–589. https://doi.org/10.1007/s11469-011-9323-8

Colton, M., & Roberts, S. (2007). Factors that contribute to high turnover among residential child care staff. *Child & Family Social Work*, *12*(2), 133–142. https://doi.org/10.1111/j.1365-2206.2006.00451.x

Connor, D. F., Doerfler, L. A., Toscano, P. F., Volungis, A. M., & Steingard, R. J. (2004). Characteristics of Children and Adolescents Admitted to a Residential Treatment Center. *Journal of child and family studies*, *13*(4), 497–510. https://doi.org/10.1023/B:JCFS.0000044730.66750.57

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse Negl*, *30*(10), 1071–1080. https://doi.org/10.1016/j.chiabu.2006.03.009

Cossar, J., Brandon, M., & Jordan, P. (2016). 'You've got to trust her and she's got to trust you': children's views on participation in the child protection system. *Child & Family Social Work*, *21*(1), 103–112. https://doi.org/10.1111/cfs.12115

Costa, M., Tagliabue, S., Matos, P. M., & Mota, C. P. (2020). Stability and change in adolescents' well-being: The role of relationships with caregivers in residential care. *Children and Youth Services Review, 119*. Advanced online publication. https://doi.org/10.1016/j.childyouth.2020.105567

Costa, M., Tagliabue, S., Melim, B., Mota, C. P., & Matos, P. M. (2022). Adolescents' attachment, quality of relationships with residential caregivers, and emotion regulation. *Journal of Adolescence, 94*(5), 703–717. https://doi.org/10.1002/jad.12057

Courtney, M. E., & Iwaniec, D. (2009). *Residential Care of Children : Comparative Perspectives*. Oxford University Press, Incorporated. http://ebookcentral.proquest.com/lib/hioa/detail.action?docID=415720

Coutant, I. (2016). The psychiatric treatment of 'behavioural problems' in adolescence: Between coercion and socialisation. *Anthropology & Medicine*, *23*(3), 259–274. https://doi.org/10.1080/13648470.2016.1185681

Cox, A. (2011). Doing the programme or doing me? The pains of youth imprisonment. *Punishment & Society*, *13*(5), 592–610. https://doi.org/10.1177/1462474511422173

Cox, R. (2004). The path-dependency of an idea: why Scandinavian welfare states remain distinct. *Social Policy & Administration, 38*(2), 204–219.

Craib, I. (1997). Social Constructionism as a Social Psychosis. Sociology 31(1), 1– 15.

Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. SAGE Publications. https://books.google.se/books?id=4uB76IC_pOQC

Crewe B (2009) *The Prisoner Society: Power, Adaptation and Social Life in an English Prison*. Clarendon Press.

Crewe, B. (2011). Soft power in prison: Implications for staff–prisoner relationships, liberty and legitimacy. *European Journal of Criminology*, *8*(6), 455–468. https://doi.org/10.1177/1477370811413805

Cruikshank, B. (1999). *The Will to Empower: Democratic Citizens and other Subjects.* New York: Cornell University Press

Côté, C., & Clément, M.-È. (2022). Let's talk about love: Perceptions of children in residential care. *Children and Youth Services Review*, *140*, 106584. https://doi.org/10.1016/j.childyouth.2022.106584

Daly, D. L., Huefner, J. C., Bender, K. R., Davis, J. L., Whittaker, J. K., & Thompson, R. W. (2018). Quality care in therapeutic residential programs: definition, evidence for effectiveness, and quality standards. *Residential treatment for children & youth*, *35*(3), 242–262. https://doi.org/10.1080/0886571X.2018.1478240

Daly, W. (2009). “Adding Their Flavour to the Mix”: Involving Children and Young People in Care in Research Design. *Australian Social Work*, *62*(4), 460–475. https://doi.org/10.1080/03124070903265732

Day, D. M. (2002). Examining the therapeutic utility of restraints and seclusion with children and youth: The role of theory and research in practice. *American Journal of Orthopsychiatry*, *72*(2), 266–278. https://doi.org/10.1037/0002-9432.72.2.266

De Hert, M., Dirix, N., Demunter, H., & Correll, C. U. (2011). Prevalence and correlates of seclusion and restraint use in children and adolescents: a systematic review. *Eur Child Adolesc Psychiatry*, *20*(5), 221–230. https://doi.org/10.1007/s00787-011-0160-x

De Los Reyes, A., & Kazdin, A. E. (2005). Informant discrepancies in the assessment of childhood psychopathology: a critical review, theoretical framework, and recommendations for further study. *Psychological Bulletin*, *131*(4), 483.

De Valk, S., Kuiper, C., van der Helm, G. H. P., Maas, A. J. J. A., & Stams, G. J. J. M. (2016). Repression in Residential Youth Care: A Scoping Review. *Adolescent Research Review*, *1*(3), 195–216. https://doi.org/10.1007/s40894-016-0029-9

De Valk, S., Kuiper, C., van der Helm, G. H. P., Maas, A. J. J. A., & Stams, G. J. J. M. (2019). Repression in Residential Youth Care: A Qualitative Study Examining the Experiences of Adolescents in Open, Secure and Forensic Institutions. *Journal of Adolescent Research*, *34*(6), 757–782. https://doi.org/10.1177/0743558417719188

De Valk, S., van der Helm, G. H. P., Beld, M., Schaftenaar, P., Kuiper, C., & Stams, G. J. J. M. (2015). Does punishment in secure residential youth care work? An overview of the evidence. *Journal of Children's Services*, *10*(1), 3–16. https://doi.org/10.1108/JCS-11-2014-0048

Dean, A. J., Duke, S. G., George, M., & Scott, J. (2007). Behavioral Management Leads to Reduction in Aggression in a Child and Adolescent Psychiatric Inpatient Unit. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(6), 711–720. https://doi.org/10.1097/chi.0b013e3180465a1a

Dean, A. J., Gibbon, P., McDermott, B. M., Davidson, T., & Scott, J. (2010). Exposure to Aggression and the Impact on Staff in a Child and Adolescent Inpatient Unit. *Archives of psychiatric nursing*, *24*(1), 15–26. https://doi.org/10.1016/j.apnu.2009.01.002

Dean, M., (2009). *Governmentality: Power and Rule in Modern Society.* Sage

Dean, M., (2012). The signature of power. *Journal of political power, 5*(1), 101–117. https://doi.org/10.1080/2158379X.2012.659864

DeWall, C. N., Anderson, C. A., & Bushman, B. J. (2013). Aggression. In *Handbook of psychology: Personality and social psychology, Vol. 5, 2nd ed.* (449–466). John Wiley & Sons, Inc.

Dillon, J., Greenop, D., & Hills, M. (2016). Participation in child protection: A small-scale qualitative study. *Qualitative Social Work*, *15*(1), 70–85. https://doi.org/10.1177/1473325015578946

Doek, J. E. (2009). The CRC 20 years: An overview of some of the major achievements and remaining challenges. *Child abuse & neglect*, *33*(11), 771–782. https://doi.org/10.1016/j.chiabu.2009.08.006

DosReis, S., McCulloch, J. R., Colantuoni, E., Barnett, S. R., Pruitt, D., Zachik, A., & Riddle, M. A. (2010). Early Identification of Seclusion and Restraint Patterns During Adolescents' Course of Residential Treatment. *Residential treatment for children & youth*, *27*(3), 160–174. https://doi.org/10.1080/0886571X.2010.500145

Du Plessis, R. (2013). Constructing patient–psychiatrist relations in psychiatric hospitals: the role of space and personal action. *Social Semiotics*, *23*(3), 424–443. https://doi.org/10.1080/10350330.2012.739003

Earle, K. A., & Forquer, S. L. (1995). Use of seclusion with children and adolescents in publiv psychiatric hospitals. *American Journal of Orthopsychiatry*, *65*(2), 238–244. https://doi.org/10.1037/h0079621

Egelund, T. (2009). *Anbragte børn og unge : en forskningsoversigt* (Vol. 09:24). SFI.

Eide, S. (2016). Sosialt arbeid–et normativt fag. I R. Kroken & OJ Madsen (Red.) *Forvaltning av makt og moral i velferdsstaten—Fra sosialt arbeid til «arbeid med deg selv*, *1*.

Eisenberg, N., Spinrad, T.L., & Eggum, N.D. (2010). Emotion-related self-regulation and its relation to children`s maladjustment. *Annual Review of Clinical Psychology, 6,* 495–525. https://doi.org/10.1146/annurev.clinpsy.121208.131208

Ekeland, T.-J. (2021). Myndiggjorte brukere og umyndiggjorte hjelpere. In E. Skjeldal (Red.), *Kritiske perspektiver på brukermedvirkning* (153-176). Univeristetsforlaget

Eltink, E. M. A., van der Helm, P., Wissink, I. B., & Stams, G.-J. J. M. (2015). The Relation between Living Group Climate and Reactions to Social Problem Situations in Detained Adolescents: "I Stabbed Him Because He Looked Mean at Me". *International Journal of Forensic Mental Health*, *14*(2), 101–109. https://doi.org/10.1080/14999013.2015.1033110

Engström, I., Engström, K., Pelto-Piri, V., Sellin, T., & Kjellin, L. (2023). *Tvångsvårdade ungdomars erfarenheter av personalens bemötande vid SiS- och BUP-institutioner* (Institutionsvård i fokus, Issue. S. i. SiS. http://www.stat-inst.se/webbshop/2-2023-tvangsvardade-ungdomars-erfarenheter-av-personalens-bemotande-vid-sis--och-bup-institutioner/)

Engström, I., Engström, K., & Sellin, T. (2020). Adolescents' Experiences of the Staff's Different Interaction Styles in Coercive Youth Care in Sweden: A Qualitative Study. *Issues in mental health nursing*, *41*(11), 1027–1037. https://doi.org/10.1080/01612840.2020.1757794

EPOC. (2015). *Effective Practice and Organization of Care (EPOC). Suggested risk of bias criteria for EPOC reviews*. Norwegian Knowledge Center for Health Services.

Ericsson, K. (2009). *Samfunnets stebarn*. Universitetsforlaget

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics*, *5*(1), 1–4.

Euser, S., Alink, L. R. A., Tharner, A., van Ijzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2014). Out of home placement to promote safety? The prevalence of physical abuse in residential and foster care. *Children and Youth Services Review*, *37*, 64–70. https://doi.org/10.1016/j.childyouth.2013.12.002

Farmer, E. M., Seifert, H., Wagner, H. R., Burns, B. J., & Murray, M. (2017). Does model matter? Examining change across time for youth in group homes. *Journal of Emotional and Behavioral Disorders*, *25*(2), 119–128.

Farragher, B. (2002). A System-Wide Approach to Reducing Incidents of Therapeutic Restraint. *Residential treatment for children & youth*, *20*(1), 1–14. https://doi.org/10.1300/J007v20n01_01

Fish, R., & Culshaw, E. (2005). The last resort?:Staff and client perspectives on physical intervention. *Journal of Intellectual Disabilities*, *9*(2), 93–107. https://doi.org/10.1177/1744629505049726

Forbat, L., & Barclay, S. (2019). Reducing healthcare conflict: outcomes from using the conflict management framework. *Archives of disease in childhood*, *104*(4), 328–332. https://doi.org/10.1136/archdischild-2018-315647

Forbat, L., Simons, J., Sayer, C., Davies, M., & Barclay, S. (2017). Training paediatric healthcare staff in recognising, understanding and managing conflict with patients and families: findings from a survey on immediate and 6-month impact. *Archives of*

disease in childhood, *102*(3), 250–254. https://doi.org/10.1136/archdischild-2016-310737
Forman, J., & Damschroder, L. (2008). Qualitative content analysis. In L. Jacoby, & L.A. Siminoff (Eds.). *Empirical methods for bioethics: A primer (39–62).* Elsevier
Foucault, M. (1980). Two lectures. In Gordon C (Ed.) *Power/knowledge. Selected Interviews and Other Writings 1972–1977.* Random house
Foucault, M. (1982). The Subject and Power. In: H. Dreyfus and P. Rabinow (Eds.) *Michel Foucault: Beyond Structuralism and Hermeneutics.* The University of Chicago Press
Foucault, M. (1991). Governmentality. In: G. Burchel, C. Gordon and P. Miller (Eds.). *The Foucault effect: Studies in Governmentality*. Harvester Wheatsheaf.
Foucault, M. & Østerberg, D. (1994). *Discipline and Punish (Norwegian edition).* (2.ed.). Gyldendal
Fraser, S. L., Archambault, I., & Parent, V. (2016). Staff Intervention and Youth Behaviors in a Child Welfare Residence. *Journal of child and family studies*, *25*(4), 1188–1199. https://doi.org/10.1007/s10826-015-0312-6
Freeman, M. & Toope, S. (1996). *Children`s rights: A comparative perspective.*
Freundlich, M., Avery, R. J., & Padgett, D. (2007). Care or scare: The safety of youth in congregate care in New York City. *Child abuse & neglect*, *31*(2), 173–186. https://doi.org/10.1016/j.chiabu.2006.09.002
Frønes, I. (2018). *Den krevende barndommen: om barndom, sosialisering og politikk for barn*. Cappelen Damm Akademisk.
Fudge Schormans, A., & Rooke, J. (2008). When there are no choices: The consequences of a lack of adult living placements for young adults with intellectual and/or developmental disabilities leaving cild welfare care. *Journal of Developmental Disabilities*, *14* (1), 107–126. http://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.620.4389
Furnivall, J. (2018). Reclaiming complexity: beneath the surface in residential child care. *Journal of Social Work Practice*, *32*(4), 373–390. https://doi.org/10.1080/02650533.2018.1503164
Furre, A., Sandvik, L., Friis, S., Knutzen, M., & Hanssen-Bauer, K. (2016). A nationwide study of why and how acute adolescent psychiatric units use restraint. *Psychiatry research*, *237*, 60–66. https://doi.org/10.1016/j.psychres.2016.01.067
Gal, T. (2017). An ecological model of child and youth participation. *Children and Youth Services Review*, *79*, 57–64. https://doi.org/10.1016/j.childyouth.2017.05.029
Gallagher, B., & Green, A. (2012). In, out and after care: Young adults' views on their lives, as children, in a therapeutic residential establishment. *Children and Youth Services Review*, *34*(2), 437–450.
Garsjø, O. (2008). *Institusjon som hjem og arbeidsplass: et arbeidstaker-og brukerperspektiv*. Gyldendal.
Gaskell, C. (2010). If the social worker had called at least it would show they cared. Young care leavers' perspectives on the importance of care. *Children and Society, 24*(2), 136–147. https://doi.org/10.1111/j.1099-0860.2009.00214.x
Gatwiri, K., Cameron, N., McPherson, L., & Parmenter, N. (2020). What is known about child sexual exploitation in residential care in Australia? A systematic scoping review. *Children and Youth Services Review*, *116*, https://doi.org/10.1016/j.childyouth.2020.105188
Gautun, H., Sasaoka, K., & Gjerustad, C. (2006). *Brukerundersøkelse i barnevernsinstitusjonene* (Vol. 9/06). Norsk institutt for forskning om oppvekst, velferd og aldring.

Gelkopf, M., Roffe, Z., Behrbalk, P., Melamed, U., Werbloff, N., & Bleich, A. (2009). Attitudes, Opinions, Behaviors, and Emotions of the Nursing Staff Toward Patient Restraint. *Issues in Mental Health Nursing, 30*(12), 758–763. https://doi.org/10.3109/01612840903159777

Generell kommentar nr. 12. Barnets rett til å bli hørt (2009). https://www.regjeringen.no.globalassets/upload/bld/barnets-rettigheter/generell-kommentar-12.pdf

Generell kommentar nr. 14 om barnets rett til at hans eller hennes beste skal være et grunnleggende hensyn (2013). https://www.regjeringen.no/contentassets/1376fac2fe2a427389f9f94b52acdefc/crc_c_gc_14_eng_nor.pdf

Geoffrion, Lamothe, J., Fraser, S. L., Lafortune, D., & Dumais, A. (2021). Worker and perceived team climate factors influence the use of restraint and seclusion in youth residential treatment centers: Results from a mixed-method longitudinal study. *Child abuse & neglect*, *111*, 104825. https://doi.org/10.1016/j.chiabu.2020.104825

Geoffrion, S., Hills, D. J., Ross, H. M., Pich, J., Hill, A. T., Dalsbø, T. K., Riahi, S., Martínez-Jarreta, B., & Guay, S. (2020). Education and training for preventing and minimizing workplace aggression directed toward healthcare workers. *Cochrane Database Syst Rev*, *9*(9), Cd011860. https://doi.org/10.1002/14651858.CD011860.pub2

Geoffrion, S., Lamothe, J., Drolet, C., Dufour, S., & Couvrette, A. (2021). Exploring Reasons Motivating the Use of Restraint and Seclusion by Residential Workers in Residential Treatment Centers: A Qualitative Analysis of Official Reports. *Residential treatment for children & youth*, 1–21. https://doi.org/10.1080/0886571X.2021.1973940

Gergen, K. J. (2015). *An invitation to social construction,* 3rd. ed. Sage: https://doi.org/10.4135/9781473921276

Gharabaghi, K. (2014). Relationships and relational practice *CYC-Online*, *185*, 6–9.

Gharabaghi, K., & Phelan, J. (2011). Beyond Control: Staff Perceptions of Accountability for Children and Youth in Residential Group Care. *Residential treatment for children & youth*, *28*(1), 75–90. https://doi.org/10.1080/0886571X.2011.550172

Gilbert, N., Parton, N., & Skivenes, M. (2011). *Child Protection Systems: International Trends and Orientations*. Oxford University Press, USA. https://books.google.se/books?id=gZpiInakhiIC

Gilligan, R. (2008). Promoting resilience in young people in long-term care — The relevance of roles and relationships in the domains of recreation and work. *Journal of Social Work Practice*, *22*(1), 37–50. https://doi.org/10.1080/02650530701872330

Glaser, B.G. & Strauss, A.L. (1967). *The discovery of grounded theory : strategies for qualitative research.* Aldine

Glaser, B. (1992). *Basics of grounded theory analysis: Emergence vs. forcing.* Sociology Press

Goldstein, N. E. S., Giallella, C. L., Haney-Caron, E., Peterson, L., Serico, J., Kemp, K., Romaine, C. R., Zelechoski, A. D., Holliday, S. B., Kalbeitzer, R., Kelley, S. M., Hinz, H., Sallee, M., Pennacchia, D., Prelic, A., Burkard, C., Grisso, T., Heilbrun, K., Nunez, A., Leff, S., & Lochman, J. (2018). Juvenile Justice Anger Management (JJAM) Treatment for Girls: Results of a randomized controlled trial. *Psychological services*, *15*(4), 386–397. https://doi.org/10.1037/ser0000184

Goodkind, S., Schelbe, L. A., & Shook, J. J. (2011). Why youth leave care: Understandings of adulthood and transition successes and challenges among youth aging out of child welfare. *Children and Youth Services Review*, *33*(6), 1039–1048. https://doi.org/10.1016/j.childyouth.2011.01.010

Goodyer, A. (2013). Understanding looked-after childhoods. *Child & Family Social Work*, *18*(4), 394–402. https://doi.org/10.1111/j.1365-2206.2012.00858.x
Green, R. S., & Ellis, P. T. (2008). Foster youth evaluate the performance of group home services in California. *Evaluation and program planning*, *31*(2), 174–180.
Green-Hennessy, S., & Hennessy, K. D. (2015). Predictors of Seclusion or Restraint Use Within Residential Treatment Centers for Children and Adolescents. *Psychiatr Q*, *86*(4), 545–554. https://doi.org/10.1007/s11126-015-9352-8
Grix, J. (2001). *Demystifying postgraduate research: From MA to PhD.* University of Birmingham Press.
Gross, T. J., Hurley, K. D., Sullivan, J. J., Lambert, M. C., Van Ryzin, M. J., & Thompson, R. W. (2015). Program records as a source for program implementation assessment and youth outcomes predictors during residential care. *Children and Youth Services Review*, *58*, 153–162. https://doi.org/10.1016/j.childyouth.2015.09.016
Grunnloven. (1814). Kongerikets Norges Grunnlov. https://lovdata.no/dokument/NL/lov/1814-05-17
Grünfeld, L., Backe-Hansen, E., Guldvik, M. K., Kjelsaas, I., Winje, E., Engebretsen, L. S. & Westberg, N. B. (2020). *Institusjonstilbudet i barnevernet*. Menon-publikasjon nr. 54/2020. Menon Economics.
Gudde, C. B., Olso, T. M., Whittington, R., & Vatne, S. (2015). Service users' experiences and views of aggressive situations in mental health care: a systematic review and thematic synthesis of qualitative studies. *Journal of Multidisciplinary Healthcare*, *8*, 449–462. https://doi.org/10.2147/jmdh.S89486
Gulbrandsen, L. M., Seim, S., & Ulvik, O. S. (2012). Barns rett til deltakelse i barnevernet: Samspill og meningsarbeid. *Sosiologi i dag*, *42*(3–4). http://ojs.novus.no/index.php/SID/article/view/1019
Gullick, K., McDermott, B., Stone, P., & Gibbon, P. (2005). Seclusion of children and adolescents: Psychopathological and family factors. *International journal of mental health nursing*, *14*(1), 37–43. https://doi.org/10.1111/j.1440-0979.2005.00353.x
Gundersen, T. (2021). Embedded in relations—Interactions as a source of agency and life opportunities for care-experienced young adults. *Children & Society*, *35*(5), 680–693. https://doi.org/10.1111/chso.12434
Gundersen, T., Havre, M., Neumann, C., Fugletveit, R., Jevne, K. (2023). Enetiltak og alenetiltak i barnevernet. NOVA-Rapport-9-2023 Children living alone with staff in residential care.
Gundersen, T., Neumann, C., Fugletveit, R., Jevne, K. (2024). Grensedragning mellom frivillighet, tvang, omsorg og behandling. NOVA_rapport_1_24_UUweb (1).pdf
Habermas, J. (1994) "Questions concerning the theory of power". In Kelly, HM. (Ed). (1994). *Critique and power: recasting the Foucault/Habermas debate.* Camebridge, Massaschsetts Institute of Technology
Hagen, A. L. & Lyng, S.T. (2019). Barn og unges deltakelse i forskning: Muligheter og utfordringer. *Norsk sosiologisk tidsskrift,* 3(1): 6–12
Hagen, I. M., & Svalund, J. (2019). *Vold, trusler og trakassering i helse- og sosialsektoren (Violence, threats and harassment in the health and social sector)* Fafo-rapport 2019:32
Haldar, M., & Engebretsen, E. (2014). Governing the liberated child with self-managed family displays. *Childhood*, *21*(4), 475–487. https://doi-org.ezproxy.oslomet.no/10.1177/0907568213508589
Hammer, J.H., Springer, J., Beck, N.C., Menditto, A., &Coleman, J. (2011). The relationship between seclusion and restraint use and childhood abuse among psychiatric inpatients.

Journal of Interpersonal Violence, 26(3), 567–579. https://doi.org/10.1177/0886260510363419
Hammer, E. (2006). Individualisering og trygghet i det senmoderne samfunn. I T.H. Eriksen (Red.). *Trygghet.* Universitetsforlaget
Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2013). A secure base? The adolescent–staff relationship in secure residential youth care. *Child & Family Social Work*, *18*(3), 305–317. https://doi.org/10.1111/j.1365-2206.2012.00846.x
Harris, B., & Leather, P. (2012). Levels and Consequences of Exposure to Service User Violence: Evidence from a Sample of UK Social Care Staff. *The British journal of social work*, *42*(5), 851–869. https://doi.org/10.1093/bjsw/bcr128
Haugom, E.W., Ruud, T., & Hynnekleiv, T. (2019). Ethical challenges of seclusion in psychiatric inpatient wards: A qualitative study of the experiences of Norwegian mental health professionals. *BMC Health Services Research, 19*(1), 1–12. https://doi.org/10.1186/s12913-019-4727-4
Hedman-Lindgren, B. (2011). *No power - no lose : en metod för konflikthantering: handbok / Birgitta Hedman-Lindgren, Bernhard Taylor*. Statens institutionsstyrelse SiS.
Heimer, M., Näsman, E., & Palme, J. (2018). Vulnerable children's rights to participation, protection, and provision: The process of defining the problem in Swedish child and family welfare. *Child & Family Social Work*, *23*(2), 316-323. https://doi.org/10.1111/cfs.12424
Helsetilsyn, Statens. (2018). *Undersøkelse av Fylkesmannen i Hordalands tilsyn med Vestlundveien ungdomssenter*. Statens Helsetilsyn. https://www.helsetilsynet.no/globalassets/opplastinger/tilsyn/undersokelse_av_fm_hordalands_tilsyn_med_vestlundveien_ungdomssenter.pdf
Helsetilsyn, Statens. (2019). *Oppsummering av landsomfattende tilsyn med barnevernsinstitusjoner i 2018*, «Barnas hjem. Voksnes ansvar». *3*. https://www.helsetilsynet.no/globalassets/opplastinger/publikasjoner/rapporter2019/helsetilsynetrapport3_2019.pdf
Hennum, N. 1997: Den komplekse virkelighet. Krise- og utredningsinstitusjoners tvetydige verden, Oslo: NOVA-rapport 11/1997.
Henriksen, A., Degner, J., & Oscarsson, L. (2008). Youths in coercive residential care: attitudes towards key staff members' personal involvement, from a therapeutic alliance perspective. *European Journal of Social Work*, *11*(2), 145–159. https://doi.org/10.1080/13691450701531976
Henriksen, A.-K., & Prieur, A. (2019). 'So, Why Am I Here?' Ambiguous Practices of Protection, Treatment and Punishment in Danish Secure Institutions for Youth. *The British Journal of Criminology*, *59*(5), 1161–1177. https://doi.org/10.1093/bjc/azz018
Henriksen, A.-K., & Øye, C. (2023). The ambiguities of coercion: Mapping adolescents' experiences of coercion in institutional everyday life. *Children & Society*. https://doi.org/10.1111/chso.12699
Heynen, E., van der Helm, P., Cima, M., Stams, G.-J., & Korebrits, A. (2017). The Relation Between Living Group Climate, Aggression, and Callous-Unemotional Traits in Delinquent Boys in Detention. *International journal of offender therapy and comparative criminology*, *61*(15), 1701–1718. https://doi.org/10.1177/0306624x16630543
Higgins, J.P.T., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M.J., Welch, V.S. (2019). *Cochrane Handbook for Systematic Reviews of Intervention 6.1.*
Holden, M. J. (2009). *Children and residential experiences: Creating conditions for change*. Residential Child Care Project, Cornell University.

Holland, S. (2009). Listening to Children in Care: A Review of Methodological and Theoretical Approaches to Understanding Looked after Children's Perspectives. *Children & Society*, *23*(3), 226–235. https://doi.org/10.1111/j.1099-0860.2008.00213.x

Hood, C. (1995). The "New Public Management" in the 1980s: variations on a theme. *Accounting, organizations and society, 20*(2), 93–109.

Horwath, J., Kalyva, E., & Spyru, S. (2012). "I want my experiences to make a difference" promoting participation in policy-making and service development by young people who have experienced violence. *Children and Youth Services Review*, *34*(1), 155–162. https://doi.org/10.1016/j.childyouth.2011.09.012

Houston, S. (2001). Beyond social constructionism: Critical realism and social work. *British Journal of Social Work, 31*(6), 845–861. https://doi.org/10.1093/bjsw/31.6.845

Huefner, J., & Ainsworth, F. (2021). Commentary:Recognizing the value of the milieu in therapeutic residential care for children and youth. *Residential treatment for children & youth*, *38*(3), 324–335. https://doi.org/10.1080/0886571X.2021.1915225

Hultqvist, K. &Dahlberg, G. (Eds) (2001). *Governing the Child in the New Millennium.* Routledge Falmer

Husby, I. S. D., Kiik, R., & Juul, R. (2019). Children's encounters with professionals – recognition and respect during collaboration. *European Journal of Social Work*, *22*(6), 987–998. https://doi.org/10.1080/13691457.2018.1473841

Husby, I. S. D., Slettebø, T., & Juul, R. (2018). Partnerships with children in child welfare: The importance of trust and pedagogical support. *Child & Family Social Work*, *23*(3), 443–450. https://doi.org/10.1111/cfs.12435

Hsieh, H.-F. & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15(9),* 1277–1288. https://doi.org.10.1177/0011000097254001

Hyde, J., & Kammerer, N. (2009). Adolescents' perspectives on placement moves and congregate settings: Complex and cumulative instabilities in out-of-home care. *Children and Youth Services Review*, *31*(2), 265–273. https://doi.org/10.1016/j.childyouth.2008.07.019

Hylén, U., Kjellin, L., Pelto-Piri, V., & Warg, L. E. (2018). Psychosocial work environment within psychiatric inpatient care in Sweden: Violence, stress, and value incongruence among nursing staff. *Int J Ment Health Nurs*, *27*(3), 1086–1098. https://doi.org/10.1111/inm.12421

Høilund, P., & Juul, S. (2015). *Anerkendelse og dømmekraft i socialt arbejde* (2. udg. ed.). Reitzel.

Isdal, P. (2000). *Meningen med volden*. Kommuneforlaget. https://books.google.se/books?id=m5cvAAAACAAJ

Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the Setting Level to Prevent Behavioral Incidents in Residential Child Care: Efficacy of the CARE Program Model. *Prevention science*, *17*(5), 554–564. https://doi.org/10.1007/s11121-016-0649-0

Jacard, J. & Jacoby, J. (2010). *Theory construction and model-building skills: A practical guide for social scientists.* Guilford

James K.L., Randall N.P., & Haddaway N.R. (2016) A methodology for systematic mapping in environmental sciences. Environmental evidence. 5(1):1–13.

James, S. (2011). What works in group care? — A structured review of treatment models for group homes and residential care. *Children and Youth Services Review*, *33*(2), 308–321. https://doi.org/10.1016/j.childyouth.2010.09.014

James, S. (2015). Evidence-based practice in therapeutic residential care. In: *Therapeutic residential care for children and youth developing evidence-based international practice*, 142–155. Jessica Kingsley Publisher

James, S. (2017) Implementing Evidence-Based Practice in Residential Care - How Far Have We Come? Resid Treat Child Youth. 2017;34(2):155–175. https://doi.org/10.1080/0886571X.2017.1332330

Jamieson, L. (2017). Children and young people's right to participate in residential care in South Africa. *The International Journal of Human Rights*, *21*(1), 89–102. https://doi.org/10.1080/13642987.2016.1248126

Jaycox, L. H., Ebener, P., Damesek, L., & Becker, K. (2004). Trauma exposure and retention in adolescent substance abuse treatment. *Journal of traumatic stress*, *17*(2), 113–121. https://doi.org/10.1023/B:JOTS.0000022617.41299.39

Jensen, B. S. (2014). *Inddragelse af udsatte børn og unge i socialt arbejde - reel inddragelse eller symbolsk retorik?* Aalborg universitet.

Jobe, A., & Gorin, S. (2013). 'If kids don't feel safe they don't do anything': young people's views on seeking and receiving help from Children's Social Care Services in England. *Child & Family Social Work*, *18*(4), 429–438. https://doi.org/10.1111/j.1365-2206.2012.00862.x

Johnson, T. D. (2007). Respiratory Assessment in Child and Adolescent Residential Treatment Settings: Reducing Restraint-Associated Risks. *Journal of Child and Adolescent Psychiatric Nursing*, *20*(3), 176–183. https://doi.org/10.1111/j.1744-6171.2007.00108.x

Jolivette, K., Boden, L. J., Sprague, J. R., Parks Ennis, R., & Kimball, K. A. (2015). Youth voice matters: Perceptions of facility-wide PBIS implementation in secure residential juvenile facilities. *Residential treatment for children & youth*, *32*(4), 299–320.

Jones, N., Gius, B. K., Shields, M., Collings, S., Rosen, C., & Munson, M. (2021). Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Social psychiatry and psychiatric epidemiology*, *56*(11), 2017–2027. https://doi.org/10.1007/s00127-021-02048-2

Jones, R. (2015). The end game: The marketisation and privatisation of children's social work and child protection. *Critical Social Policy, 35*(4), 447–469.

Joy, D. S. (1981). The Maintenance of Order on an Adolescent Inpatient Unit. *Psychiatry*, *44*(3), 253–262. https://doi.org/10.1080/00332747.1981.11024111

Jozefiak, T., Kayed, N. S., Rimehaug, T., Wormdal, A. K., Brubakk, A. M., & Wichstrøm, L. (2016). Prevalence and comorbidity of mental disorders among adolescents living in residential youth care. *European Child & Adolescent Psychiatry*, *25*(1), 33–47. https://doi.org/10.1007/s00787-015-0700-x

Justesen, L. N., & Mik-Meyer, N. (2012). *Qualitative research methods in organisation studies*. Gyldendal.

Kaijadoe, S. P. T., Nijhof, K. S., Klip, H., De Weerd, A., Popma, A., & Scholte, R. H. J. (2023). The impact of adolescent suicide on professionals in secure residential youth care. *Residential Treatment for Children and Youth,* 1–28. https://doi.org/10.1080/0886571X.2023.2253724

Kanestrøm, H., Stallvik, M., Lydersen, S., Skokauskas, N., & Kaasbøll, J. (2023). Adolescents in therapeutic residential care: treatment needs and characteristics. *European Journal of Social Work,* 1–15. https://doi.org/10.1080/13691457.2023.2266779

Kelly, M. (1994). *Critique and power: recasting the Foucault/Habermas debate.* Cambridge, UK: Massachusetts Institute of Technology.

Kelly, M. (2010). The role of theory in qualitative health research. *Fam Pract*. 27(3):285–290. https://doi.org/10.1093/fampra/cmp077
Kendrick, A., Steckley, L., & Lerpiniere, J. (2008). Ethical issues, research and vulnerability: gaining the views of children and young people in residential care. *Children's Geographies*, *6*(1), 79–93. https://doi.org/10.1080/14733280701791967
Kennan, D., Brady, B., & Forkan, C. (2018). Space, Voice, Audience and Influence: The Lundy Model of Participation (2007) in Child Welfare Practice. *Practice*, *31*, 1–14. https://doi.org/10.1080/09503153.2018.1483494
Kim, J., & Cicchetti, D. (2010). Longitudinal pathways linking child maltreatment, emotion regulation, peer relations and psychopathology. *Journal of Child Psychology and Psychiatry, 51*(6), 706–716. https://doi.org/10.1111/j.1469-7610.2009.02202.x
Kind, N., Eckert, A., Steinlin, C., Fegert, J. M., & Schmid, M. (2018). Verbal and physical client aggression - A longitudinal analysis of professional caregivers' psychophysiological stress response and burnout. *Psychoneuroendocrinology*, *94*, 11–16. https://doi.org/10.1016/j.psyneuen.2018.05.001
Kjelsaas, I., Backe-Hansen, E., Ellingsen, D., Guldvik, M. K., Vennerød, Ø., & Pedersen, S. (2020). Best egnede tiltak når barn og unge skal bo utenfor hjemmet. *Hentet fra https://www.menon.no/best-egnede-tiltak-nar-barn-unge-bo*
Knorth, E. J., Klomp, M., Van den Bergh, P. M., & Noom, M. J. (2012). Aggressive adolescents in residential care: A selective review of treatment requirements and models. *Adolescence, 42*(167), 461–485.
Knorth, E. J., Harder, A. T., Huyghen, A. M. N., Kalverboer, M. E., & Zandberg, T. (2010). Residential youth care and treatment research: Care workers as key factor in outcomes? *International Journal of Child & Family Welfare*, *13*(1/2), 49–67. http://hdl.handle.net/1765/115858
Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. *Children and Youth Services Review*, *30*(2), 123–140. https://doi.org/10.1016/j.childyouth.2007.09.001
Kor, K., Fernandez, E., & Spangaro, J. (2021). Practitioners' experience of implementing therapeutic residential care: A multi-perspective study. *Children and Youth Services Review*, *131*, https://doi.org/10.1016/j.childyouth.2021.106301
Kosher, H., & Ben-Arieh, A. (2020). Social workers' perceptions of children's right to participation. *Child & Family Social Work*, *25*(2), 294–303. https://doi.org/10.1111/cfs.12685
Križ, K., & Roundtree-Swain, D. (2017). "We are merchandise on a conveyer belt": How young adults in the public child protection system perceive their participation in decisions about their care. *Children and Youth Services Review*, *78*, 32–40. https://doi.org/10.1016/j.childyouth.2017.05.001
Križ, K., & Skivenes, M. (2017). Child welfare workers' perceptions of children's participation: a comparative study of England, Norway and the USA (California). *Child & Family Social Work*, *22*(S2), 11–22. https://doi.org/10.1111/cfs.12224
Krueger, R. A. (2014). *Focus groups: A practical guide for applied research*. Sage publications.
Kumar R. (2014). Research methodology: A step-by-step guide for beginners. Sage
Kvale, S., Brinkmann, S., Anderssen, T. M., & Rygge, J. (2015). Det kvalitative forskningsintervju (3. utg.) *Gyldendal akademisk*e.
Kvello, Ø. (2015). *Barn i risiko - skadelige omsorgssituasjoner*. Gyldendal akademiske.
Laiho, T., Kattainen, E., Åstedt-Kurki, P., Putkonen, H., Lindberg, N., & Kylmä, J. (2013). Clinical decision making involved in secluding and restraining an adult psychiatric

patient: an integrative literature review. *Journal of psychiatric and mental health nursing*, *20*(9), 830–839. https://doi.org/10.1111/jpm.12033
Lamothe, J., Couvrette, A., Lebrun, G., Yale-Soulière, G., Roy, C., Guay, S., & Geoffrion, S. (2018). Violence against child protection workers: A study of workers' experiences, attributions, and coping strategies. *Child Abuse Negl*, *81*, 308–321. https://doi.org/10.1016/j.chiabu.2018.04.027
Lanctôt, N., & Guay, S. (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggression and Violent Behavior*, *19*(5), 492–501.
Lansdown, G. (2010). The realisation of children`s participation rights. Critical reflections. In B. Percy-Smith & N. Thomas (Eds.), *A Handbook of Children and Young People's Participation: Perspectives from Theory and Practice*. Routledge. https://doi.org/10.4324/9780203871072
Larue, C., Dumais, A., Ahern, E., Bernheim, E., & Mailhot, M.-P. (2009). Factors influencing decisions on seclusion and restraint. *Journal of psychiatric and mental health nursing*, *16*(5), 440–446. https://doi.org/10.1111/j.1365-2850.2009.01396.x
Lausten, M., & Andreasen, A.G. (2019): Anbragt på en kostskole: Hvordan klarer unge, der er anbragt på kostskoler, sig efter endt grundskole, sammenlignet med unge i andre anbringelsestyper? København: VIVE – Det Nationale Forsknings- og Analysecenter for Velfærd.
Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer publishing company.
LeBel, J., Huckshorn, K. A., & Caldwell, B. (2010). Restraint use in residential programs: why are best practices ignored? *Child Welfare*, *89*(2), 169–187.
LeBlanc, V. R., Regehr, C., Shlonsky, A., & Bogo, M. (2012). Stress responses and decision making in child protection workers faced with high conflict situations. *Child Abuse Negl*, *36*(5), 404–412. https://doi.org/10.1016/j.chiabu.2012.01.003
Ledoux, M. B. (2013). *Physical restraint in residential facilities: Staff members` perspectives* Doctoral dissertation, Antioch university. http://rave.ohiolink.edu/etdc/view?acc_num=antioch1363343108
Lee-Lipkins, H. A. (2014). *The influence of selected aggression, demographic, gender role, and temperament factors on the level of physical restraint among staff in residential treatment centers for youth.* Texas Southern University
Leeson, C. (2007). My life in care: experiences of non-participation in decision-making processes. *Child & Family Social Work*, *12*(3), 268–277. https://doi.org/10.1111/j.1365-2206.2007.00499.x
Leidy, B. D., Haugaard, J. J., Nunno, M. A., & Kwartner, J. K. (2006). Review of Restraint Data in a Residential Treatment Center for Adolescent Females. *Child and Youth Care Forum*, *35*(5), 339–352. https://doi.org/10.1007/s10566-006-9021-z
Leipoldt, J. D., Harder, A. T., Kayed, N. S., Grietens, H., & Rimehaug, T. (2019). Determinants and outcomes of social climate in therapeutic residential youth care: A systematic review. *Children and Youth Services Review*, *99*, 429–440. https://doi.org/10.1016/j.childyouth.2019.02.010
Leloux-Opmeer, H., Kuiper, C., Swaab, H., & Scholte, E. (2016). Characteristics of children in foster care, family-style group care, and residential care: A scoping review. *Journal of child and family studies*, *25*(8), 2357–2371. http://dx.doi.org/10.1007/s10826-016-0418-5
Lillevik, O. G., Strømgren, B., Søvig, K. H., Ulset, A. F., & Borgenvik, J. A. (2016). *Kunnskapsgrunnlaget for arbeid med trygghet og sikkerhet i barneverninstitusjoner (The knowledge base for safety and security in child welfare institutions)*.

https://bibliotek.bufdir.no/BUF/101/Kunnskapsgrunnlag_for_arbeid_med_trygghet_og_sikkerhet_i_barnevernsinstitusjoner_201117.pdf

Lillevik, O. G., & Øien, L. (2010). Kvaliteter hos hjelperen som bidrar til å forebygge trusler og vold fra klienter. . *Nordisk Tidsskrift for Helseforskning*, *6*(2), 84–96. https://doi.org/10.7557/14.1191

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation*, *1986*(30), 73–84. https://doi.org/10.1002/ev.1427

Lionetti, F., Pastore, M., & Barone, L. (2015). Attachment in institutionalized children: a review and meta-analysis. *Child abuse and neglect, 42*, 135–145. https://doi.org/10.1016/j.chiabu.2015.02.013

Littlechild, B. (2003). Managing violence, aggression and conflict in social work.

Littlechild, B. (2005). The Nature and Effects of Violence against Child-Protection Social Workers: Providing Effective Support. *The British journal of social work*, *35*(3), 387–401. https://doi.org/10.1093/bjsw/bch188

Lochman, J. E., Barry, T., Powell, N. & Young, L. (2009). Anger and Aggression. In Nangle D., Hansen D., Erdley C., & N. P. (Eds.), *Practitioner's Guide to Empirically Based Measures of Social Skills. ABCT Clinical Assessment Series*. Springer. https://doi.org/10.1007/978-1-4419-0609-0_10

Lombart, B., De Stefano, C., Dupont, D., Nadji, L., & Galinski, M. (2020). Caregivers blinded by the care: A qualitative study of physical restraint in pediatric care. *Nursing ethics*, *27*(1), 230–246. https://doi.org/10.1177/0969733019833128

Lundström, T., Sallnäs, M., & Shanks, E. (2020). Stability and change in the field of residential care for children. On ownership structure, treatment ideas and institutional logics. *Nordic Social Work Research*, 10(1), 39–50.

Lundy, L. (2007). 'Voice' Is Not Enough: Conceptualising Article 12 of the United Nations Convention on the Rights of the Child. *British Educational Research Journal*, *33*(6), 927–942. http://www.jstor.org.ezproxy.oslomet.no/stable/30032800

Macdonald, G., & Millen, S. (2012). Implementing therapeutic approaches to residential child care in Northern Ireland: Report of interviews with trust staff. 10.13140/RG.2.1.1855.4400

Macdonald, G., Millen, S., McCann, M., Roscoe, H., & Ewart-Boyle, S. (2012). Therapeutic approaches to social work in residential child care settings. Social Care Institute of Excellence. Report 58.

MacFarlane, A., & O'Reilly-de Brún, M. (2012). Using a Theory-Driven Conceptual Framework in Qualitative Health Research. *Qualitative Health Research*, *22*(5), 607–618. https://doi.org/10.1177/1049732311431898

MacRae, R., & Skinner, K. (2011). Learning for the Twenty-First Century: Maximising Learning Transfer from Learning and Development Activity. *Social Work Education*, *30*(8), 981–994. https://doi.org/10.1080/02615479.2010.520118

Magnowski, S. R., & Cleveland, S. (2019). The Impact of Milieu Nurse-Client Shift Assignments on Monthly Restraint Rates on an Inpatient Child/Adolescent Psychiatric Unit. *Journal of the American Psychiatric Nurses Association*, 1078390319834358. https://dx.doi.org/10.1177/1078390319834358

Maier, G. J., Stava, L. J., Morrow, B. R., Van Rybroek, G. J. a., & Bauman, K. G. (1987). A Model for Understanding and Managing Cycles of Aggression Among Psychiatric Inpatients. *Psychiatric Services*, *38*(5), 520–524. https://doi.org/10.1176/ps.38.5.520

Maier, S. F., & Seligman, M. E. P. (2016). Learned helplessness at fifty: Insights from neuroscience. *Psychological Review*, *123*(4), 349–367. https://doi.org/10.1037/rev0000033

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job Burnout. *Annual Review of Psychology*, *52*(1), 397–422. https://doi.org/10.1146/annurev.psych.52.1.397
Masschelein, J., & Quaghebeur, K. (2005). Participation for Better or for Worse? *Journal of philosophy of education*, *39*(1), 51–65. https://doi.org/10.1111/j.0309-8249.2005.00419.x
Mathieu, C. A., & Geoffrion, S. (2023). Individual and environmental characteristics of 18 residential workers using restraint and seclusion in youth treatment centers. *Residential Treatment for Children & Youth*, 40(2), 238–260. 20 https://doi.org/10.1080/0886571X.2022.2076761
Mazzone, A., Nocentini, A., & Menesini, E. (2018). Bullying and peer violence among children and adolescents in residential care settings: A review of the literature [Nursing Homes & Residential Care 3377]. *Aggression and Violent Behavior*, *38*, 101–112. https://doi.org/10.1016/j.avb.2017.12.004
McCarthy, E. (2016). Young People in Residential Care, their Participation and the Influencing Factors. *Child Care in Practice*, *22*(4), 368–385. https://doi.org/10.1080/13575279.2016.1188763
McCrory, E., De Brito, S. A., & Viding, E. (2010). Research Review: The neurobiology and genetics of maltreatment and adversity. *J Child Psychol Psychiatry*, *51*(10), 1079–1095. https://doi.org/10.1111/j.1469-7610.2010.02271.x
McIntosh, I., Punch, S., & Emond, R. (2016). Creating spaces to care: Children's rights and food practices in residential care. *Politics, citizenship and rights*, 39–53.
McLean, S. (2015). Managing behaviour in child residential group care: unique tensions. *Child & Family Social Work*, *20*(3), 344–353. https://doi.org/10.1111/cfs.12083
McPherson, L., Gatwiri, K., Tucci, J., Mitchell, J., & Macnamara, N. (2018). A paradigm shift in responding to children who have experienced trauma: The Australian treatment and care for kids program. *Children and Youth Services Review*, *94*, 525–534. https://doi.org/10.1016/j.childyouth.2018.08.031
McPherson, L., Vosz, M., Gatwiri, K., Parmenter, N., Macnamara, N., Mitchell, J., & Tucci, J. (2021). What does research tell us about young people's participation in decision making in residential care? A systematic scoping review. *Children and Youth Services Review*, *122*, 105899. https://doi.org/10.1016/j.childyouth.2020.105899
Meehan, T., Vermeer, C., & Windsor, C. (2000). Patients' perceptions of seclusion: a qualitative investigation. *Journal of advanced nursing*, *31*(2), 370–377. https://doi.org/10.1046/j.1365-2648.2000.01289.x
Melby, L., Ulset, G., Paulsen, V., Wågø, S. I., Høyland, K. & Kaasbøll, J. (2020). Nytt institusjonstilbud for unge med samtidig behov for omsorg og psykisk helsehjelp. Sluttrapport. Trondheim: NTNU samfunnsforskning.
Merton, R. K., & Kendall, P. L. (1946). The focused interview. *American journal of Sociology*, *51*(6), 541–557.
Messel, J. (2014). Barnevernspedagogutdanningens historie. *Tidsskriftet Norges Barnevern*, *91*(4), 178–194. https://doi.org/10.18261/ISSN1891-1838- 2014-04-03
Middleton, J. S., & Potter, C. C. (2015). Relationship Between Vicarious Traumatization and Turnover Among Child Welfare Professionals. *Journal of public child welfare*, *9*(2), 195–216. https://doi.org/10.1080/15548732.2015.1021987
Mik-Meyer, N. (2017). The power of citizens and professionals in welfare encounters: The influence of bureaucracy, market and psychology. In *The power of citizens and professionals in welfare encounters*. Manchester University Press.
Miller, D. E. (1986). The Management of Misbehavior by Seclusion. *Residential treatment for children & youth*, *4*(1), 63–73. https://doi.org/10.1300/J007v04n01_09

Mitchell, M. B., Kuczynski, L., Tubbs, C. Y., & Ross, C. (2010). We care about care: advice by children in care for children in care, foster parents and child welfare workers about the transition into foster care. *Child & Family Social Work*, *15*(2), 176–185. https://doi.org/10.1111/j.1365-2206.2009.00657.x

Moore, T., & McArthur, M. (2017). 'You feel it in your body': How Australian children and young people think about and experience feeling and being safe. *Children & Society*, *31*(3), 206–218.

Moore, T., McArthur, M., Death, J., Tilbury, C., & Roche, S. (2017). Young people's views on safety and preventing abuse and harm in residential care: "It's got to be better than home". *Children and Youth Services Review*, *81*(October), 212–219. https://doi.org/10.1016/j.childyouth.2017.08.010

Moore, T., McArthur, M., Death, J., Tilbury, C., & Roche, S. (2018). Sticking with us through it all: The importance of trustworthy relationships for children and young people in residential care. *Children and Youth Services Review*, *84*, 68–75. https://doi.org/10.1016/j.childyouth.2017.10.043

Moore, T. P. (2017). Children and young people's views on institutional safety: It's not just because we're little. *Child abuse & neglect*, *74*, 73–85.

Mota, C. P., Costa, M., & Matos, P. M. (2016). Resilience and deviant behavior among institutionalized adolescents: The relationship with significant adults. *Child Adolescence Social Work, 33*, 313–325. https://doi.org/10.1007/s10560-015-0429-x

Mouton, J. (2011). *How to succeed in your Master's and Doctoral Studies: A South African guide and resource book*. 11th ed. Van Schaik.

Munobwa, J. S., Ahmadi, F., & Öberg, P. (2023). 'Anxiety, frustration and understanding'. Swedish personal social service workers' cognitive appraisals of encounters with violent clients. *Nordic Social Work Research*, *13*(2), 188–201.

Muzi, S., & Pace, C.S. (2021). Multiple facets of attachment in residential-care, late adopted, and community adolescents: An interview-based comparative study. *Attachment & Human Development, 24* (2), 169–188. https://doi.org/10.1080/14616734.2021.1899386

National knowledge center handbook for health services. (2014). National Knowledge Center for health services.

NESH (2021). *Forskningsetiske retningslinjer for samfunnsvitenskap og humaniora.* De nasjonale forskningsetiske komiteene.

Neumann, C. B. (2021). Kjærlighet på bestilling - om staten, barnevernsarbeidere og følelser. Tidsskriftet Norges Barnevern. Vol. 98. https://doi.org/10.18261/issn.1891-1838-2021-04-05

Neumann, C. B., & Neumann, I. B. (2012). *Forskeren i forskningsprosessen: En metodebok om situering*. Cappelen Damm Akademisk.

Neuman, W.L. (2000). *Social research methods: Qualitative and quantitative approaches*. 4th ed. Allyn & Bacon

Nielsen, M. B., Christensen, J. O., Hetland, J., & Finne, L. B. (2020). Organizational prevention and management strategies for workplace aggression among child protection workers: a project protocol for the Oslo Workplace Aggression Survey (OWAS). *Frontiers in psychology*, *11*, 1401.

Nielson, S., Bray, L., Carter, B., & Kiernan, J. (2021). Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis. *Journal of Child Health Care*, *25*(3), 342–367.

Nolbeck, K., Wijk, H., Lindahl, G., & Olausson, S. (2020). "If you don't behave, you're in real shit, you don't get outside the doors"—a phenomenological hermeneutic study of adolescents' lived experiences of the socio-spatial environment of involuntary

institutional care. *International Journal of Qualitative Studies on Health and Well-Being*, *15*(1), 1726559. https://doi.org/10.1080/17482631.2020.1726559

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The Long-Term Health Consequences of Child Physical Abuse, Emotional Abuse, and Neglect: A Systematic Review and Meta-Analysis. *PLoS medicine*, *9*(11), e1001349. https://doi.org/10.1371/journal.pmed.1001349

NOU 2000:10. *Barnevernet i Norge. Tilstandsvurderinger, nye perspektiver og forslag til reformer.*

NOU 2023:24. (2023). *Med barnet hele vegen – Barnevernsinstitusjoner som har barnas tillit.* Barne- og familiedepartementet.

Nourian, M., Mohammadi Shahbolaghi, F., Nourozi Tabrizi, K., Rassouli, M., & Biglarrian, A. (2016). The lived experiences of resilience in Iranian adolescents living in residential care facilities: A hermeneutic phenomenological study. *International Journal of Qualitative Studies on Health and Well-Being*, *11*(1), 30485. https://doi.org/10.3402/qhw.v11.30485

Nowak, M., & Krishan, M. (2022). The United Nations Global Study on Children Deprived of Liberty: 'Leaving No One Behind, in Particular Children Behind Bars'. In C. Burbano Herrera & Y. Haeck (Eds.), *Human Rights Behind Bars: Tracing Vulnerability in Prison Populations Across Continents from a Multidisciplinary Perspective* (pp. 13-33). Springer International Publishing. https://doi.org/10.1007/978-3-031-11484-7_2

Nunno, M. A., Holden, M. J., & Leidy, B. (2003). Evaluating and Monitoring the Impact of a Crisis Intervention System on a Residential Child Care Facility. *Children and Youth Services Review*, *25*(4), 295–315. https://doi.org/10.1016/S0190-7409(03)00013-6

Nybell, L. (2013). Locating "youth voice:" Considering the contexts of speaking in foster care. *Children and Youth Services Review*, *35*, 1227–1235. https://doi.org/10.1016/j.childyouth.2013.04.009

Nyttingnes, O., Ruud, T., Norvoll, R., Rugkasa, J., & Hanssen-Bauer, K. (2018). A cross-sectional study of experienced coercion in adolescent mental health inpatients. *BMC health services research*, *18*, Article 389. https://doi.org/10.1186/s12913-018-3208-5

O'Hara, C. A. (2019). From therapy to therapeutic: the continuum of trauma-informed care. *Children Australia*, *44*(2), 73–80.

Ormstad, S. S., Hestevik, C. H., Munthe-Kaas, H. M., Blasvær, N., Muller, A. S., & Berg, R. C. (2020). *Barn og unges medvirkning i barnevernet: en systematisk kartleggingsoversikt*. https://hdl.handle.net/11250/2721156

Parveen, S., Birkeland Nielsen, M., Endresen Reme, S., & Finne, L. B. (2023). Exposure to Client-Perpetrated Violence in the Child Welfare Service: Prevalence and Outcomes Using Two Different Measurement Methods. *Journal of interpersonal violence*, *38*(7–8), 5963–5992. https://doi.org/10.1177/08862605221127216

Paulsen, V., & Berg, B. (2016). Social support and interdependency in transition to adulthood from child welfare services. *Children and Youth Services Review*, *68*, 125–131. https://doi.org/10.1016/j.childyouth.2016.07.006

Pecora, P.J. & English, D.J. (2016). Elements of effective practice for children and young people served by therapeutic residential care: Research Brief. Casey Family Programs

Pelto-Piri, V., Engström, I., Sandèn, P., Warg, L.-E., & Kjellin, L. (2017). *Hantering av hot och våld. Personalens syn på etik, bemötande och säkerhet i mötet med ungdomar på institutioner (Handling threats and violence. Staffs view at ethics, treatment and security with young people at institutions).* 978-91-87053-54-2). Statens Institutionsstyrelse.

Pelto-Piri, V., Kjellin, L., Lindvall, C., & Engström, I. (2016). Justifications for coercive care in child and adolescent psychiatry, a content analysis of medical documentation in

Sweden. *BMC health services research*, *16*(1). https://doi.org/10.1186/s12913-016-1310-0

Pelto-Piri, V., Warg, L. E., & Kjellin, L. (2020). Violence and aggression in psychiatric inpatient care in Sweden: a critical incident technique analysis of staff descriptions. *BMC Health Serv Res*, *20*(1), 362. https://doi.org/10.1186/s12913-020-05239-w

Pinchover, S., & Attar-Schwartz, S. (2014). Institutional social climate and adjustment difficulties of adolescents in residential care: The mediating role of victimization by peers. *Children and Youth Services Review*, *44*, 393–399. https://doi.org/10.1016/j.childyouth.2014.07.005

Pollastri, A. R., Lieberman, R. E., Boldt, S. L., & Ablon, J. S. (2016). Minimizing Seclusion and Restraint in Youth Residential and Day Treatment Through Site-Wide Implementation of Collaborative Problem Solving. *Residential treatment for children & youth*, *33*(3–4), 186–205. https://doi.org/10.1080/0886571X.2016.1188340

Polvere, L. (2014). Agency in Institutionalised Youth: A Critical Inquiry. *Child Soc*, *28*(3), 182–193. https://doi.org/10.1111/chso.12048

Pollitt, C. & Brouckaert, G. (2011). *Public management reform, a comparative analysis*. Oxford University Press.

Preisler, J. (2013). Being safe vs. feeling safe. *Fostering Perspectives*, *17*(2), 1–8.

Price, C. J., & Hooven, C. (2018). Interoceptive awareness skills for emotion regulation: theory and approach of mindful awareness in body-oriented therapy (MABT). Frontiers in Psychology, 9, 798. https://doi.org/10.3389/fpsyg.2018.00798

Pölkki, P., Vornanen, R., Pursiainen, M., & Riikonen, M. (2012). Children's Participation in Child-protection Processes as Experienced by Foster Children and Social Workers. *Child Care in Practice*, *18*(2), 107–125. https://doi.org/10.1080/13575279.2011.646954

Pösö, T., Skivenes, M., & Hestbæk, A.-D. (2014). Child protection systems within the Danish, Finnish and Norwegian welfare states—time for a child centric approach? *European Journal of Social Work*, *17*(4), 475–490. https://doi.org/10.1080/13691457.2013.829802

Q-27/2006B (2006). *Deltakelse og innflytelse fra barn og ungdom – informasjon og veiledning for arbeidet i kommunene.*

Quiroga, M.G., & Hamilton-Giachritsis, C., (2016). Attachment styles in children living in alternative care: A systematic review of the literature. *Child and Youth Care Forum* *45*(4), 625–653. https://doi.org/10.1007/s10566-015-9342-x

Radey, M., Langenderfer-Magruder, L., & Schelbe, L. (2022). "Business as Usual": Child protective services workers' perceptions and experiences of and responses to client-perpetrated violence. *Journal of interpersonal violence*, *37*(3-4), NP2101-NP2125.

Rambøll. (2016). *Brukerundersøkelsen 2016. Rapport beregnet til Barne-, ungdoms- og familiedirektoratet*.

Rambøll. (2022). *Barn og unge i barnevernsinstitusjoner - hvordan har de det?*

Ransome, P. (2013). *Ethics and values in social research*. Bloomsbury Publishing.

Rap, S., Verkroost, D., & Bruning, M. (2019). Children's participation in Dutch youth care practice: an exploratory study into the opportunities for child participation in youth care from professionals' perspective. *Child Care in Practice*, *25*(1), 37–50. https://doi.org/10.1080/13575279.2018.1521382

Reime, M. A. (2017). Mellom uansvarlig og kompetent - Forståelser av barnet og rettighetspraksiser blant ansatte i barnevernsinstitusjoner. *Tidsskriftet Norges barnevern*, *94*(1), 22–39. https://doi.org/10.18261/issn.1891-1838-2017-01-03

Reime, M. A. (2018). Between diverging discourses of the child: juveniles' self-construction in coercive residential care. *Child Care in Practice*, *24*(3), 273–287. https://doi.org/10.1080/13575279.2017.1319797

Rivard, J. C., McCorkle, D., Duncan, M. E., Pasquale, L. E., Bloom, S. L., & Abramovitz, R. (2004). Implementing a Trauma Recovery Framework for Youths in Residential Treatment. *Child and Adolescent Social Work Journal*, *21*(5), 529–550. https://doi.org/10.1023/B:CASW.0000043363.14978.e6

Robson, A., Cossar, J., & Quayle, E. (2014). Critical Commentary: The Impact of Work-Related Violence towards Social Workers in Children and Family Services. *British Journal of Social Work*, *44*(4), 924–936. https://doi.org/10.1093/bjsw/bcu015

Ros, N., Van der Helm, P., Wissink, I., Stams, G.-J., & Schaftenaar, P. (2013). Institutional climate and aggression in a secure psychiatric setting. *The journal of forensic psychiatry & psychology*, *24*(6), 713–727. https://doi.org/10.1080/14789949.2013.848460

Rose, N. (1993). Government, authority and expertise in advanced liberalism. *Economy and Society* 23(3): 283–299

Rose, N. (1996). *Inventing our Selves: Psychology, Power and Personhood.* Cambridge University Press

Roy, C., Castonguay, A., Fortin, M., Drolet, C., Franche-Choquette, G., Dumais, A., Lafortune, D., Bernard, P., & Geoffrion, S. (2019). The Use of Restraint and Seclusion in Residential Treatment Care for Youth: A Systematic Review of Related Factors and Interventions. *Trauma, violence & abuse*, 1524838019843196. https://dx.doi.org/10.1177/1524838019843196

Roy, C., Morizot, J., Lamothe, J., & Geoffrion, S. (2020). The influence of residential workers social climate on the use of restraint and seclusion: A longitudinal study in a residential treatment center for youth. *Children and youth services review*, 114, 105035. https://doi.org/10.1016/j.childyouth.2020.105035

Röll, J., Koglin, U., & Petermann, F. (2012). Emotion regulation and childhood aggression: Longitudinal associations. Child Psychiatry & Human Development, 43, 909–923. https://doi.org/10.1007/s10578-012-0303-4

Rudkjoebing, L. A., Bungum, A. B., Flachs, E. M., Eller, N. H., Borritz, M., Aust, B., Rugulies, R., Rod, N. H., Biering, K., & Bonde, J. P. (2020). Work-related exposure to violence or threats and risk of mental disorders and symptoms: a systematic review and meta-analysis. *Scandinavian journal of work, environment & health*, *46*(4), 339.

Sandberg, K. (2020). «Barns rett til å bli hørt.» i Barnekonvensjonen. *Barns rettigheter i Norge*, 92–122.

Sandbæk, M. (2004). Barn i hjelpeapparatet–kompetente og sårbare aktører. *Nordisk sosialt arbeid*, *24*(2), 98–109.

Sanders, R., & Mace, S. (2006). Agency policy and the participation of children and young people in the child protection process. *Child Abuse Review*, *15*(2), 89–109. https://doi.org/10.1002/car.927

Santos, L. F., Pinheiro, M. D. R. C., & Rijo, D. M. (2023). Compassionate Mind Training for caregivers in residential youth care: Investigating their experiences through a thematic analysis. *Mindfulness, 14*(11), 2807–2823. https://doi.org/10.1007/s12671-023-02239-9

Schwandt, T. A. (2003). Three epistemological stances for qualitative inquiry: Interpretativism, hermeneutics and social constructionism. In N. Denzin and Y. Lincoln (Eds.), The Landscape of Qualitative Research: Theories and issues. (292–331). Sage.

Scanlan, J. N. (2010). Interventions To Reduce the Use of Seclusion and Restraint in Inpatient Psychiatric Settings: What We Know So Far a Review of the Literature. *International Journal of Social Psychiatry*, *56*(4), 412–423. https://doi.org/10.1177/0020764009106630

Seeman, M., & Evans, J. W. (1962). Alienation and Learning in a Hospital Setting. *American Sociological Review*, *27*(6), 772–782. https://doi.org/10.2307/2090405

Seim, S., & Slettebø, T. (2017). Challenges of participation in child welfare. *European Journal of Social Work*, *20*(6), 882–893. https://doi.org/10.1080/13691457.2017.1320531

Sekol, I. (2013). Peer violence in adolescent residential care: A qualitative examination of contextual and peer factors. *Children and Youth Services Review*, *35*(12), 1901–1912. https://doi.org/10.1016/j.childyouth.2013.09.006

Sekol, I., & Farrington, D. P. (2016). Psychological and background correlates of bullying in adolescent residential care. *Journal of Social Work*, *16*(4), 429–452. https://doi.org/10.1177/1468017315581530

Seligman, M. E. (1974). Depression and learned helplessness. In M. M. Katz, R. J. Friedman, V. H. Winston, & J. Wiley (Eds.), *The psychology of depression: Contemporary theory and research.* (pp. xvii, 318-xvii, 318). John Wiley & Sons.

Sellers, D. E., Smith, E. G., Izzo, C. V., McCabe, L. A., & Nunno, M. A. (2020). Child feelings of safety in residential care: The supporting role of adult-child relationships. *Residential treatment for children & youth*, *37*(2), 136–155.

Sequeira, H., & Halstead, S. (2004). The psychological effects on nursing staff of administering physical restraint in a secure psychiatric hospital: 'When I go home, it's then that I think about it'. *British Journal of Forensic Practice*, *6*(1), 3–15. http://www.emeraldinsight.com/loi/bjfp

Seti, C. L. (2008). Causes and Treatment of Burnout in Residential Child Care Workers: A Review of the Research. *Residential treatment for children & youth*, *24*(3), 197–229. https://doi.org/10.1080/08865710802111972

Shanks, E., Backe-Hansen, E., Eriksson, P., Lausten, M., Lundström, T., Ranta, H., & Sallnäs, M. (2021). Privatisation of residential care for children and youth in Denmark, Finland, Norway, and Sweden. *Nordisk välfärdsforskning | Nordic Welfare Research*, *6*(3), 128–141. https://doi.org/10.18261/issn.2464-4161-2021-03-02

Shea, B. J., Grimshaw, J. M., Wells, G. A., Boers, M., Andersson, N., Hamel, C., Porter, A. C., Tugwell, P., Moher, D., & Bouter, L. M. (2007). Development of AMSTAR: a measurement tool to assess the methodological quality of systematic reviews. *BMC Medical Research Methodology*, *7*(1), 10. https://doi.org/10.1186/1471-2288-7-10

Shier, M. L., Turpin, A., Nicholas, D. B., & Graham, J. R. (2019). Dynamics of a culture of workplace safety in human service organizations: A qualitative analysis. *International Social Work*, *62*(6), 1561–1574.

Shin, J. (2011). Client violence and its negative impacts on work attitudes of child protection workers compared to community service workers. *Journal of interpersonal violence*, *26*(16), 3338–3360.

Sivesind, K. H. (2017). The changing roles of for-profit and nonprofit welfare provision in Norway, Sweden, and Denmark. In H. Sivesind, K., & J. Saglie (2017). *Promoting active citizenship: Markets and choice in Scandinavian welfare*. Palgrave Macmillan, Cham.

Sim, J., & Waterfield, J. (2019). Focus group methodology: some ethical challenges. *Quality & Quantity*, *53*(6), 3003–3022. https://doi.org/10.1007/s11135-019-00914-5

Sinclair, R. (2004). Participation in practice: making it meaningful, effective and sustainable. *Children & Society*, *18*(2), 106–118. https://doi.org/10.1002/chi.817

Sismondo, T. S. (1993) Some social constructions. *Social Studies of Science* 23, 515–553.
Sivilombudsmannen. (2018). Besøksrapport Kvammen akuttinstitusjon 16.–17.januar. *januar*. https://www.sivilombudet.no/wp-content/uploads/2018/04/Bes%C3%B8ksrapport-Kvammen-akuttinstitusjon-januar-2018.pdf
Skauge, B., Storhaug, A. S., & Marthinsen, E. (2021). The What, Why and How of Child Participation—A Review of the Conceptualization of "Child Participation" in Child Welfare. *Social Sciences*, *10*(2), 54. https://doi.org/10.3390/socsci10020054
Skivenes, M. (2018). Barneperspektiv i fokus. I A. Proff., G. Proff, G. Toresen & I. Steinrem, I.(Red). *Barnas barnevern: trygt, nyttig og samarbeidende for barn*, 12–17.
Slaatto, A., Baugerud, G. A., & Mellblom, A. V. (2023). 'I never win': How Children and Staff in Residential Facilities Experience Meaningful Participation. *Child & Family Social Work*, *n/a*(n/a). https://doi.org/10.1111/cfs.13090
Slaatto, A., Kleppe, L. C., Mellblom, A. V., & Baugerud, G. A. (2022). Youth in Residential Facilities: "Am I Safe?," "Do I Matter?," and "Do You Care?". *Residential treatment for children & youth*, 1–22. https://doi.org/10.1080/0886571X.2022.2082628
Slaatto, A., Mellblom, A. V., Kleppe, L. C., & Baugerud, G. A. (2021b). Safety in Residential Youth Facilities: Staff Perceptions of Safety and Experiences of the "Basic Training Program in Safety and Security". *Residential treatment for children & youth*, 1–26. https://doi.org/10.1080/0886571X.2021.1978035
Slaatto, A., Mellblom, A. V., Kleppe, L. C., Baugerud, G. A., & Kjøbli, J. (2021a). Conflict prevention, de-escalation and restraint in children/youth inpatient and residential facilities: A systematic mapping review. *Children and Youth Services Review*, *127*(august), 106069. https://doi.org/10.1016/j.childyouth.2021.106069
Smith, M., & Myers-Bowman, K. (2009). The restraint spiral: Emergent themes in the perceptions of physical restraint of juveniles. *Child Welfare*, *88*, 57–83.
Smith, Y. (2014). Rethinking Decision Making: An Ethnographic Study of Worker Agency in Crisis Intervention. *Social Service Review*, *88*(3), 407–442. https://doi.org/10.1086/677846
Smith, Y., Colletta, L., & Bender, A. E. (2017). Client Violence Against Youth Care Workers: Findings of an Exploratory Study of Workforce Issues in Residential Treatment. *Journal of interpersonal violence*, *0*(0), 0886260517743551. https://doi.org/10.1177/0886260517743551
Smith, Y., & Spitzmueller, M. C. (2016). Worker Perspectives on Contemporary Milieu Therapy: A Cross-Site Ethnographic Study. *Soc Work Res*, *40*(2), 105–116. https://doi.org/10.1093/swr/svw003
Sommerfeldt, M. B. (2019). Relasjoner mellom barn og voksne på barneverninstitusjoneri Norge: Vår tids forståelser sett i et historisk perspektiv. *Tidsskriftet Norges barnevern*, *96*(3), 172–188. https://doi.org/10.18261/ISSN.1891-1838-2019-03-04
Sommerfeldt, M. B. (2022). "Sometimes I feel at home" Adolescents' narratives of everyday life in residential care. *Nordic Social Work Research.* https://doi.org/10.1108/JCS-12-2020-0086
Sorensen, J. L., Hettema, J.E. & Larios, S. (2009). Chapter one – What Is Evidence-Based Treatment? *Evidence-Based Addiction Treatment.* 1-20. https://doi.org/10.1016/B978-0-12-374348-0.00001-x
Souverein, F., Hales, H., Anderson, P., Argent, S. E., Bartlett, A., Blower, A., Delmage, E., Enell, S., Eske Henriksen, A.-K., Koomen, K., & Oostermeijer, S. (2022). Mental health, welfare or justice: An introductory global overview of differences between countries in the scale and approach to secure placements of children and young people. *Criminal Behaviour and Mental Health*, *32*(3), 238–247. https://doi.org/10.1002/cbm.2234

Souverein, F. A., Van der Helm, G. H. P., & Stams, G. J. J. M. (2013). 'Nothing works' in secure residential youth care? *Children and Youth Services Review*, *35*(12), 1941–1945. https://doi.org/10.1016/j.childyouth.2013.09.010

SSB. (2022). *tabell 10660*.

Stake, R. E. (2010). *Qualitative Research: Studying How Things Work*. Guilford Publications. https://books.google.se/books?id=mBwVGAFkd1YC

Stanko, E. A. (2005). *The meanings of violence*. Routledge.

Steckley, L. (2012). Touch, physical restraint and therapeutic containment in residential child care. *British Journal of Social Work*, *42*(3), 537–555. http://bjsw.oxfordjournals.org/

Steckley, L. (2018). Catharsis, containment and physical restraint in residential child care. *British Journal of Social Work*, *48*(6), 1645–1663. https://doi.org/10.1093/bjsw/bcx131

Stenius, K., & Storbjörk, J. (2020). Balancing welfare and market logics: Procurement regulations for social and health services in four Nordic welfare states. *Nordic Studies on Alcohol and Drugs, 37*(1), 6– 31.

Stevenson, K. N., Jack, S. M., O'Mara, L., & LeGris, J. (2015). Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: an interpretive descriptive study. *BMC nursing*, *14*, 35. https://dx.doi.org/10.1186/s12912-015-0079-5

Stewart, D. W., & Shamdasani, P. N. (2014). *Focus groups: Theory and practice* (Vol. 20). Sage publications.

Stewart, S. L., Theall-Honey, L., Armieri, A., & Cullion, C. (2010). Predicting the utilization of intrusive interventions at a tertiary residential treatment center. *Residential treatment for children & youth*, *27*(3), 175–190. https://doi.org/10.1080/0886571X.2010.500152

Storø, J., Backe-Hansen, E., & Løvgren, M. (2017). Hva muliggjør godt institusjonsarbeid?- Kunnskapsoversikt til prosjektet «Barneverninstitusjoner som arena for omsorg». *Tidsskriftet Norges barnevern*, *94*(3), 166–184.

Strandbu, A. (2010). Barnets deltakelse og barnets beste i barnevernet. In A. T. Kjøholt (Ed.), *Barn som samfunnsborgere - til barnets beste?* Universitetsforlaget.

Strijbosch, E. L. L., Wissink, I. B., van der Helm, G. H. P., & Stams, G. J. J. M. (2019). Building a positive group climate together: How monitoring instruments are part of an improvement process in residential care for children. *Children and Youth Services Review*, *96*, 266–277. https://doi.org/10.1016/j.childyouth.2018.11.051

Stuart, C. (2009). *Foundations of child and youth care*. Kendall Hunt.

Swedish National Board of Health and Welfare (2019). *Statistik om socialtjänstinsatser till barn och unga 2018.* Socialstyrelsen.

Sæbjørnsen, S. E. N., & Willumsen, E. (2017). Service user participation in interprofessional teams in child welfare in Norway: vulnerable adolescents' perceptions. *Child & Family Social Work*, *22*(S2), 43–53. https://doi.org/10.1111/cfs.12242

Ten Brummelaar, M., Harder, A. T., Kalverboer, M. E., Post, W. J., & Knorth, E. J. (2018). Participation of youth in decision-making procedures during residential care: A narrative review. *Child & Family Social Work*, *23*(1), 33–44. https://doi.org/10.1111/cfs.12381

Thoburn, J., & Ainsworth, F. (2015). Making sense of differential cross-national placement rates for therapeutic residential care. Some takeaway messages for policy. J.K. Whittaker, J.F. del Valle & L. Holmes, L. (Eds.), Therapeutic residential care with children and youth: Developing evidence-based international practice, 37–49.

Thoburn, J. (2016). Residential care as a permanence option for young people needing longer-term care. *Children and Youth Services Review*, *69*, 19–28. https://doi.org/10.1016/j.childyouth.2016.07.020

Thomas, N. (2002). *Children, family and the state: Decision-making and child participation*. MIT Press.
Thomas, N., & O'Kane, C. (1998). When children's wishes and feelings clash with their `best interests'. *International Journal of Children's Rights*, *6*(2), 137–154. https://doi.org/10.1163/15718189820494003
Thompson, R.A., & Meyer, S. (2007). Socialization of emotion regulation in the family. In J.J. Gross (Ed.), *Handbook of emotion regulation* (249–268)
Thuen, H. (2002). Barnevernsinstitusjonens legitimitet i historien. *Norsk pedagogisk tidsskrift*, *86*(2–3).
Tjelflaat, T., & Ulset, G. (2007). Barn og unges medvirkning i barneverninstitusjon. *Rapport nr. 11*
Tjelflaat, T., & Ulset, G. (2008). Kan rutiner og regler hindre barn og unges medvirkning i barneverninstitusjon. *Norges barnevern*, *1*.
Tjora, A. H. (2019). *Qualitative research as stepwise-deductive induction* (Vol. 26). Routledge.
Tjora, A. H. (2021). *Kvalitative forskningsmetoder i praksis*. Gyldendal
Trawick, E. S., Aber, M., Allen, N., & Fitts, J. (2019). The strength of youth voice: exploring the influence of youth strength-perspectives on desired outcomes for youth enrolled in system-of-care services. *Journal of Prevention & Intervention in the Community*, *47*(2), 104–124.
Tremblay, C., Haines III, V. Y., & Joly, J. (2016). Staff turnover and service quality within residential settings. *Human Service Organizations: Management, Leadership & Governance*, *40*(1), 22–36.
Trieschman, A. E., Whittaker, J. K., & Brendtro, L. K. (1969). *The other 23 hours*. Aldine Transaction.
Ulset, G. (2014). Tilværelse og oppvekst i barneverninstitusjon. *Tidsskrift for ungdomsforskning*, *10*(1).
Ulset, G. (2018). Skiftende regler og praksiser i omsorgsmiljøet i en barneverninstitusjon: – betydninger for ungdommenes opplevde trygghet og trivsel. *Tidsskriftet Norges barnevern*, *95*(2–3), 182–199.
Ulset, G., & Melheim, S. (2013). *Håndtering av tvang i barnevernsinstitusjoner. Ansattes, lederes og tilsynets perspektiver (Handling coercion in child welfare institutions. The perspectives of employees, managers and supervisors)* (25). NTNU Samfunnsforskning/NTNU Regionalt kunnskapssenter for barn og unge - psykisk helse og barnevern). N.S.N.R.k.f.b.o.u.-p.h.o. barnevern. https://www.ntnu.no/documents/10293/0/Håndtering+av+tvang+i+barneverninstitusjoner/9f436c1b-92ef-4989-99c9-da243e704dda
Ulset, G., & Tjelflaat, T. (2012). *Tvang i barneverninstitusjoner : ungdommens perspektiver* (Vol. nr. 12). NTNU samfunnsforskning, Barnevernets utviklingssenter.
Ulset, G., & Tjelflaat, T. (2013). Ikke et sted å kalle et hjem? – Betydningen av tvangsbruk ved opphold i barneverninstitusjon. *Tidsskriftet Norges barnevern*, *90*(2), 69–83. https://doi.org/10.18261/ISSN1891-1838-2013-02-02
UNCRC. Convention on the Rights of the Child (1989). United Nations Human Rights. http://www.ohchr.org/en/professionalinterest/pages/crc.aspx
Valentine, k. (2011). Accounting for Agency. *Children & Society*, *25*(5), 347–358. https://doi.org/10.1111/j.1099-0860.2009.00279.x
Van Bijleveld, G. G., Bunders-Aelen, J. F. G., & Dedding, C. W. M. (2020). Exploring the essence of enabling child participation within child protection services. *Child & Family Social Work*, *25*(2), 286–293. https://doi.org/10.1111/cfs.12684

Van Bijleveld, G. G., Dedding, C. W. M., & Bunders-Aelen, J. F. G. (2014). Seeing eye to eye or not? Young people's and child protection workers' perspectives on children's participation within the Dutch child protection and welfare services. *Children and Youth Services Review*, *47*, 253–259. https://doi.org/10.1016/j.childyouth.2014.09.018

Van Bijleveld, G. G., Dedding, C. W. M., & Bunders-Aelen, J. F. G. (2015). Children's and young people's participation within child welfare and child protection services: a state-of-the-art review. *Child & Family Social Work*, *20*(2), 129–138. https://doi.org/10.1111/cfs.12082

Van Dam, C., Nijhof, K. S., Veerman, J. W., Engels, R. C. M. E., Scholte, R. H. J., & Delsing, M. J. M. H. (2011). Group Care Worker Behavior and Adolescents' Internalizing and Externalizing Problems in Compulsory Residential Care. *Residential treatment for children & youth*, *28*(3), 232–250. https://doi.org/10.1080/0886571X.2011.605050

Van der Helm, Stams, G. J. J. M., van der Stel, J. C., van Langen, M. A. M., & van der Laan, P. H. (2012). Group Climate and Empathy in a Sample of Incarcerated Boys. *International journal of offender therapy and comparative criminology*, *56*(8), 1149–1160. https://doi.org/10.1177/0306624x11421649

Van der Helm, G. H. P. (2011). *First do no harm: Living group climate in secure juvenile correctional institutions*. Doctoral, Uitgeverij SWPBV.

Van der Helm, G. H. P., Kuiper, C. H. Z., & Stams, G. J. J. M. (2018). Group climate and treatment motivation in secure residential and forensic youth care from the perspective of self determination theory. *Children and Youth Services Review*, *93*, 339–344. https://doi.org/10.1016/j.childyouth.2018.07.028

Van der Helm, P., Boekee, I., Jan Stams, G., & van der Laan, P. (2011). Fear is the key: keeping the balance between flexibility and control in a Dutch youth prison. *Journal of Children's Services*, *6*(4), 248–263. https://doi.org/10.1108/17466661111190947

Van der Helm, P., Stams, G.-J., van Genabeek, M., & van der Laan, P. (2012). Group climate, personality, and self-reported aggression in incarcerated male youth. *The journal of forensic psychiatry & psychology*, *23*(1), 23–39. https://doi.org/10.1080/14789949.2011.633615

Van der Helm, P., Stams, G. J., & Van der Laan, P. (2011). Measuring Group Climate in Prison. *The Prison Journal*, *91*(2), 158–176. https://doi.org/10.1177/0032885511403595

Van der Waldt, G. (2021). The judicious use of theory in social science research. Journal for Transdisciplinary Research in Southern Africa, 17 (1). e1-e9. https://doi.org/10.4102/td.v17i1.1039

Van Dorp, M., Nijhof, K. S., Popma, A., Twisk, J., & Mulder, E. A. (2023). Change over time: The use of seclusion in secure residential youth care in The Netherlands. *Residential Treatment for Children & Youth, 40*(3), 305–323. https://doi.org/10.1080/0886571X.2022.2105277

Van Dorp, M., Nijhof, K. S., Mulder, E. A., & Popma, A. (2021). Defining Seclusion: A Qualitative Multiphase Study Based on the Perspectives of Youth and Professionals in Secure Residential Youth Care in the Netherlands. *Residential treatment for children & youth*, *38*(4), 404–423. https://doi.org/10.1080/0886571X.2021.1879710

Van Gink, K., Vermeiren, R., Goddard, N., van Domburgh, L., van der Stegen, B., Twisk, J., Popma, A., & Jansen, L. (2018). The influence of Non-violent Resistance on work climate, living group climate and aggression in child and adolescent residential care. *Children and Youth Services Review*, *94*, 456–465. https://doi.org/10.1016/j.childyouth.2018.08.009

Van IJzendoorn, M.H., Palacios, J., Sonuga-Barke, E.J.S., Gunnar, M.R., Vorria, P., McCall, R.B., & Juffer, F. (2011). Children in institutional care: Delayed development and resilience. In R. B. McCall, M. H. IJzendoorn, F. Juffer, C.J. Groark, & V. K. Groza (Eds.), *Children without permanent parents: Research, practice and policy* (Vol. 76, 8–30). Monographs of the Society for Research in Child Development. https://doi.org/10.1111/j.1540-5834.2011.00626.x

Van Wijk-Herbrink, M. F., Arntz, A., Broers, N. J., Roelofs, J., & Bernstein, D. P. (2021). A schema therapy based milieu in secure residential youth care: Effects on aggression, group climate, repressive staff interventions, and team functioning. *Residential Treatment for Children & Youth, 38*(3), 289–306. https://doi.org/10.1080/0886571X.2019.1692758

Vasileva, M., & Petermann, F. (2018). Attachment, development, and mental health in abused and neglected preschool children in foster care: A meta-analysis. *Trauma, Violence & Abuse, 19*(4), 443–458. https://doi.org/10.1177/1524838016669503

Verhellen, E. (2000). *Convention on the rights of the child: background, motivation, strategies, main themes*. ERIC.

Vis, S. A., Holtan, A., & Thomas, N. (2012). Obstacles for child participation in care and protection cases—why Norwegian social workers find it difficult. *Child Abuse Review*, *21*(1), 7–23. https://doi.org/10.1002/car.1155

Vis, S. A., Strandbu, A., Holtan, A., & Thomas, N. (2011). Participation and health – a research review of child participation in planning and decision-making. *Child & Family Social Work*, *16*(3), 325–335. https://doi.org/10.1111/j.1365-2206.2010.00743.x

Vis, S. A., & Thomas, N. (2009). Beyond talking – children's participation in Norwegian care and protection cases. *European Journal of Social Work*, *12*(2), 155–168. https://doi.org/10.1080/13691450802567465

Vårdanalys. (2018). *Fatta läget. Om systematisk uppföljning av den sociala dygnsvården för barn och unga.* (2018:9).

Warming, H. (2015). The life of children in care in Denmark: A struggle over recognition. *Childhood*, *22*(2), 248-262. https://doi.org/10.1177/0907568214522838

Warming, H. (2017). The Role of Social Work Practice and Policy in the Lived and Intimate Citizenship of Young People with Psychological Disorders. In H. Warming & K. Fahnøe (Eds.), *Lived Citizenship on the Edge of Society: Rights, Belonging, Intimate Life and Spatiality* (63–87). Springer International Publishing. https://doi.org/10.1007/978-3-319-55068-8_4

Warwick, D. P. (1982). Types of harm in social research. *Ethical issues in social science research*, 101–124.

Whittaker, J. K., Holmes, L., del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J., Bellonci, C., Berridge, D., Bravo, A., Canali, C., Courtney, M., Currey, L., Daly, D., Gilligan, R., Grietens, H., Harder, A., Holden, M., James, S., Kendrick, A., Knorth, E., Lausten, M., Lyons, J., Martin, E., McDermid, S., McNamara, P., Palareti, L., Ramsey, S., Sisson, K., Small, R., Thoburn, J., Thompson, R., & Zeira, A. (2016). Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care*. *Residential treatment for children & youth*, *33*(2), 89–106. https://doi.org/10.1080/0886571X.2016.1215755

Willig, C. (2013). *Introducing qualitative research in psychology,* 3rd. ed. Open University Press

Winstanley, S., & Hales, L. (2014). A Preliminary Study of Burnout in Residential Social Workers Experiencing Workplace Aggression: Might It Be Cyclical? *The British journal of social work*, *45*(1), 24–33. https://doi.org/10.1093/bjsw/bcu036

Woolfson, R. C., Heffernan, E., Paul, M., & Brown, M. (2009). Young People's Views of the Child Protection System in Scotland. *The British journal of social work*, *40*(7), 2069–2085. https://doi.org/10.1093/bjsw/bcp120
Young, I. M. (2011). *Justice and the Politics of Difference*. Princeton University Press. https://doi.org/10.1515/9781400839902
Zegers, M. A., Schuengel, C., Van IJzendoorn, M. H., & Janssens, J. M. (2008). Attachment and problem behavior of adolescents during residential treatment. *Attachment & human development*, *10*(1), 91–103.

Vurdering av behandling av personopplysninger

Referansenummer
339013

Vurderingstype
DPIA

Dato
12.04.2021

Tittel
Økt trygghet og sikkerhet for barn/ungdom og ansatte i barnevernsinstitusjoner

Behandlingsansvarlig institusjon
OsloMet – storbyuniversitetet / Fakultet for samfunnsvitenskap / Institutt for sosialfag

Prosjektansvarlig
Ane Slaatto

Prosjektperiode
01.11.2019 - 26.08.2023

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Allmennhetens interesse (Personvernforordningen art. 6 nr. 1 bokstav e)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)
Arkivformål i allmenhetens interesse, eller for formål knyttet til vitenskapelig eller historisk forskning eller for statistiske formål (Personvernforordningen art. 9 nr. 2 bokstav j)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 26.08.2028.

Meldeskjema

Kommentar
Prosjektet ble ved innmelding vurdert å innebære en høy risiko for de registrertes rettigheter og friheter, noe som utløser krav om personvernkonsekvensvurdering (DPIA) jf. personvernforordningen art. 35. NSD har i samråd med prosjektansvarlig og personvernombud gjennomført en slik vurdering.

Ved å gjennomføre de planlagte tiltakene, mener NSD at personvernrisikoen er redusert i en slik grad at behandlingen kan gjennomføres i samsvar med personvernforordningen, uten behov for forhåndsdrøfting med Datatilsynet. Behandlingsansvarlig institusjon har bekreftet at vurderingen er tilfredsstillende utført og at prosjektet kan gjennomføres, jf. brev av 25.03.2021. Godkjent DPIA er lastet opp til meldeskjema med versjon 24.03.2021.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp underveis (hvert annet år) og 30 dager før planlagt avslutning for å avklare om behandlingen av personopplysningene avsluttes som planlagt/pågår i tråd med den behandlingen som er dokumentert.

Lykke til med prosjektet!

Kontaktperson hos NSD: Siri Tenden

Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Vil du delta i forskningsprosjektet

"Opplæring og trening for økt trygghet og sikkerhet på barneverninstitusjoner"?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å få mer kunnskap om hvordan ungdom og ansatte opplever trygghet og sikkerhet på barnevernsinstitusjoner. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål
Dette prosjektet inngår i en doktorgradsstudie utført av stipendiat Ane Slaatto. Doktorgradens overordnede problemstilling er: «Implementeres og virker opplæringsprogrammet for økt trygghet og sikkerhet for barn/ungdom og ansatte i statlige barneverninstitusjoner etter intensjonene?».

Hovedmålet er å få kunnskap om opplæringsprogrammet dere har deltatt i bidrar til økt trygghet og sikkerhet for barn/ungdom og ansatte i barnevernsinstitusjoner. Det skal undersøkes hvordan praksis påvirkes og hvilken betydning det har for både ungdom og ansatte, og hva som evt. bør forbedres.

Delmål er å få sikker kunnskap om opplæringsprogrammet fører til:
- økt bevissthet og bedre forebyggende arbeid utført av de ansatte
- at det oppstår færre uønskede og konfliktfylte hendelser som bedre forutses, forebygges og håndteres på en trygg og sikker måte
- at ungdommer opplever å bli møtt på en konfliktdempende måte
- at behovet for bruk av tvang og fysisk makt reduseres
- økt trygghet og sikkerhet for både barn/ungdom og ansatte
- at kvaliteten på institusjonsoppholdet forbedres i sin helhet

Resultatene av forskningsprosjektet skal bidra til å videreutvikle effektive omsorgstjenester av høy kvalitet for barn/ungdom, samt helsefremmende arbeidsplasser med fokus på trygghet og sikkerhet. Forskningsprosjektet i sin helhet skal resultere i vitenskapelige artikler publisert i internasjonale tidsskrift.

Hvem er ansvarlig for forskningsprosjektet?
OsloMet – storbyuniversitetet er ansvarlig for prosjektet, og utfører dette i samarbeid med Regionsenter for barn og unges psykiske helse (RBUP).

Hvorfor får du spørsmål om å delta?
Utvalget til denne studien er et strategisk utvalgt ut fra variasjonskriterier, blant annet geografi, plasseringshjemler. Tilsammen skal 3-4 institusjoner/enheter delta i denne studien. I tillegg til fokusgruppeintervju med ansatte, inviteres ungdom fra 16 år og oppover som bor hos dere spurt om de kan tenke seg å delta i et eget fokusgruppeintervju. Din enhetsleder er kontaktet og godkjent at alle ansatte på din enhet med over 50% stilling får denne forespørselen.

Hva innebærer det for deg å delta?
Hvis du velger å delta i prosjektet, innebærer det at du deltar på et fokusgruppeintervju med forhåpentligvis mellom 4-7 deltakere/ansatte fra din enhet. Dette vil ta ca 1-2 timer. Fokusgruppeintervjuer egner seg godt til å belyse temaer gjennom en samtale/diskusjon mellom deltakerne. Intervjuet tas opp på lydopptak og lagres sikkert i henhold til personvernlovgivning og retningslinjer.

Temaene i intervjuet omhandler trygghet på arbeidsplassen, konflikthåndtering og ungdommenes rettigheter, samt hvordan programmet i trygghet og sikkerhet påvirker praksis på institusjonen.

Det er frivillig å delta i prosjektet
Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

- Stipendiaten, hovedveileder ved behandlingsansvarlig institusjon Lise Kleppe og biveileder ved RBUP John Kjøbli, samt en observatør som deltar på intervjuene har tilgang til dataene.
- Dataene som samles inn vil lagres på en sikker forskningsserver «TSD2.0».
- Navnet og kontaktopplysningene dine vil jeg erstatte med en kode. Koblingene mellom koden og navnet ditt (kodenøkkelen) lagres og oppbevares adskilt fra øvrige data.

Under intervju med ungdom vil det presiseres for ungdommene at de ikke skal nevne navn på ansatte, men det kan likevel forekomme. Navnene vil i slike tilfeller bli anonymisert.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?
Prosjektet skal etter planen avsluttes 01.09.2023. Datamaterialet lagres i inntil 5 år etter dette, for å kunne anvende disse i videre analysearbeid. Dataene lagres i godkjent datalagringssystem, TSD 2.0.

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke. På oppdrag fra OsloMet – storbyuniversitetet har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- OsloMet – storbyuniversitetet ved Ane Slaatto på tlf 46617976 eller epost: anejacob@oslomet.no.
- Vårt personvernombud: Ingrid Jacobsen, epost: personvernombud@oslomet.no
- NSD – Norsk senter for forskningsdata AS, på epost personverntjenester@nsd.no eller telefon: 55 58 21 17.

Med vennlig hilsen

Prosjektansvarlig
Ane Slaatto

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet «Opplæring og trening for økt trygghet og sikkerhet på barneverninstitusjoner», og har fått anledning til å stille spørsmål. Jeg samtykker til:

- ☐ å delta i fokusgruppeintervju
- ☐ at mine personopplysninger lagres i inntil 5 år etter prosjektslutt, til mulig videre analyse

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, senest september 2028.

(Signert av prosjektdeltaker, dato)

Vil du delta i forskningsprosjektet

”Opplæring og trening for økt trygghet og sikkerhet på barneverninstitusjoner”?

Dette er et spørsmål til deg om du vil delta i et forskningsprosjekt. Vi vil vite mer om hvordan ungdom og ansatte opplever trygghet og sikkerhet på barnevernsinstitusjoner. Her gir vi deg informasjon om prosjektet og hva det betyr for deg å være med.

Ane Slaatto er doktorgradsstipendiat ved OsloMet – Storbyuniversitetet og er den som skal være med på intervjuene sammen med en person til. Vi vil gjerne vite hvordan opplæringen de ansatte har fått i trygghet og sikkerhet påvirker deg som bor her. Vi lurer på hvordan du og de andre ungdommene blir sett, hørt og forstått av ansatte når det oppstår konflikter. Vi lurer også på hva som kan gjøre at ungdom føler seg trygge når de bor på institusjon.

Det vi finner ut i prosjektet skal bidra til at både ungdom og ansatte har det så trygt og sikkert som mulig når de bor og jobber på institusjon. I prosjektet skal Ane skrive om hva både ansatte og ungdommer mener, og alle som vil kan lese det.

Hvem er ansvarlig for prosjektet?
OsloMet – storbyuniversitetet er ansvarlig for prosjektet og samarbeider med Regionsenteret for barn og unges psykiske helse (RBUP).

Hvorfor får du spørsmål om å delta?
Vi har valgt din institusjon ut fra hvor i landet den ligger, hvor mange som bor der og hvorfor dere bor her. Det er til sammen 3 eller 4 institusjoner i hele Norge som får være med på intervjuer. I tillegg til intervju med dere som er ungdommer, blir de ansatte også spurt om de kan være med i et eget intervju. Vi har spurt lederen på institusjonen din om det er greit at vi spør både ungdom og ansatte om de vil være med. Han eller hun sa ja til det.

Hva betyr det for deg å være med?
Hvis du velger å være med i prosjektet, betyr det at du er med på et fokusgruppeintervju med mellom 4-7 ungdom fra din enhet. Det vil ta ca 1 time, og vi tar med noe godt å spise og drikke. Fokusgruppeintervju er en samtale mellom ungdommene om forskjellige temaer. De viktigste temaene i intervjuet er trygghet, konflikter og rettigheter. Hvis du blir med på et individuelt intervju kan vi snakkes på telefon eller møtes et sted der det passer deg. Dette tar ca 15-30 minutter. Det vil være de samme temaene som i gruppeintervju.

Intervjuet tas opp på lydopptak og lagres på en sikker måte, i henhold til personvernloven.

Det er frivillig å delta
Det er frivillig å være med i prosjektet. Hvis du velger å være med, kan du når som helst si at du ikke vil likevel, uten å si hvorfor. Alle opplysninger om deg vil bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil være med eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Vi vil bare bruke opplysningene om deg til det vi har fortalt om her. Vi behandler opplysningene slik at ingen kan kjenne deg igjen og få vite noe om deg. Dette er i samsvar med personvernregelverket.

- Stipendiaten Ane Slaatto, hovedveileder ved behandlingsansvarlig institusjon Lise Kleppe og biveileder ved RBUP John Kjøbli, samt en observatør som deltar på intervjuene kan se opplysningene.
- Dataene som samles inn vil lagres på en sikker forskningsserver «TSD2.0».
- Navnet og kontaktopplysningene dine vil jeg erstatte med en kode. Koblingene mellom koden og navnet ditt (kodenøkkelen) lagres og oppbevares adskilt fra det du har sagt.

Hva skjer med opplysningene dine når vi avslutter prosjektet?
Prosjektet skal etter planen avsluttes 01.09.2023. Datamaterialet lagres i inntil 5 år etter prosjektslutt. Dette for å kunne bruke disse til å skrive mer om resultatene. Dataene lagres i godkjent datalagringssystem, TSD 2.0.

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:

- å få se hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger, og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi kan bare gjøre dette hvis du er 16 år eller eldre, og at du godkjenner og skriver under på samtykkeskjema nederst på arket.

På oppdrag fra OsloMet – storbyuniversitetet har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til prosjektet, eller ønsker å bruke dine rettigheter, ta kontakt med:

- OsloMet – storbyuniversitetet ved Ane Slaatto på tlf 46617976 eller mail anejacob@oslomet.no.
- Vårt personvernombud: Ingrid Jacobsen, epost: personvernombud@oslomet.no
- NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Prosjektansvarlig
Ane Slaatto

Samtykkeerklæring

Jeg har fått og forstått informasjon om prosjektet «Opplæring og trening for økt trygghet og sikkerhet på barneverninstitusjoner», og har fått stille spørsmål jeg ønsker. Jeg samtykker til:

- ☐ å delta i individuelt intervju
- ☐ at mine personopplysninger lagres i inntil 5 år etter prosjektslutt, til mulig videre analyse

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, senest september 2028.

(Signert av prosjektdeltaker, dato)

Intervjuguide miljøterapeuter

Trygghet på arbeidsplassen

I hvilken grad kjenner dere trygghet på institusjonen? Hva påvirker tryggheten? Hva er trygt eller utrygt? Kan dere gi eksempler?

Hvordan ivaretas både ungdom og ansattes trygghet og sikkerhet?

(Sykefravær, vikarbruk, turnover, arbeidsmiljø, ledelse, støtte, lokaler?)

Opplæringsprogrammet i trygghet og sikkerhet

Hvordan har opplæringsprogrammet i trygghet og sikkerhet, med påfølgende trening på enheten påvirket deres praksis?

Hvis dere tenker tilbake til før opplæring, er det noe som er annerledes nå?

Hvilke utfordringer, hindringer og suksessfaktorer har dere opplevd underveis i prosessen?

Lederstøtte?

Hva tror dere skal til for at dere skal få trent 4 timer per måned?

Konflikthåndtering

Hva gjør dere i konfliktsituasjoner med ungdommer?

Hvordan møter dere ungdom i konfliktsituasjoner?

Hva gjør dere etter konfliktsituasjoner – ansatte? ungdom?

Hva gjøres for å forebygge at det skal skje igjen?

Hva gjør dere for å forebygge aggresjon og utagering, vold?

Ungdommenes rettigheter? Kjenner ungdommen disse? Hva gjør dere for at de skal kjenne til disse? Rettighetsforskriften?

Intervjuguide ungdom

Kontaktetablering

Kan du/dere (du) fortelle litt om hvordan en vanlig dag ser ut her?

Innhold i hverdagen?

Trygghet

Hva er trygghet for deg?

Hvordan kjenner du trygghet her? Hva kan være utrygt her (på...)?

Hvordan kan du vise forskjellige følelser her?

Kan du gi eksempler?

Informasjon

Vet du hva som skal skje fremover i livet ditt/deres?

Får du informasjon fra ansatte om hva som skal skje og hva som er bestemt?

Hvilke rettigheter tenker du at du har? Noen du ikke opplever blir oppfylt?

Hvordan vet du om de? Noen snakket med deg om de, hvordan?

Får du informasjon om dine rettigheter fra de ansatte? På hvilken måte får du informasjonen?

Blir du hørt?

Syns du at de voksne hører på hva du sier? Lytter de til dine meninger?

Er det trygt å si hva du mener? Holder du noe tilbake?

Føler du deg fri til å si din mening om ditt liv og hva som skal skje videre?

Innflytelse

Føler du at du har kontroll i livene deres?

Hva får du være med å bestemme?

Syns du at du får påvirke det som blir bestemt for deg i ditt liv? Små ting og store ting?

Konflikt

Hva er en konflikt for deg?

Har du opplevd konflikter her med de voksne?

Hva gjør de voksne når det oppstår en konflikt mellom ungdom og voksne?

Hvordan føler du deg behandlet/møtt av de voksne i en sånn situasjon? Hørt, sett, forstått, tatt hensyn til?
Hva gjøres etter sånne hendelser? Samtale?
Hva gjøres for at det ikke skal skje igjen? Har noen snakket med deg om hvordan du ønsker å bli møtt i en konfliktsituasjon?
Har du sett andre ha konflikter med voksne? Hvordan blir det for deg?

Published articles:

Article 1: Conflict prevention, de-escalation and restraint in children/youth inpatient and residential facilities: A systematic mapping review (Slaatto et al., 2021a). Children & Youth Services Review, 127, 106069.
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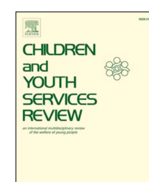

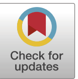

Conflict prevention, de-escalation and restraint in children/youth inpatient and residential facilities: A systematic mapping review

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ABSTRACT

Conflict and aggression are well-known concerns in youth inpatient and residential facilities, frequently affecting both the quality of children/youth (hereafter, youth) care and the well-being of staff. Responses, such as restraint and seclusion (R&S), also pose challenges and can threaten the safety of youth and staff.

Various educational and training programs have been implemented to improve practice and create safer places to live and work for both youth and staff. This article reviews the research on the results of measures taken in response to conflict and aggression in youth facilities. Because very little on this topic was published before 2015, we searched for both systematic reviews and original studies published between January 2015 and November 2020 in a total of 7 databases. Our aims in this article are to 1) describe and review the literature related to the effects of interventions to prevent and manage aggression and violence in inpatient and residential youth facilities, 2) describe and review the literature on the effects of R&S and experiences of youth and staff, related to youth violence, R&S, and 3) identify potential gaps in knowledge about these issues that future research could narrow or close.

The literature search retrieved 4,698 potentially relevant publications. A total of 14 publications—2 reviews and 12 individual case studies—met our inclusion criteria. Most of the 14 studies were conducted in residential-care and hospital/psychiatric facilities; a small number were conducted in juvenile justice facilities.

Our review indicates that interventions that contributed to a reduction in episodes of R&S differed from those that led to a reduction in conflicts and aggression. The review also indicates that both youth and staff have negative experiences of physical restraint. Results also show that further studies are needed of both the effects and experiences of physical restraint and the effectiveness of de-escalation measures in preventing violence and aggression.

1. Introduction

Many children and youth under 22 years of age (hereafter, youth) who receive care and treatment in various youth facilities, such as juvenile justice facilities, inpatient and residential facilities, have pasts disrupted by incidents of neglect and maltreatment (Carr et al., 2020), histories of abandonment and abuse, and experiences of failure (Briggs et al., 2012; Rivard et al., 2004). Exposure to such life events contributes to higher rates of anti-social behavior, aggression and/or delinquent behaviors (Braga et al., 2017; Connor et al., 2004; Norman et al., 2012). Aggression is understood here as any behavioral act that includes verbal, physical or relational violence against others, the destruction of objects and/or self-harm (Lochman et al., 2009). These youth often struggle with physical, mental and/or social challenges (Jozefiak et al., 2016).

Staff engaged in these facilities are responsible for providing care characterized by good quality and safety, and to facilitate positive development in these youth. Understanding acts of aggression and finding ways to prevent them and intervene when they occur are important given that the facilities are generally oriented towards treatment and rehabilitation of youth (O'Donoghue et al., 2020). The capacity to respond purposefully, safely and effectively to potential and escalating aggression is essential for staff. In situations posing risks of

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violence and damage to person or property, restraint and seclusion (R&S) are sometimes deemed necessary for the safety of youth and/or staff. Seclusion is generally defined as the placement of a person in a specifically designed room in order to deescalate and control behaviors, and assure physical safety (De Hert et al., 2011). The use of restraint refers to a physical intervention, either through therapeutic holding by staff or through the use of mechanical restraining tools. Although interventions in critical situations are needed, use of R&S have been criticized and questioned, as these procedures are considered to be coercive, and have the potential to escalate physical conflicts and/or reduce treatment alliance (De Hert et al., 2011). R&S are also associated with harm to youth and staff, significant costs, reduced quality of care, and less engagement of youth and families (LeBel et al., 2010; Pollastri et al., 2016).

High-risk demographics as well as the clinical characteristics that lead to seclusion can provide information to guide interventions and prevent seclusion events (Vidal et al., 2020). Studies show that aggressive behaviors, escalation in aggression, experiences of restraint and involvement in critical incidents are all associated with the characteristics of youth placed in inpatient and residential facilities (Baeza et al., 2013; Dean et al., 2008; dosReis et al., 2010; Green-Hennessy & Hennessy, 2015; Jacob et al., 2013; van Kessel et al., 2012). Some youth, such as those with intellectual disabilities or autism spectrum disorder, are at significantly increased risk for experiencing R&S during psychiatric hospitalization (O'Donoghue et al., 2020). Multiple studies suggest that the use of R&S correlates with organizational factors, including staff-to-youth ratio and program characteristics (Earle & Forquer, 1995; Joy, 1981; Larue et al. 2009; Maier et al., 1987). Studies, mostly conducted in these settings, have found an association between aggression and environmental factors and facility practices (Delaney et al., 2005; dosReis et al., 2010; Earle & Forquer, 1995; Goren et al., 1993; Green-Hennessy & Hennessy, 2015; Gullick et al., 2005; Leidy et al., 2006; Sourander et al., 2002).

Conflicts, aggression and use of R&S can affect both youth and staff negatively (Miller, 1986; Smith, Colletta, & Bender, 2017; Steckley, 2018; Nyttingnes et al., 2018; Ulset and Melheim, 2013; Ulset and Tjelflaat, 2012). According to Miller (1986), a gap exists between youth and staff perceptions of seclusion, and his results show that for the vast majority of children observed, seclusion resulted in increased anxiety, fear, anger, and hostility as well as power struggles between staff and child. Physical restraint can also be a distressing practice for both youth and staff (Lombart et al., 2020); it can be perceived by youth as offensive, leading to a weakening of the relationship between youth and staff and of youth's perception of the institution as a safe place to live (Ulset & Tjelflaat, 2012).

To counteract these negative impacts, youth facilities have devoted considerable resources to improve quality of practice (Bogo et al., 2014; MacRae & Skinner, 2011). A variety of interventions have been implemented to provide staff with the knowledge and skills needed to prevent and reduce aggressive behavior in youth and to limit the use of R&S (Bower et al., 2003). These interventions are often intended to train staff in how to assess risks and to teach them strategies to prevent, de-escalate and manage conflicts and behavioral crises in a secure manner (Smith, 2014; Smith & Spitzmueller, 2016). De-escalation skills training often involves teaching effective communication and active-listening skills, in addition to role-playing, which involves practicing the use of the desired skills. Smith et al. (2017) concludes that client violence (CV) could be reduced if proper use of de-escalation techniques and behavior management techniques.

Key factors to avoid unnecessary use of R&S are according to Ulset and Melheim (2013) communication with and participation by youth. Reviews of strategies aimed at reducing the use of R&S have concluded that strong leadership, coupled with staff training and preventive interventions, yield promising outcomes (LeBel et al., 2010; Scanlan, 2010). Valenkamp et al. (2014) showed that several interventions reduced both the occurrence and duration of R&S.

Although considerable research has been devoted to adult inpatient facilities, significantly less attention has been paid to similar facilities for youth. A systematic review of literature up through 2015 found very few relevant studies (Lillevik et al., 2016). In this article, we carry forward the literature review by Lillevik et al. (2016) to cover the years 2015 through November 2020 with the aim of determining whether research on this issue has increased. Based on the limited studies found up through 2015, we found it relevant to investigate both effects of interventions to prevent and manage aggression and violence and effects and experiences of R&S. Aims were framed and compiled using PICO format as a framework, which includes four concepts: 1) the patient problem or population, 2) the intervention, 3) the comparison, and 4) the outcome(s) (Aslam & Emmanuel, 2010).

The aims of this study were to 1) describe and review the literature related to the effects of interventions to prevent and manage aggression and violence in inpatient and residential youth facilities, 2) describe and review the literature on the effects of R&S and experiences of youth and staff, related to youth violence, R&S, and 3) identify potential gaps in knowledge about these issues that future research could narrow or close. The aims were prepared based on the assumption that the literature still is limited, as well as we considered aim 1 and 2 to be connected.

2. Materials and methods

This study used systematic mapping in accordance with the Template for a Mapping Study Protocol steps, including research directives, data collection and final results (Template for a mapping study protocol 2019).

2.1. Research directives

We used the search strategy implemented in Lillevik et al. (2016) and replicated by us in the present search. In this first phase, a protocol was produced that included the study topic, its justification, study aims, search strategy, selection criteria and data extraction form.

2.2. Data collection

The search was conducted by the first author in September 2019, and then updated in November 2020, to yield reviews and single case studies in the following electronic databases: Medline, PsycINFO, Web of Science, Cochrane Library, Social Care Online and NCJRS. The following search terms were used in the search strings: health facilities, prisons, residential care, inpatient, institutions, clinics, hospitals, shelters, orphanages, group home, center, jails, de-escalation, prevention, physical intervention, violence, workplace violence, aggression, antisocial behavior, conflict, abuse, safe, safety, unsafe, childhood, youth, minors, child, juvenile, adolescent, young adult, childcare, patient, client, intervention, risk management, experiment, interview, systematic review, *meta*-analysis, isolation, restraint, seclusion, coercion, patient isolation. Due to space limitations, a description of the search strategies is not provided here but is available as a supplementum.

Inclusion/exclusion criteria for abstracts and articles were selected following the method used in Lillevik et al. (2016). Abstracts were reviewed and included if the studies met the following inclusion criteria: (a) residents, users, patients and employees in institutions of mental health care, child welfare and/or youth criminal care, (b) articles published in English, Norwegian, Danish or Swedish, (c) randomized and non-randomized, interrupted time series, systematic overviews, qualitative, cross-section and/or controlled pre- and post-studies, (d) interventions using decreasing/de-escalation measures or techniques in order to avoid, reduce or prevent aggression and violence by residents, users or patients against employees or others; all forms of physical action by employees aimed at residents demonstrating aggressive behavior (such as restraint, isolation, placement on the ground, and evasive maneuvers), and deemed unavoidable to ensure safety, (e) Outcomes, such

as extent of physical and psychological trauma to employees/other residents, deviation reports, damage to fixtures/buildings, duration and extent of aggression/violence, or other adverse events.

Exclusion criteria for published studies comprised the following: (a) chemical restraint, (b) mechanical measures (use of straps), (c) general preventive measures, general violence or general aggression prevention, (d) elderly (60 years +) and the demented, (e) patients with severe developmental disorders, (f) sexually motivated violence, (g) adult patients/residents. Criteria (g) was not an exclusion criterion in the Lillevik et al. (2016) study and was added by us.

The search was defined using the search filter for relevant study designs and was applied first to the period January 2015 – September 2019 and then updated in November 2020.

2.3. Quality assessment

All quality assessments were rated by two authors independently of each other. The systematic reviews were quality rated by using AMSTAR quality assessment. Qualitative research and cross-sectional studies were quality rated by using the Norwegian National Knowledge Center's checklist for qualitative and cross-sectional studies (National knowledge center handbook for health services, 2014). Risk of bias in effect studies was assessed using the Effective Practice and Organization of Care (EPOC) risk-of-bias tool (EPOC, 2015).

3. Results

The results are organized into three sections. First, we present a description of the data selection process. Second, we present characteristics of the included studies, organized into the categories of effect studies, qualitative and cross-sectional studies, and systematic reviews. Third, we present the quality assessment results.

3.1. Results of the search

The selection process involved 3 steps. In the first step, all 3687 identified titles were screened in September 2019 by the first author, who excluded duplicates and made a first selection based on titles (see Fig. 1). In this initial screening, titles referring to the following were excluded: drug prevention, research and treatment of somatic diseases (e.g., HIV, cancer, diabetes), general preventive measures, interventions for the elderly and demented, measures for patients with severe developmental disorders, and measures aimed at sexually motivated violence. In the case of unclear titles, the keywords and abstracts were also screened. To test the quality of the first screening, one of the co-authors screened 10% of the total number of identified abstracts; the result was 100% agreement. This step produced 320 abstracts and titles.

In the second step, the 320 abstracts and titles were screened by two authors. Independently of each other, they identified the titles and summaries against the exclusion and inclusion criteria. This step resulted in 60 references. The third step involved assessing these 60 references for eligibility. All were read in full independently by two researchers. In cases of disagreement as to whether or not to include an article, all 4 researchers conferred to arrive at a consensus decision. This step produced 12 articles—2 systematic reviews and 10 single studies—that met the criteria for inclusion in the review. The first author then screened the reference lists of the 12 articles, finding no additional relevant studies. 320 articles passed the first step, 60 the second and finally 12 articles were deemed eligible for inclusion.

The updated search conducted in November 2020 identified 557 titles. These were screened by the first author, who excluded duplicates and made a first selection based on titles, and in the case of an unclear title, by consulting the abstract. During this initial screening, studies including adults and/or outpatient facilities were excluded, as well as articles not written in English, Norwegian, Swedish nor Danish. To ensure the quality of the first screening, one additional author screened

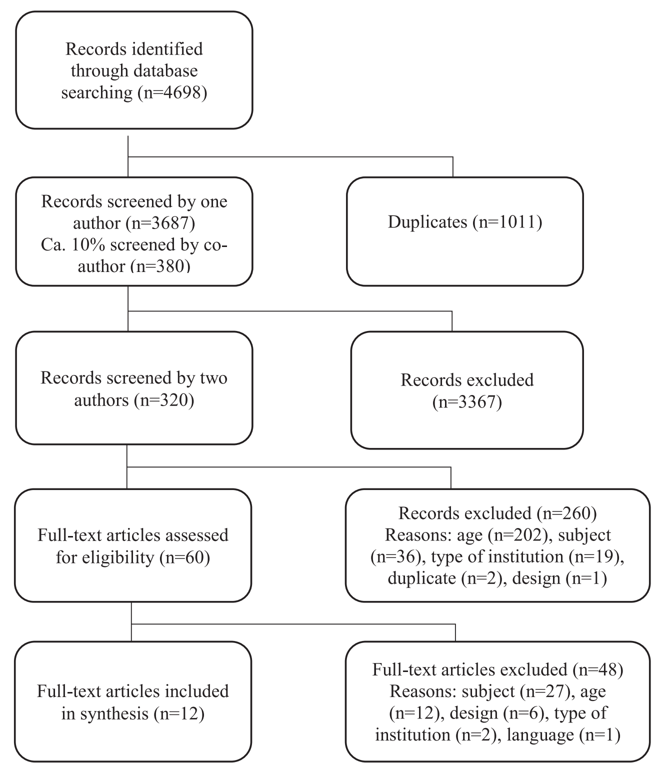

Fig. 1. A flowchart of the systematic mapping review selection procedure, 2015–2019.

10% of the total number of identified abstracts and a 100% agreement was reached. This screening left 7 articles. These were assessed for eligibility and read in full independently by two researchers. None of the articles met the inclusion criteria.

In February 2021 we were made aware of two additional studies (Azeem et al., 2017; Black et al., 2020) that were not captured by our initial search, because neither title, abstract or keywords contained terms like "aggression", "violence", "homicide", "agitat*" or "arous*". However, as both studies were considered eligible for inclusion they were included in the current review, and the total number of studies and reviews became 14.

3.2. Characteristics of the included studies

An overview of the papers included in the study can be found in Tables 1, 2 and 3. Most of the included publications dealt with inpatient hospital care (n = 6) and residential care (n = 5), followed by juvenile justice facilities (n = 2). One review included both inpatient psychiatric care and residential care settings (n = 1) (see Table 2). These facilities are characterized by a structured environment, employing staff who provide 24-hour supervision, treatment and protection to youth during their stay. The age of the youth staying in the facilities ranged from 5 to 22 years. The reason for placement included the youth's health or behavioral problems, criminal activity, or unsafe home environments.

3.2.1. Effect studies

Eight of the articles were effect studies and answer to aim number 1; interventions to prevent and manage aggression and violence in inpatient and residential youth facilities. Of these, 5 were conducted in the United States of America (USA), 1 in England, 1 in New Zealand and 1 in Australia (see Table 1). The aim of the interventions varied across the studies, although most aimed to improve the participants' skills and knowledge, mainly to prevent and manage aggression and conflict, as well as to reduce the use of R&S.

Table 1
Effect studies – design, context, intervention and results.

Study	Design	Participants and context	Intervention	Results
Forbat et al., 2017	Survey/multiple baseline study	Staff/healthcare in paediatric hospital (711 completed at baseline, 313 completed at 6 month follow up). England	A 4-hour training course provided to staff	Learning was retained at 6 months, with staff more able than at baseline to recognize conflict triggers and manage conflict situations.
Forbat & Barclay, 2019	Mixed-methods: Pre/post measures and interviews	Paediatric oncology department. Recordings of frequency and severity of conflicts were completed by the ward staff. Interviews with 10 staff. Australia	A two-stage conflict management framework (CMF) used by staff during daily handovers	Staff found the CMF to be helpful in identifying and managing/de-escalating conflicts between them and patients/families. The number of reported conflicts decreased.
Goldstein et al., 2018	Randomized controlled trial (RCT)	70 female youth (14–20 years) placed at 3 different juvenile justice facilities. 57 completed the study. USA	Juvenile Justice Anger Management (JJAM) treatment for girls	A reduction in anger, reactive physical aggression, and reactive relational aggression.
Izzo et al., 2016	Multiple baseline interrupted time series design	Data from 11 residential childcare agencies. Average number of staff was 13. Average number of youths was 24 per agency. USA	CARE model/program (Children and Residential Experiences)	Led to significant declines in different types of behavioral incidents involving youth aggression and running away.
Lee et al., 2016	Retrospectively examined administrative data, 2003–2012	Data from 3 Washington State Juvenile Justice and Rehabilitation. Administration (JJRA) residential facilities. USA	Implementing psychiatric practice guidelines	Psychiatric medication costs decreased at the facility after implementing the guidelines. Youth aggression did not increase at the same facility.
Magnowski & Cleveland, 2019	Quantitative, retrospective, comparative project. Administrative data, T-test	Inpatient psychiatric unit: 5 beds: 5–12 years, 13 beds: 13–18 years. Inpatient clients admitted to the unit who were physically (71%) or mechanically restrained were included. USA	Milieu nurse-client shift assignment	Use of milieu nurse-client shift assignment is associated with lower monthly restraint rates.
Azeem et al., 2017	Retrospectively examined medical records, July 2004 - March 2007	458 youth in a state psychiatric hospital, 9-bed adolescent girls unit, 9-bed adolescent boys unit and 8-bed unit for children (6–12 years). USA	Six core strategies based on trauma informed care (TIC)	This study shows downward trend in seclusion/restraints among hospitalized youth after implementation of the strategies
Black et al., 2020	Survey pre and post implementation	Child and adolescent inpatient unit, a regional 16 bed unit	Implementation of a collaborative problem-solving approach	The number of restrictive events significantly decreased, including full and partial restraint and seclusion.

Table 2
Systematic reviews – context, intervention and results.

Article	Studies included	Population and context	Interventions	Outcomes, results
Bryson et. al., 2017	13	Children and youth in inpatient psychiatric and residential care settings. Mostly USA	Trauma-informed care (TIC) interventions	Reduced number of episodes of R&S, fewer staff and patient injuries, greater patient and staff satisfaction.
Roy et al., 2021	23	Youth under the age of 21 in residential treatment care. Mostly USA	Interventions aimed at reducing the use of R&S	The majority of the studies evaluating the implementation of programs reported a reduction in the use of R&S

3.2.1.1. Preventing, de-escalating and managing aggression and conflicts. Of the effect studies, one looked at the result of implementation of a four-hour training course on identifying, understanding and managing conflict provided for staff in a paediatric hospital in England (Forbat et al., 2017). The course aimed to enable staff to identify and understand warning signs of conflict and to implement conflict resolution strategies. Findings showed that of the 57% who had experienced conflicts after six months, 91% reported the training to have enabled them to de-escalate the conflict (Forbat et al., 2017). Forbat et al. (2017) concluded that this training has the potential to reduce substantially the human and economic costs of conflicts for healthcare providers, healthcare staff, patients and relatives.

In another study looked at the results of an Australian peadiatric department's implementation of a conflict management framework (CMF), the objective of which was to help staff identify and de-escalate conflicts between staff and patients/families (Forbat & Barclay, 2019). The number of conflicts reported decreased by 64% from baseline to

Table 3
Qualitative and cross-sectional studies – design, context, content and results.

Article	Design	Context	Participants	Content	Results
Bitton & Rajpurkar, 2015	Quantitative/ Questionnaire Comparative	2 residential facilities for children at risk. Israel	50 trained and 50 untrained educational and therapeutic staff	Knowledge and attitudes toward the use of Trauma-informed care (TCI), relationships among style of coping, knowledge and attitudes toward use of TCI	Trained and untrained workers were equally aware of situations requiring physical restraint. Untrained workers supported the use of physical restraint and TCI more than trained workers did.
Smith et al., 2017	Exploratory study, interviews, observations, document review	Residential treatment center. USA	490 h of participant observation, 65 interviews with 51 promise employees	Youth care workers exposure to client violence (CV). Study of workforce issues	Workers reported that CV is common, expected, inevitable and a hard part of their job.
Steckley, 2018	In-depth interviews Qualitative	20 residential childcare establishments. Scotland	Interviews with 37 youths (10–17 years) and 41 practitioners	Experiences of youth and practitioners related to restraint	The majority of youth appear to evince intense emotions during physical restraint. Practitioners reported being affected by the intensity.
Nyttingnes et al., 2018	Cross-sectional study/ Questionnaires/ Quantitative	10 acute and combined (acute and sub-acute) psychiatric wards. Norway	96 inpatients (13–17 years old), staff and clinical records	Adolescents' perceptions or experiences of coercion during inpatient mental health care	34,4% of the total sample reported high experienced coercion (ECS score > 2). 28% of the sample reported a lack of confidence and trust both in parents and staff.

follow-up. Communication regarding conflict identification improved and the number of burnouts decreased. Scores rating compassion and secondary traumatic stress did not change. Forbat and Barclay (2019) concluded that CMF substantially reduces the incidence of conflicts and is an acceptable approach for staff. Both of these effect studies found that staff believed the interventions had been helpful in de-escalating conflicts.

One effect study explored the efficacy of the CARE Program Model, a principle-based program that helps agencies use a set of evidence-informed tenets to guide programming and enrich the relational dynamics (Izzo et al., 2016). The study examined the impact of a setting-level intervention in preventing aggressive or dangerous behavioral incidents among youth living in group-care environments. The three-year implementation of CARE involved intensive training of and consultation with leaders regarding support for and facilitation of daily application of the principles. Results showed that the program led to a significant reduction in 3 different types of behavioral incidents involving youth aggression toward adult staff, property destruction and running away. Aggression toward peers and self-harm also decreased, but less consistently (Izzo et al., 2016). Staff ratings indicating positive organizational social context predicted fewer incidents. These findings support the potential efficacy of the CARE model and illustrate that the intervention may help to disrupt and reduce patterns of coercive caregiving patterns and as well as increase opportunities for healthy social interactions.

A recent study (Magnowski & Cleveland, 2019) aimed to identify the impact of milieu nurse-client assignments on an inpatient psychiatric unit in the USA. The milieu nurse-client shift assignment combined two evidence-based practices, cognitive milieu therapy and nurse presence, to provide an environment of structure, safety, consistency, and empathy. The study concluded that the assignment provided this type of environment and lead to early intervention and use of de-escalation techniques with clients displaying aggressive behaviors. Results also showed that use of the milieu nurse-client shift assignments was associated with lower monthly restraint rates, a reduction not found with individual nurse-client shifts (Magnowski & Cleveland, 2019).

3.2.1.2. Reducing R&S. In the study of Azeem et al. (2017) psychiatric hospital staff received training in six core strategies to be implemented in reducing R&S. These are based on trauma-informed and strength-based care, with the focus on primary prevention principles. These principles included: (1) leadership towards organizational change, (2) use of data to inform practice, (3) workforce development, (4) R&S reduction tools, (5) improve customer‘s role in inpatient units and 6) debriefing techniques. The findings show that R&S reduction can be possibly maintained and safely implemented through the collaborative and concerted effort of staff by utilizing the six core strategies (Azeem et al., 2017).

Another study (Black et al., 2020) which aim was to determine whether implementation of a collaborative problem-solving (CPS) approach would be associated with a decrease in R&S in a child and adolescent inpatient unit, the unit had already begun to implement the six core strategy. Black et al. (2020) considered that they needed additional youth focused tools to help implement Strategy 4. CPS hypothesizes that many episodes of behavioral and emotional dysregulation can be understood as a youth being faced with an expectation that they find difficult to meet based on their lagging skills (Black et al., 2020). The CPS approach facilitates to build lagging skills through the use of a three-step process: (a) the empathy step, (b) adult concern step, (c) the invitation step. The study concluded that a CPS approach significantly decrease use of R&S (Black et al., 2020)

3.2.1.3. Youth aggression, medication and psychiatric practice guidelines. An effect study conducted in juvenile justice facilities sought to assess the impact on medication costs and youth aggression of implementing psychiatric practice guidelines (Lee et al., 2016). Psychiatric practice guidelines involved screening, shared decision making, psychosocial treatments, medication prescribing, and monitoring of side effects. The researchers examined whether implementing these guidelines in 1 facility with an organized psychosocial treatment program reduced medication costs, and whether doing so would affect youth aggression. At this facility the medication cost decreased by 26%. The medication cost decreasing did not affect youth aggression. At the two comparison facilities that did not implement the guidelines, the medication cost increased by 104% and 152% from baseline.

3.2.1.4. Anger management for youth. Goldstein et al. (2018) examined the efficacy of the Juvenile Justice Anger Management (JJAM) treatment program for girls, a group-based anger management and aggression reduction intervention for adolescent in residential juvenile justice placements. The program were designed to meet the needs of adolescent girls in these facilities. Program implementation resulted in a significant reduction in anger, reactive physical aggression and reactive relational aggression among girls in the JJAM treatment program compared with girls receiving regular treatment (Goldstein et al., 2018). Results suggest that anger-management treatment can effectively reduce anger and reactive aggression among girls placed in juvenile justice facilities.

3.2.2. Systematic reviews

The two systematic reviews included intervention studies conducted mostly in the USA, with a few from the United Kingdom (UK) (see Table 2). Both reviews included studies that evaluated the outcomes of interventions aimed at reducing R&S.

3.2.2.1. Reducing R&S. Bryson et al. (2017) concentrated specifically on studies that explored implementation of Trauma-Informed Care intervention (TIC) in psychiatric and residential facilities. TIC is an organizational change strategy which aligns service delivery with treatment principles and interventions designed to reduce rates of retraumatization through responsive and non-coercive staff-client interactions (Bryson et al., 2017). According to Bryson et al. (2017), of the 13 reviewed studies, 9 reported an outcome of reducing or eliminating the use of restraint and/or seclusion. The review indicated that staff need to feel and be supported throughout the implemented change that may involve recertification as ongoing training, coaching, and supervision; in addition to reinforced trainings.

The review by Roy et al. (2019) examined several studies whose aim was to evaluate outcomes of a program implemented to affect rates of R&S use. One objective was to identify the factors related to the use of R&S measures and to examine the interventions aimed at reducing their use (Roy et al., 2019). The authors identified 63 variables influencing the use of R&S and categorized them into four groups: (1) characteristics of the youth, (2) characteristics of the staff, (3) environmental characteristics and (4) programs implementation (Roy et al., 2019). They also found that younger children displayed aggressive behavior more frequently and tended to experience more R&S than did older children. Males were also more likely to be the subjects of R&S than females. The after-school period was associated with more frequents use of R&S (Roy et al., 2019). Elevated stress, paired with a possible lack of situational training, may play a role in staff decisions to use R&S. The majority of the implemented programs led to a reduction in use of R&S (Roy et al., 2019). However, none of the studies reviewed by Roy et al. (2019) explored which specific elements of the intervention program influenced the reduction in use of R&S.

3.2.3. Qualitative and cross-sectional studies

The qualitative and cross-sectional studies were conducted in Israel, Scotland, USA and Norway (see Table 3). These studies refer to aim number 2; effects of R&S and experiences of youth and staff related to youth violence, R&S.

3.2.3.1. Experiences on physical interventions and restraint techniques. Among these studies, the one by Nyttingnes et al. (2018) looked at perceptions and experiences of physical interventions by adolescents. Using a mixed effects model, the study found that patients under formal coercion experienced a worse relationship with their parent(s) and lower psychosocial functioning, which were predictive of reports of experienced a high level of coercion. Results indicate that formal coercion can contribute to a lack of confidence and trust in both parents and staff (Nyttingnes et al., 2018).

Data from another study, conducted by Steckley (2018), strongly indicate that both youth and staff were strongly affected by physical restraints. The study were analyzed through lenses of catharsis and containment theories, and offers evidence of cathartic expression in situations involving restraint (Steckley, 2018). The authors argue that it has explanatory power in making sense of physical restraint and how to minimize its use in residential and other relevant settings.

3.2.3.2. Restraint technique – Staff knowledge and attitudes. Bitton and Rajpurkar (2015) examined attitudes of staff toward the use of the Therapeutic Crisis Intervention System (TCI) technique, a technique in order to proactively restrain violent behaviour. TCI is employed in several residential treatment facilities for youth in Israel. In addition to examining staff attitudes, the study explored the association between staff attitudes, knowledge and strategies for coping with stressful situations. No differences in knowledge about the use of TCI were found between the two groups of participants. The researchers found that the greater the worker's knowledge and support of physical restraint, the greater was the use of TCI. Bitton and Rajpurkar (2015) also showed that despite a physical intervention technique being taught and implemented, staff members tend to be cautious about using it, even when doing so was essential. This may indicate that trained staff will be cautious about using a technique to restrain violent behavior and display greater awareness of the controversy over the efficacy of the technique as well as its possible risks (Bitton & Rajpurkar, 2015).

3.2.3.3. Staff experiences of client violence (CV). The study that explored the exposure to CV of youth care-workers (Smith et al., 2017) found that these workers viewed CV as the hardest part of their job. Although participants reported exposure to CV incidents and stated that they were common and to be expected, they also indicated a belief that proper use of de-escalation and behavior management techniques could reduce the incidence of CV (Smith et al., 2017).

3.3. Quality assessment results

Both systematic reviews (Bryson et al., 2017; Roy et al., 2019) received a "critically low" quality assessment score using the AMSTAR evaluative tool (Shea et al., 2007). The tool is considered to have content validity for measuring the methodological quality of systematic reviews. The research questions and criteria for including/excluding reviews lacked the components of PICO. Additionally, the AMSTAR explanation for the assessment score explicitly stated that the methods employed by the researchers had been established prior to the conduct of their review study and failed to justify any significant deviations from the protocol. Additionally, the authors did not use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that they included in their reviews, and they did not account for RoB in individual studies when interpreting and discussing the results. Furthermore, the authors did not report the funding sources for the studies included in their reviews, and they did not offer a satisfactory explanation for any heterogeneity observed in their reviews. Bryson et al. (2017) neglected to perform both study selection and data extraction in duplicate and provided neither a list of excluded studies nor an explanation for why they were excluded.

Results of Risk of Bias in effect studies are shown in Table 4.

Both qualitative studies (Smith et al., 2017; Steckley, 2018) were rated to be of medium/high quality based on "yes" answers to 8 of these 10 questions—was the research question/aim well described? Was the context of the study clear? Was the study connected to a theoretical framework? Was the design of the study clear and correct? Is the choice of population described, relevant and justified? Is the collection of data described and systematic? Is the data analysis described and systematic? Have attempts been made to substantiate results with other sources of information/methods? Is there agreement between conclusions and results? Is the relation between the researcher's point of view and the design of the study and results discussed? On the last question the studies either scored "no" or provided an unclear answer. One study showed no attempt to substantiate its results with other methods or sources of information (Steckley, 2018). Smith et al., 2017 did not provide a clear answer to "Was the question/aim well described?"

One cross-sectional study was rated as being of high quality (Nyttingnes et al., 2018). To 6 of 7 questions:—Was the population defined? Was the population group representative? Was the response rate sufficiently high? Was the data collection standardized? Were the criteria for measuring outcome objective? Were the methods used for data analysis adequate?—it was possible to answer YES. The flaw was that the study failed to consider differences between the participants who did and did not respond. Using these same questions to judge quality, Bitton and Rajpurkar (2015) scored low /medium quality. That study also failed to consider how respondents and nonrespondents differed. Additionally, the response rate was unclear and the sample was not representative for the population group.

4. Discussion

This study sought to describe and review literature published between 2015 and 2020 related to interventions to prevent aggression and violence in inpatient and residential youth facilities. Another purpose was to achieve an overview of the literature on the effects and experiences of R&S and staff experiences related to youth violence. The third aim was to identify gaps in this area and to indicate where more research is needed. This study used the same method of a study done in 2015; that review identified 6 studies regarding youth (Lillevik et al., 2016). We discovered a growing number of studies conducted in inpatient and residential youth facilities and were able to identify a total of 14 papers. Surprisingly, we found that only one additional article were published between September 2019 and November 2020.

4.1. Effects of interventions and experiences of R&S

The eight effect studies and two reviews included in our study show the existence and implementation of various interventions, among them training courses, strategies, frameworks and guidelines (see Tables 1 and 2). These interventions aimed to improve staff ability to identify, prevent and manage/de-escalate conflict and aggression (Forbat & Barclay, 2019; Forbat, Simons, Sayer, Davies, & Barclay, 2017; Izzo et al., 2016; Magnowski & Cleveland, 2019), and to reduce episodes of restraint and seclusion (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2017; Black et al., 2020; Bryson et al., 2017; Magnowski & Cleveland, 2019; Roy et al., 2019). One intervention was anger-management treatment directed at female youth (Goldstein et al., 2018). Overall, the studies of the different interventions found several indicators of positive outcomes. These included improvements in staff ability to de-escalate conflicts (Forbat et al., 2017); reduction in number of conflicts reported (Forbat & Barclay, 2019); decline in youth aggression towards staff (Goldstein et al., 2018; Izzo et al., 2016); fewer injuries (Bryson et al., 2017) and lower R&S rates (Azeem et al., 2017; Black et al., 2020; Bryson et al., 2017; Magnowski & Cleveland, 2019; Roy et al., 2019).

Our search revealed that the number of studies done in youth inpatient and residential facilities has increased since the search done by Lillevik et al. (2016). Youth were participants in only one literature

Table 4
Risk of Bias – Effect studies.

Author, year	Forbat et al., 2017	Forbat & Barclay, 2019	Goldstein et al., 2018	Izzo et al., 2016	Lee et al., 2016	Magnowski & Cleveland, 2019	Azeem et al., 2017	Black et al.,2020
Random sequence generation	Not applicable (NA)	NA	Unclear	NA	NA	NA	NA	NA
Allocation concealment	NA	NA	Unclear (no information)	NA	NA	NA	NA	NA
Blinding of participants and personnel	NA (register study)	Low risk (participants) High risk (personnel)	Low risk (participants) High risk (personnel)	Low risk (participants) High risk (personnel)	NA (register study)	Low risk (participants) High risk (personnel)	NA (medical records study)	High risk (personnel)
Blinding of outcome assessment	Unclear (no information)	Unclear (no information)	Low risk	Unclear (no information)	Unclear (no information)	Unclear (no information)	Low risk	Low risk
Incomplete outcome data	High risk	Low risk	Low risk	Low risk	Low risk	Low risk	Unclear (no information)	Unclear (no information)
Selective reporting	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	Unclear	Unclear
Other biases	High risk (conflict in interests)	Low risk	Low risk	Low risk	Low risk	Low risk	Unclear	Low risk

review before 2015 (Valenkamp et al., 2014). In 2015, the studies reviewed in Lillevik et al. (2016) centered on youth and staff experiences and perceptions of R&S use (Berg et al., 2011; Goren & Curtis, 1996; Miller, 1986; Ulset & Melheim, 2013; Ulset & Tjelflaat, 2012). Our study, in contrast, found more effect studies evaluating interventions of different types, including education and training programs, than qualitative studies. These effect studies can be seen as indicating a growing research field. However, five of the eight effect studies were conducted in USA, as were the two reviews of intervention studies. Due to the distinctiveness of systems and contexts, it may be difficult to generalize results from the USA to other settings, cultures and countries. The number of papers on this subject remains modest, evidence that this area of research remains underdeveloped, especially outside of the USA.

Our review of the studies of experiences of restraint found negative outcomes and experiences. For example, approximately one-third of the sample of youth in Nyttingnes et al. (2018) reported a lack of confidence and trust in both parents and staff. Another study found that young people react with intensely negative emotions to physical restraint (Steckley, 2018). These results are consistent with the literature search conducted in 2015 (Lillevik et al., 2016), which found that physical restraints may be perceived as offensive by youth and may thus weaken the relationship between youth and staff (Ulset & Tjelflaat, 2012). Additionally, staff members found using physical restraint challenging. Untrained workers supported the use of physical restraint more than did trained workers (Bitton & Rajpurkar, 2015). Trained professionals seem to show extra caution and awareness compared to the untrained when it comes to in using restraint techniques.

4.2. Risk of bias and quality assessment of included studies

Two tools were employed to assess risk of bias of effect studies and the quality of the reviews. Risk-of-bias assessments using the EPOC tool (Higgins et al., 2019) suggest that the effect studies included in this review article were for the most part at low risk of bias; this increases confidence in our findings. Five of the studies report that certain measures, like blinding of personnel, were difficult to carry out in these interventions, because, for example, intervention practitioners are aware of the program they are implementing. EPOC yielded a significant number of determinations that bias risk was “not applicable”. This may indicate that the EPOC tool is not adjusted to these types of studies. All of the effect studies included in our review failed to report, or reported unclear, information on domains crucial to internal validity, such as the use of randomization procedure. This weakens the conclusion of our study. In several of the effect studies, the risk of blinding of outcome assessment was unclear or information was lacking, suggesting that the results of these studies should be interpreted with caution.

Despite the limitations of the reviews based on AMSTAR’s quality assessment checklist (Shea et al., 2007), we include them for different reasons: first, because the findings contribute significantly to the field of inpatient and residential youth facilities, and second, because the literature in the field is limited. Another reason is that the AMSTAR tool might be ill-suited for assessing the design of the 2 included reviews, as several questions present in the tool were not relevant for the review included studies.

4.3. Strengths and limitations of this review

While this review has several strengths, we also wish to acknowledge possible limitations. The first potential limitation derives from the breadth of this review, which involved reviewing studies of considerable heterogeneity with respect to samples, facilities, measures, designs and programs. Thus, we could neither perform a *meta*-analysis nor readily make comparisons among the studies. Effectively summarizing the results to indicate some findings as more important than others also posed challenges. Given the diversity of the research under review, a mapping review seemed to be the best design and one that would allow us to identify gaps in research on this topic.

The second limitation is potential selective reporting bias (Higgins et al., 2019). To minimize the possibility of unintentional, skewed article selection, we searched seven different databases. Nevertheless, we must acknowledge that some important articles could have been missed. Additionally, we decided to exclude grey literature—that is, articles published without a rigorous review process. It is possible that this also led to selection bias. Finally, establishing search criteria always carries the risk of selection bias. To mitigate this risk, we clearly defined both the inclusion and exclusion criteria.

A third possible limitation is that data was inaccurately extracted and/or misclassified. To mitigate this risk, we classified and extracted data as described in “2. Materials and Methods”. Ninety percent of the initial screening was done by the first author, which could have induced bias. Some studies may have been excluded in this screening, when they should not have been. The risk that occurred is small, however, because of the clear exclusion criteria and the double screening of 10%.

The potential limitation posed by language bias was minimized by searching all databases for all manuscripts published in English, Danish, Swedish or Norwegian. To diminish familiarity bias, we included studies from several contexts.

These potential limitations are diminished further by the main

strength of this review, which is its broad focus and inclusion of several different samples and facilities. To ensure coverage of the subject from different perspectives, we included qualitative, quantitative, and mixed-design studies. We also included a co-author outside of the field of youth inpatient and residential care to maximize objectivity in the review process.

4.4. Future directions and implications

We believe this study is sufficiently rigorous, despite some limitations, to enable us to identify some future directions for research. Taken together, data from this review suggest that more research is needed on the practical implications of education and training programs for preventing and minimizing aggression, violence and R&S.

Our results indicate a slow but notable growth in interest in interventions aimed at identifying, preventing and managing aggression and conflict situations. This is shown by the number of papers published since 2015 in comparison to those published before that year. Despite the well-documented history of youth-care violence, this mapping review shows that few studies have explicitly addressed how aggression, violence, R&S are experienced and can be prevented and managed in youth inpatient and residential facilities. More empirical work is needed to determine whether interventions work as intended, and whether they benefit both youth and staff at residential, health and juvenile justice facilities. Most of the studies and reviews included in our study were based on self-reported data, such as surveys, questionnaires, interviews, and reports (Bitton & Rajpurkar, 2015; Black et al., 2020; Bryson et al., 2017; Forbat & Barclay, 2019; Forbat et al., 2017; Izzo et al., 2016; Nyttingnes et al., 2018; Roy et al., 2019; Steckley, 2018). Although these studies suggest that guidelines, frameworks, education and training may increase personal knowledge and change attitudes, we still need studies that reveal how the prevention and management of aggression and R&S are perceived by others who are not among the self-reporting participants. Most of the studies that assessed learning outcomes used knowledge-acquisition questionnaires, self-reporting measures of learning and transfer, or reported participant-satisfaction with the training; all of these can lead to biased results. Additionally, studies that explore interpersonal factors associated with aggression among youth have relied on information reported by staff at some time point prior to the acts of aggression being documented.

To explore the most effective strategies for safely preventing and managing conflicts and aggression, youth inpatient and residential facilities need to be receptive to implementing training programs and participating in research on the effect of those programs. We recommend that studies include a conceptual framework that links competencies and skills to be achieved to training content and method. Additionally, this review found a lack of randomized, controlled studies that investigate the effects of interventions. Only one of the included studies employed a randomized design (Goldstein et al., 2018). We recommend more research using this design, in order to gain more knowledge about causality.

To advance the field and gain knowledge about how to improve the safety and quality of care for youth, as well as the health and safety of staff, research is needed into how staff prevent and manage aggression and conflicts in practice and how that affects youth; such studies might, for example, use observational data. More research on this topic is also needed in other cultures and contexts other than the USA.

5. Conclusion

Our review demonstrates that the number of studies on the effects of interventions in preventing/managing aggression and violence in inpatient and residential youth facilities, and on the effects and experiences of R&S in these facilities, is quite limited. Despite their limitations, the findings of previous research suggest that, overall, reports of conflicts/aggressive incidents and the use of R&S can be reduced by implementing various interventions, such as education and training programs.

The knowledge gained from this review is insufficient for us to offer specific recommendations as to how to increase the quality of care or safety of youth living in these facilities. However, the results indicate that some interventions may contribute to positive consequences, for example, a reduction of reported conflicts and more cautious use of R&S methods. They also indicate that the interventions most likely benefit staff in preventing and managing aggression, conflict and unwanted situations. However, few studies of the studies in our review can be considered methodologically rigorous. Although education and training programs might increase staff knowledge and attitudes, such programs might not affect the number of aggressive behavior incidents. Further, how youth experience these interventions, and if they experience any difference and/or improvement in communication with staff after implementation remains unclear. Moreover, no research has been conducted on the specific elements (e.g., role-play of communication skills) in interventions that brought about desired changes. The studies have not made use of observational data, except one (Smith et al., 2017).

The search for evidence of effective interventions and training approaches continues and would benefit significantly from further research. More thorough empirical studies focused on identifying which training elements are effective are needed to improve the effectiveness of interventions targeting youth in inpatient facilities. More studies of youth experiences of staff conflict management and R&S are also needed, particularly of youth in facilities marked by high rates of aggressive behavior and use of R&S.

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Authorship contribution

Ane Slaatto (AS) managed the literature search and wrote the protocol. AS, John Kjøbli, Anneli V. Mellblom, Gunn Astrid Baugerud (GAB) and Lise Cecilie Kleppe reviewed the papers. AS and GAB undertook the analysis and made the tables. AS wrote the first draft of the manuscript. All authors contributed to and approved the final manuscript.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

Aslam, S., & Emmanuel, P. (2010). Formulating a researchable question: A critical step for facilitating good clinical research. *Indian Journal of Sexually Transmitted Diseases and AIDS, 31*(1), 47–50. https://doi.org/10.4103/0253-7184.69003

Azeem, M., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2017). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing, 30*(4), 170–174. https://doi.org/10.1111/jcap.12190.

Baeza, I., Correll, C. U., Saito, E., Amanbekova, D., Ramani, M., Kapoor, S., … Carbon, M. (2013). Frequency, Characteristics and Management of Adolescent Inpatient Aggression. *Journal of Child and Adolescent Psychopharmacology, 23*(4), 271–281. https://doi.org/10.1089/cap.2012.0116

Berg, J., Kaltiala-Heino, R., & Välimäki, M. (2011). Management of aggressive behaviour among adolescents in forensic units: A four-country perspective. *Journal of Psychiatric and Mental Health Nursing, 18*(9), 776–785. https://doi.org/10.1111/j.1365-2850.2011.01726.x

Bitton, M. S., & Rajpurkar, S. (2015). Therapeutic crisis intervention system in residential care for children and youth: Staff knowledge, attitudes, and coping styles. *Children and Youth Services Review, 56*, 1–6. http://www.journals.elsevier.com/children-and-youth-services-review/.

Black, V., Bobier, C., Thomas, B., Prest, F., Ansley, C., Loomes, B., … Mountford, H. (2020). Reducing seclusion and restraint in a child and adolescent inpatient area:

Implementation of a collaborative problem-solving approach. *Australasian Psychiatry, 28*(5), 578–584. https://doi.org/10.1177/1039856220917081
Bogo, M., Shlonsky, A., Lee, B., & Serbinski, S. (2014). Acting Like It Matters: A Scoping Review of Simulation in Child Welfare Training. *Journal of Public Child Welfare, 8*(1), 70–93. https://doi.org/10.1080/15548732.2013.818610
Bower, F. L., McCullough, C. S., & Timmons, M. E. (2003). A Synthesis of What We Know About the Use of Physical Restraints and Seclusion with Patients in Psychiatric and Acute Care Settings: 2003 Update. *Worldviews on Evidence-based Nursing presents the archives of Online Journal of Knowledge Synthesis for Nursing, E10*(1), 1–29. https://doi.org/10.1111/wvn.2003.e10.issue-110.1111/j.1524-475X.2003.00001.x
Braga, T., Gonçalves, L. C., Basto-Pereira, M., & Maia, Â. (2017). Unraveling the link between maltreatment and juvenile antisocial behavior: A meta-analysis of prospective longitudinal studies. *Aggression and Violent Behavior, 33*, 37–50. https://doi.org/10.1016/j.avb.2017.01.006.
Briggs, E. C., Greeson, J. K. P., Layne, C. M., Fairbank, J. A., Knoverek, A. M., & Pynoos, R. S. (2012). Trauma Exposure, Psychosocial Functioning, and Treatment Needs of Youth in Residential Care: Preliminary Findings from the NCTSN Core Data Set. *Journal of Child & Adolescent Trauma, 5*(1), 1–15. https://doi.org/10.1080/19361521.2012.646413
Bryson, S. A., Gauvin, E., Jamieson, A., Rathgeber, M., Faulkner-Gibson, L., Bell, S., … Burke, S. (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International journal of mental health systems, 11*(1). https://doi.org/10.1186/s13033-017-0137-3
Carr, A., Duff, H., & Craddock, F. (2020). A Systematic Review of the Outcome of Child Abuse in Long-Term Care. *Trauma, Violence, & Abuse, 21*(4), 660–677. https://doi.org/10.1177/1524838018789154
Connor, D. F., Doerfler, L. A., Toscano, P. F., Volungis, A. M., & Steingard, R. J. (2004). Characteristics of Children and Adolescents Admitted to a Residential Treatment Center. *Journal of child and family studies, 13*(4), 497–510. https://doi.org/10.1023/B:JCFS.0000044730.66750.57
De Hert, M., Dirix, N., Demunter, H., & Correll, C. U. (2011). Prevalence and correlates of seclusion and restraint use in children and adolescents: A systematic review. *European Child & Adolescent Psychiatry, 20*(5), 221–230. https://doi.org/10.1007/s00787-011-0160-x
Dean, A. J., Duke, S. G., Scott, J., Bor, W., George, M., & McDermott, B. M. (2008). Physical Aggression During Admission to a Child and Adolescent Inpatient Unit: Predictors and Impact on Clinical Outcomes. *Australian & New Zealand Journal of Psychiatry, 42*(6), 536–543. https://doi.org/10.1080/00048670802050587
Delaney, K. R., D.N.Sc., R.N., & Louis Fogg. (2005). Patient Characteristics and Setting Variables Related to Use of Restraint on Four Inpatient Psychiatric Units for Youths. Psychiatric Services, 56(2), 186–192. https://doi.org/10.1176/appi.ps.56.2.186.
dosReis, S., McCulloch, J. R., Colantuoni, E., Barnett, S. R., Pruitt, D., Zachik, A., & Riddle, M. A. (2010). Early Identification of Seclusion and Restraint Patterns During Adolescents' Course of Residential Treatment. *Residential Treatment for Children & Youth, 27*(3), 160–174. https://doi.org/10.1080/0886571X.2010.500145
Earle, K. A., & Forquer, S. L. (1995). USE OF SECLUSION WITH CHILDREN AND ADOLESCENTS IN PUBLIC PSYCHIATRIC HOSPITALS. *American Journal of Orthopsychiatry, 65*(2), 238–244. https://doi.org/10.1037/h0079621
EPOC. (2015). Effective Practice and Organization of Care (EPOC). Suggested risk of bias criteria for EPOC reviews. Norwegian Knowledge Center for Health Services.
Forbat, L., & Barclay, S. (2019). Reducing healthcare conflict: Outcomes from using the conflict management framework. *Archives of Disease in Childhood, 104*(4), 328–332. https://dx.doi.org/10.1136/archdischild-2018-315647.
Forbat, L., Simons, J., Sayer, C., Davies, M., & Barclay, S. (2017). Training paediatric healthcare staff in recognising, understanding and managing conflict with patients and families: Findings from a survey on immediate and 6-month impact. *Archives of Disease in Childhood, 102*(3), 250–254. https://dx.doi.org/10.1136/archdischild-2016-310737.
Goldstein, Naomi E. S., Giallella, Christy L., Haney-Caron, Emily, Peterson, Lindsey, Serico, Jennifer, Kemp, Kathleen, … Lochman, John (2018). Juvenile Justice Anger Management (JJAM) Treatment for Girls: Results of a randomized controlled trial. *Psychological Services, 15*(4), 386–397.
Goren, Suzanne, & Curtis, W. John (1996). Staff members' beliefs about seclusion and restraint in child psychiatric hospitals. *Journal of Child and Adolescent Psychiatric Nursing, 9*(4), 7–14. https://doi.org/10.1111/jcap.1996.9.issue-410.1111/j.1744-6171.1996.tb00268.x
Goren, S., Singh, N. N., & Best, A. M. (1993). The aggression-coercion cycle: Use of seclusion and restraint in a child psychiatric hospital. *Journal of Child and Family Studies, 2*(1), 61–73. https://doi.org/10.1007/BF01321301
Green-Hennessy, S., & Hennessy, K. D. (2015). Predictors of Seclusion or Restraint Use Within Residential Treatment Centers for Children and Adolescents. *Psychiatr Q, 86*(4), 545–554. https://doi.org/10.1007/s11126-015-9352-8
Gullick, Karen, McDermott, Brett, Stone, Prue, & Gibbon, Peter (2005). Seclusion of children and adolescents: Psychopathological and family factors. *International Journal of Mental Health Nursing, 14*(1), 37–43. https://doi.org/10.1111/inm.2005.14.issue-110.1111/j.1440-0979.2005.00353.x
Higgins, J., Thomas, J., Chandler, J., Cumpston, M., T., L., Page, M., & Welch, V. (2019). Cochrane Handbook for Systematic Reviews of Intervention 6.1. Cochrane.
Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the Setting Level to Prevent Behavioral Incidents in Residential Child Care: Efficacy of the CARE Program Model. *Prevention Science, 17*(5), 554–564. https://doi.org/10.1007/s11121-016-0649-0
Jacob, P., Seshadri, S., Girimaji, S. C., Srinath, S., & Sagar, J. V. (2013). Clinical characteristics of aggression in children and adolescents admitted to a tertiary care centre. *Asian Journal of Psychiatry, 6*(6), 556–559. https://doi.org/10.1016/j.ajp.2013.08.070.
Joy, D. S. (1981). The Maintenance of Order on an Adolescent Inpatient Unit. *Psychiatry, 44*(3), 253–262. https://doi.org/10.1080/00332747.1981.11024111
Jozefiak, T., Kayed, N. S., Rimehaug, T., Wormdal, A. K., Brubakk, A. M., & Wichstrøm, L. (2016). Prevalence and comorbidity of mental disorders among adolescents living in residential youth care. *European Child & Adolescent Psychiatry, 25*(1), 33–47. https://doi.org/10.1007/s00787-015-0700-x
Larue., C., Dumais, A., Ahern, E., Bernheim, E., & Mailhot, M.-P. (2009). Factors influencing decisions on seclusion and restraint. Journal of Psychiatric and Mental Health Nursing, 16(5), 440–446. https://doi.org/10.1111/j.1365-2850.2009.01396.x.
LeBel, J., Huckshorn, K. A., & Caldwell, B. (2010). Restraint use in residential programs: Why are best practices ignored? *Child Welfare, 89*(2), 169–187.
Lee, T. G., Walker, S. C., & Bishop, A. S. (2016). The Impact of Psychiatric Practice Guidelines on Medication Costs and Youth Aggression in a Juvenile Justice Residential Treatment Program. *Psychiatric Services, 67*(2), 214–220. https://doi.org/10.1176/appi.ps.201400544
Leidy, B. D., Haugaard, J. J., Nunno, M. A., & Kwartner, J. K. (2006). Review of Restraint Data in a Residential Treatment Center for Adolescent Females. *Child and Youth Care Forum, 35*(5), 339–352. https://doi.org/10.1007/s10566-006-9021-z
Lillevik, O. G., Strømgren, B., Søvig, K. H., Ulset, A. F., & Borgenvik, J. A. (2016). Kunnskapsgrunnlaget for arbeid med trygghet og sikkerhet i barnevernsinstitusjoner (The knowledge base for safety and security in child welfare institutions). https://bibliotek.bufdir.no/BUF/101/Kunnskapsgrunnlag_for_arbeid_med_trygghet_og_sikkerhet_i_barnevernsinstitusjoner_201117.pdf.
Lochman, J. E., Barry T., Powell N., & L., Y. (2009). Anger and Aggression. In Nangle D., Hansen D., Erdley C., & N. P. (Eds.), Practitioner's Guide to Empirically Based Measures of Social Skills. ABCT Clinical Assessment Series. Springer. https://doi.org/10.1007/978-1-4419-0609-0_10.
Lombart, B., De Stefano, C., Dupont, D., Nadji, L., & Galinski, M. (2020). Caregivers blinded by the care: A qualitative study of physical restraint in pediatric care. *Nursing Ethics, 27*(1), 230–246. https://doi.org/10.1177/0969733019833128
MacRae, R., & Skinner, K. (2011). Learning for the Twenty-First Century: Maximising Learning Transfer from Learning and Development Activity. *Social Work Education, 30*(8), 981–994. https://doi.org/10.1080/02615479.2010.520118
Maier, G. J., Stava, L. J., Morrow, B. R., Van Rybroek, G. J. a., & Bauman, K. G. (1987). A Model for Understanding and Managing Cycles of Aggression Among Psychiatric Inpatients. Psychiatric Services, 38(5), 520–524. https://doi.org/10.1176/ps.38.5.520.
Magnowski, Stefani Rae, & Cleveland, Sandra (2019). The Impact of Milieu Nurse-Client Shift Assignments on Monthly Restraint Rates on an Inpatient Child/Adolescent Psychiatric Unit. *Journal of the American Psychiatric Nurses Association, 26*(1), 86–91.
Miller, D. E. (1986). The Management of Misbehavior by Seclusion. *Residential Treatment for Children & Youth, 4*(1), 63–73. https://doi.org/10.1300/J007v04n01_09
National knowledge center handbook for health services. (2014). National Knowledge Center for health services.
Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The Long-Term Health Consequences of Child Physical Abuse, Emotional Abuse, and Neglect: A Systematic Review and Meta-Analysis. PLoS medicine, 9(11), e1001349. https://doi.org/10.1371/journal.pmed.1001349.
Nyttingnes, O., Ruud, T., Norvoll, R., Rugkasa, J., & Hanssen-Bauer, K. (2018). A cross-sectional study of experienced coercion in adolescent mental health inpatients. BMC Health Services Research, 18, Article 389. https://doi.org/10.1186/s12913-018-3208-5.
O'Donoghue, E. M., Pogge, D. L., & Harvey, P. D. (2020). The Impact of Intellectual Disability and Autism Spectrum Disorder on Restraint and Seclusion in Pre-Adolescent Psychiatric Inpatients. *Journal of Mental Health Research in Intellectual Disabilities, 13*(2), 86–109. https://doi.org/10.1080/19315864.2020.1750742
Pollastri, A. R., Lieberman, R. E., Boldt, S. L., & Ablon, J. S. (2016). Minimizing Seclusion and Restraint in Youth Residential and Day Treatment Through Site-Wide Implementation of Collaborative Problem Solving. *Residential Treatment for Children & Youth, 33*(3–4), 186–205. https://doi.org/10.1080/0886571X.2016.1188340
Rivard, J. C., McCorkle, D., Duncan, M. E., Pasquale, L. E., Bloom, S. L., & Abramovitz, R. (2004). Implementing a Trauma Recovery Framework for Youths in Residential Treatment. *Child and Adolescent Social Work Journal, 21*(5), 529–550. https://doi.org/10.1023/B:CASW.0000043363.14978.e6
Roy, C., Castonguay, A., Fortin, M., Drolet, C., Franche-Choquette, G., Dumais, A., Lafortune, D., Bernard, P., & Geoffrion, S. (2019). The Use of Restraint and Seclusion in Residential Treatment Care for Youth: A Systematic Review of Related Factors and Interventions. Trauma, violence & abuse, 1524838019843196. https://doi.org/https://dx.doi.org/10.1177/1524838019843196.
Scanlan, J. N. (2010). Interventions To Reduce the Use of Seclusion and Restraint in Inpatient Psychiatric Settings: What We Know So Far a Review of the Literature. *International Journal of Social Psychiatry, 56*(4), 412–423. https://doi.org/10.1177/0020764009106630
Shea, Beverley J, Grimshaw, Jeremy M, Wells, George A, Boers, Maarten, Andersson, Neil, Hamel, Candyce, … Bouter, Lex M (2007). Development of AMSTAR: A measurement tool to assess the methodological quality of systematic reviews. *BMC Medical Research Methodology, 7*(1). https://doi.org/10.1186/1471-2288-7-10
Smith, Y. (2014). Rethinking Decision Making: An Ethnographic Study of Worker Agency in Crisis Intervention. *Social Service Review, 88*(3), 407–442. https://doi.org/10.1086/677846

Smith, Y., & Spitzmueller, M. C. (2016). Worker Perspectives on Contemporary Milieu Therapy: A Cross-Site Ethnographic Study. *Research on Social Work Practice (RSWP), 40*(2), 105–116. https://doi.org/10.1093/swr/svw003

Smith, Yvonne, Colletta, Lex, & Bender, Anna E. (2017). Client Violence Against Youth Care Workers: Findings of an Exploratory Study of Workforce Issues in Residential Treatment. *Journal of Interpersonal Violence, 36*(5–6), 1983–2007.

Sourander, A., Ellilä, H., Välimäki, M., & Piha, J. (2002). Use of holding, restraints, seclusion and time-out in child and adolescent psychiatric in-patient treatment. *European Child & Adolescent Psychiatry, 11*(4), 162–167. https://doi.org/10.1007/s00787-002-0274-2

Steckley, L. (2018). Catharsis, containment and physical restraint in residential child care. *British Journal of Social Work, 48*(6), 1645–1663. https://doi.org/10.1093/bjsw/bcx131

Template for a mapping study protocol (2019). Retrieved 01.09.19 from https://community.dur.ac.uk/ebse/resources/templates/MappingStudyTemplate.pdf.

Ulset, G., & Melheim, S. (2013). Håndtering av tvang i barnevernsinstitusjoner. Ansattes, lederes og tilsynets perspektiver (Handling coercion in child welfare institutions. The perspectives of employees, managers and supervisors) (25). NTNU Samfunnsforskning/NTNU Regionalt kunnskapssenter for barn og unge - psykisk helse og barnevern). N. S. N. R. k. f. b. o. u.-p. h. o. barnevern. https://www.ntnu.no/documents/10293/0/Håndtering+av+tvang+i+barneverninstitusjoner/9f436c1b-92ef-4989-99c9-da243e704dda.

Ulset, G., & Tjelflaat, T. (2012). Tvang i barneverninstitusjoner : ungdommens perspektiver (Vol. nr. 12[i.e. 20]/2012). NTNU samfunnsforskning, Barnevernets utviklingssenter.

Valenkamp, M., Delaney, K., & Verheij, F. (2014). Reducing Seclusion and Restraint During Child and Adolescent Inpatient Treatment: Still an Underdeveloped Area of Research. *J Journal of Child and Adolescent Psychiatric Nursing, 27*(4), 169–174. https://doi.org/10.1111/jcap.12084

van Kessel, K., Milne, D., Hunt, K., & Reed, P. W. (2012). Understanding inpatient violence in a New Zealand child and adolescent psychiatric setting. *International journal of mental health nursing, 21*(4), 320–329. https://doi.org/10.1111/j.1447-0349.2011.00789.x

Vidal, C., Reynolds, E. K., Praglowski, N., & Grados, M. (2020). Risk Factors for Seclusion in Children and Adolescents Inpatient Psychiatry: The Role of Demographic Characteristics, Clinical Severity, Life Experiences and Diagnoses. *Child Psychiatry & Human Development, 51*(4), 648–655. https://doi.org/10.1007/s10578-020-00963-0

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Safety in Residential Youth Facilities: Staff Perceptions of Safety and Experiences of the "Basic Training Program in Safety and Security"

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ABSTRACT

In inpatient and residential youth facilities, staff concerns over actual and potential aggression and conflict frequently affect both the quality of care and staff wellbeing. This study investigated 1) staff perceptions of safety at the residential facilities where they work, and 2) staff experiences with the Basic Training Program in Safety and Security, initiated by the Norwegian Directorate of Children, Youth and Family Affairs (Bufdir), to enhance prevention and management of aggression and conflict. We conducted three focus-group interviews at three different public residential facilities with a total of 18 staff members who work daily with youth. Findings show that staff regard safety as essential and perceive enhanced safety as linked to predictability, stability, team coordination, education and training, organizational support, and trusting and supportive relationships. They also indicate that staff regard the training program as having improved their feelings of safety, enhancing awareness of conflict situations before, during and after they occur, and contributing to more systematic work processes and cooperative and coordinated teamwork. These findings have implications for all facilities providing care and treatment to youth.

KEYWORDS

Residential youth facility; aggression; conflict; safety; staff training program

Practice Implications

- Feeling safe is reported as essential to staff in residential youth facilities in Norway
- Staff perceptions of safety influence their treatment and care of youth
- Staff who attended a training program in managing aggression and conflicts reported more awareness, team coordination, and systematic work processes
- Such training may be significant in increasing staff perceptions of safety and well-being

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Further research is needed and should include the perspectives and experiences of the youth living in residential facilities

1 Introduction

Considerations of safety are at the forefront of work with children and youth (hereafter referred to as youth) in different inpatient and residential facilities. Safety entails an environment in which one can feel secure and calm and attend to normal developmental tasks. According to H. Bath (2015), healing can only occur in this kind of environment. Youth carefully study how adults present themselves, including their mannerisms, tone of voice, and body language (Steele & Kuban, 2013). Safety is therefore closely related to the quality of interpersonal connections because it is only in relationships with others that a youth can begin to feel safe (H. Bath, 2015).

The work practices of staff are influenced by their feelings of wellbeing, safety, and job satisfaction (Knorth et al., 2010). Occupational health is critical for staff in human service occupations, whose focus is on the needs of others and whose own needs may be overlooked or neglected. Residential staff members are confronted with multiple stressors, such as aggressive and non-compliant behavior (Dean et al., 2010). Aggression can be understood as any behavior that is destructive to self, others, or property. Extensive research on different youth facilities over the past decade has shown that aggression is a result of a complex interaction among youth characteristics and environmental factors, such as ward milieu and staff behavior (Fraser et al., 2016). According to interviews with staff members working within a child and adolescent psychiatric inpatient unit, episodes of physical aggression were common and linked to problems with work attendance and other professional, as well as emotional, sequelae (Dean et al., 2010). These issues may create physical and mental health complications, increased stress levels, lower work satisfaction, lack of safety, anxiety, distress, fear, anger, and hostility, as well as power struggles between staff and youth (Lombart et al., 2020; Miller, 1986; Nyttingnes et al., 2018; Smith et al., 2017; Steckley, 2018; Woodcock & Fisher, 2008). Y. Smith (2014) suggests that the high emotional and physical stakes of managing potentially dangerous situations in the absence of effective and safe management strategies are a source of stress for workers and may impair their therapeutic capacity. Physical threats and aggression from youths can also affect staff members' attitude toward youths (Lynch et al., 2005).

If staff well-being and work satisfaction are low as a result of excessive and prolonged job stress, burn-out – a multifaceted phenomenon comprising emotional exhaustion, depersonalization, and reduced personal accomplishment – can be a result (Maslach et al., 2001). Burn-out, in turn, often leads to high staff turnover (Colton & Roberts, 2007; Conrad & Kellar-Guenther, 2006; Knorth et al., 2010; Seti, 2008). Worker turnover is harmful and disruptive to

the treatment and care of youth, who often have difficulty forming trusting relationships with caregivers; it also undermines organizational attempts to provide youth with stability and predictability (Connor et al., 2003). Long job tenure is helpful in developing the experience and skills needed to provide consistently good care. Staff who experienced a greater level of satisfaction on the job reported feeling less controlling toward their patients (Lynch et al., 2005). This suggests that autonomy, competence, and relatedness are important to the well-being of staff and have the potential to affect their attitudes, program implementation, and treatment.

Several youth facilities have devoted considerable resources to improving the quality of practice (Bogo et al., 2014; MacRae & Skinner, 2011). Fewer aggressive incidents are associated with a better ward milieu for youth and a better working environment for staff (Visser et al., 2020). The capacity of staff members to respond purposefully, safely, and effectively to potential and escalating aggression is essential. Staff often face the same challenges as do parents, such as maintaining self-control when dealing with difficult youth behaviors. Research on interactions between parents and children shows the importance of self-control and emotional regulation (Scaramella & Leve, 2004). Adults often attempt to take control over the behaviors of youths through commands, threats, and punishments; these invariably exacerbate situations and generate resistance rather than learning (H. I. Bath, 2008). The first step on the path to self-regulation is co-regulation, which depends on staff behavior. Winstanley and Hales (2014) describe a feedback loop: staff members become emotionally exhausted and detached when confronted with repeated oppositional behavior and aggression, and this emotional detachment then provokes further aggression and opposition from youth. Previous research suggests that, overall, implementation of various interventions, such as courses and education and training programs, has been effective in reducing the number of incidents involving youth aggression and staff use of restraint and seclusion (R&S) and/or in improving staff prevention and management of challenging behaviors in inpatient and residential facilities (Dean et al., 2007; Nunno et al., 2003; Slaatto et al., 2021).

Studies of violence management at youth inpatient facilities in a Nordic context have concluded that a supportive team of staff members who share common beliefs is vital (Pelto-Piri et al., 2017), as are preventive approaches (Pelto-Piri et al., 2020). First, external factors (organizational, situational, and relational) are significant causes of violence and may be easier to modify than internal youth factors. Second, improving staff competence in the use of de-escalation techniques is essential. Third, management should regularly follow up with staff after violent incidents and increase psychological support (Pelto-Piri et al., 2020).

Residential facilities typically involve a supervised and structured environment characterized by the merging of care and control, resulting in tense emotional zones in which youth often express their need for safety (Furnivall,

2018; Moore et al., 2017). Staff are responsible for providing protection and care, including enhancing each youth's chance for normal development. As a consequence, staff members and the way they prevent and manage conflicts and aggression are influential in shaping the milieu in these facilities. A positive milieu – one characterized by support of youth and opportunities for their personal growth and safety – is considered critical both to youth outcomes and to decreasing institutional aggression (Connor et al., 2003; Fraser et al., 2016; Winstanley & Hales, 2014).

Context and Background

Despite the well-documented history of concerns about aggression and violence in residential care, little research has addressed these issues explicitly and considered how they might be counteracted. Norway, like many other countries, places youth in residential facilities in response to either court orders or municipal decisions that address troublesome behavior, substance abuse, or difficult home conditions. Creating safe and development-promoting conditions for approximately 600 youths living in public facilities is one of the important responsibilities of the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir), as is providing staff with sufficient training and education to ensure safe working environments and health-promoting jobs.

Unfortunately, many of the youths placed in these facilities behave in ways that reflect their previous exposure to relationship traumas. These behaviors tend to trigger staff reactions that then reinforce the youths' lack of felt safety (H. Bath, 2015). To ensure that staff do not slip into a pattern of harmful reactions, Bufdir has increased its effort to present staff with a sound understanding of trauma and to provide staff with support, debriefing, and supervision. According to a Norwegian report about violence, threats, and harassment in the public sector (Hagen & Svalund, 2019), staff consider the development of competence in violence prevention and management to be a requirement for developing services that can address challenges related to youth aggression directed at staff members.

Basic Training Program in Safety and Security

To meet challenges related to aggression, conflict, and a lack of safety, Bufdir developed and implemented a training program – Basic Training Program in Safety and Security – for staff in Norwegian residential facilities over a five-year period, from 2015 to 2019. More than 2000 staff members have thus far completed the training program with an attendance of at least 90%. Prior to this, there was no national training program for staff working in these facilities. The program consists of a 4-day course divided in three sessions, offering a combination of theory-lessons (see Table 1) and experienced-based learning,

Table 1. Theory and Models.

Theory lessons	Perspective, aim	Content	Models
Aggression as a phenomenon	The powerlessness perspective	Anger, aggression, and violence theory	"The aggression curve" "The power curve"
Physical control (restraint)	The minimum intervention principle	Legal basis for physical restraint, limitations, and risks	
When stress takes over	Be a good affect regulatory support	How stress affects conflict management, stress reactions, brain functions	"The stress cone"
Basic safety attitude	Prevent and reflect on risks	Common risk situations, STOP exercise (Stop–think- observe-plan), defensive attitude	"Risk assessment" "The optimal tense level"
De-escalating interaction	How to create a safe dialog with a stressed/ frustrated person	De-escalate conflicts, decrease stress, accept, and support, signs in frustration and defense faze	"The aggression curve" "Green/red communication-model"
Scenario training	Training on handling demanding situations	Apply theory in practice, develop practical skills, conscious body language	"Green/red communication-model, " "STOP-scenario" "Full-scale scenario"
Youth's rights and use of coercion	Ensure legal rights	Law regulations	
Reflection on practice	Prevent conflicts and increase consciousness	Bring out how values and considerations influence staff behavior and decisions, identify intersections	"The navigation wheel"
Support and follow-up on staff	Prevent turnover and mental and physical illness among staff	Dilemma safety for youth and safety for staff, the Working Environment Act and responsibilities	
Follow-up on youth after conflicts	Preventing new conflicts and maintaining trust	How to use the learning space in "The aggression curve," to learn from the incident	"The aggression curve"

including scenario-training and physical control, feedback sessions, offered to small groups led by instructors. The physical training is training on how to restraint youth with least amount of pain and force as possible.Table 2

This course is followed by local training sessions at the residential facilities for a minimum of 4 hours per employee per month. The training program is intended to increase safety for both youth and staff. It is based on the idea that aggression, conflict, and violence can be prevented and reduced, despite the fact that youth in residential facilities often have disrupted pasts and may thus more readily experience frustration and feelings of powerlessness. To a large extent, it focuses on staff behavior, teamwork, and strategies and attitudes, intending to develop and

increase staff ability to predict, prevent, and manage aggression and conflict in a secure manner. A central part of the program is the development of communication skills. Becoming attuned to nonverbal cues, asking questions, displaying interest and honesty, and reflecting calmly the content and feelings of others are all parts of the active-listening toolkit (H. Bath, 2015). One objective of the program is to prevent the use of R&S and to teach staff to make correct decisions about when and how to perform R&S if it must be used. Secondary aims are to reduce youths' feelings of powerlessness and thus secure their participation, promote self-determination, and improve both the living and working environments.

Current Study

To address the significant gap in research identified above, we conducted a qualitative study of staff in residential youth facilities to assess 1) staff perceptions of safety while working in these facilities, and 2) staff experiences with the Basic Training Program in Safety and Security.

Method

Sample

We conducted qualitative focus-group interviews with staff members employed at state-run residential facilities in Norway. The first author approached managers of five residential facilities in three different regions of Norway, offering written information about the planned study and a request for permission to recruit participants. Three of the five facilities were willing to participate. They varied in their capacity, ranging from housing between four and twenty youths between 12 and 19 years of age. Staff work shifts varied among the facilities with some working 24-hour shifts and others, 7.5-hour shifts. To be included in the study, staff members had to meet two criteria: 1) employment at 50% or more time working directly with youths, at one of the selected units, and 2) participation in the 4-day training course. The staff members who fulfilled the criteria received written information about the study which was forwarded to them by their managers. The managers

Table 2. Participants details (N = 18).

Participants	N = 18
	N (%)
Gender	9 (50)
Female	
	Median (range)
Age	35.0 (24–50)
Residential work experience	4,5 (8 months to 18 years)
Formal education	16
Bachelor`s degree in social/health/child-welfare work:	2
No relevant education:	

encouraged participation and ensured that staff members were allowed the time and opportunity to participate. We were not able to find information that could consider if the sample were representative in regard of participants details.

18 staff members were willing to participate. Two participants were team leaders. Three participants had special responsibilities for leading the training sessions at their local facilities.

Data Collection

The focus-group interviews took place from February 2020 to September 2020 in the participants' workplaces. The three groups, one at each facility, consisted of 5, 6 and 7 participants. Two of the interviews were conducted by the first and second authors together. The third interview was conducted by the first and the fourth authors. The participant groups were asked to reflect on the main themes (see Table 3) and were asked follow-up questions to elicit more nuanced and detailed descriptions. Interviews ranged from 75 to 90 minutes and were digitally recorded and transcribed verbatim by the first author.

Data Management and Analysis

In our study, we strove to represent as truthfully as possible the responses of staff by offering accurate and credible quotes (Krefting, 1991). The systematic, rigorous approach known as the Stepwise-Deductive Induction (SDI) method was considered suitable for organizing project data (Tjora, 2019). The first author read the transcribed interviews several times and developed a list of initial codes to extract the essence of the empirical material. The software package NVivo was used to keep track of the many codes demanded by the high degree of analytical detail. The codes were text strings that corresponded closely to statements by those interviewed. To ensure quality, the codes were not produced prior to the actual coding, which would have led to replication rather than systematization of the empirical content (Tjora, 2019).

To increase reliability, ensure that no information was lost or coded differently, and avert potential coding bias, an additional author coded material from one of the three interviews; the results were then compared with those of

Table 3. A selection of themes and supplementary questions from the interview guide.

Main themes	Supplementary questions
Safety at the facility	What is safe? Unsafe? What influences safety? How can the safety of staff and youth be ensured?
Experiences of the basic training program in safety and security	How has the training program influenced your work practice? If you think back to your work before the training program, can you say that something is different now? What? Management/leadership support?

the first author and discussed until the two authors reached consensus. Most of the selected interview was initially coded identically by the two authors. A small number of codes were then modified, collapsed and/or created on the basis of discussions between the authors during the quality assurance process. Working with the codebook, the authors refined three code groups: 1) staff perceptions of safety on an individual level, 2) staff perceptions of safety on an organizational level, and 3) staff experiences with the Basic Training Program in Safety and Security. The final step was to analyze and interpret the content present in the code groups to capture the essence of staff perceptions and experiences.

Ethical Considerations

The project was granted approval by the Norwegian Center for Research Data (ref. 339013). The study was administered in accordance with the principles for ethical research of the Norwegian National Committee for Research Ethics. All participants signed informed, written consent documents prior to participation. Confidentiality was a topic of considerable importance in this study, particularly since all interviews were conducted at the participants' workplaces and all participants described specific experiences that either they or some of their colleagues had had. When writing up our findings, we removed any potentially identifying characteristics from the material to maintain anonymity of the participants.

Findings

The findings are presented based on the three code groups. The quotes from staff members (translated into English from Norwegian) illustrate and exemplify perspectives and experiences that emerged during the study analysis. The quotes highlight the perceptions that the staff members themselves identified as important. Some of the quotes have been changed somewhat to ensure confidentiality and to present the data in an appropriate manner; for example, words that lack meaning but are often interspersed when speaking orally were omitted.

Table 4. Themes and subthemes included in Code Group 1.

Theme	Subthemes
Relationships influence staff members' perceptions of safety	Trust Expectations Staying up to date
Feedback and support influence staff members' perceptions of safety	Confidence Development
Communication influences staff members' perceptions of safety	Predictability, honesty, openness Acceptability of raising concerns Risk assessments and plans

Staff Perceptions of Safety on an Individual Level (Code Group 1)

Staff members conveyed the view that safety in residential facilities is influenced by the individuals who work there and by how they interact with each other (see Table 4).

Relationships Influence Staff Members' Perceptions of Safety

The centrality of positive, trustworthy relationships was stressed by participants. As one participant stated, " … to increase my sense of safety, the most important thing is my relationship … with colleagues and with youth." The perception of safety depended on being surrounded by supportive, honest, and openminded colleagues and having close relationships based on trust. Knowledge of colleagues' limitations, strengths, and typical behaviors in different situations increased staff members' feelings of trust, predictability and safety. As one put it, it was important " … to get to know and learn one another's boundaries precisely to create safety … so that we can back each other up." Knowing that they share common skills, knowledge, and language with their colleagues also contributes to trusting relationships. One staff member viewed the relationship between safety and collegiality in the reverse: "If I don't feel safe with my colleagues, then it spreads to the rest of the group, and this creates a bad environment." Instability – the result of changing teams and working with unfamiliar colleagues – was seen as creating a lack of safety. Participants emphasized their own and their colleagues' expectations and responsibilities to be physical and mentally fit to manage difficult situations and indicated that they considered physical and mental fitness to be important for ensuring safety.

Close relationships with youth were also considered important for safety. New youths arriving at the facilities could contribute to a lack of safety. Some staff members stated that feeling tired can affect communication and relationships with youth in a negative way. "If I walk around tired, it is easy for my usually cheerful tone to sound a little more strict and sour," one participant noted. Feeling unsafe can lead staff to avoid specific situations or particular youths. As one staff member commented, "If you feel unsafe, then you become passive in your work, because you don't seek out situations that make you feel unsafe." Some participants pointed out that close relationships included being kept up to date on the plans of individual youths. They considered such knowledge as contributing to conflict prevention and de-escalation of unwanted situations. In contrast to the others, one participant said he was not dependent on his colleagues and preferred to solve problematic situations on his own: "During my time at the facility, I have mostly leaned toward relationships with youth and so I have cared less about the team."

Feedback and Support Influence Staff Members' Perceptions of Safety

Several of the participants mentioned support, feedback, and reflections from colleagues as important factors that could influence safety and enhance the care they provide to youth. One staff member said, "The support of colleagues lays a very good foundation for working with youth. We know that we have the support of one another." Feedback and support can prevent staff members from starting to doubt their ability to do their job and thereby increase feelings of being unsuccessful at work. Feeling competent and confident in their professional practice is central to the perception of safety. As one participant stated,

> If I feel that I am doing my job well, then I feel more safe . . . .[I]t helps when I receive one or two words . . . or a little pat on the shoulder. This can prevent me from feeling bad about my work, and if I begin to feel this way, then I can begin to doubt what I do. If I begin to doubt what I am doing, then I become more unpredictable and . . . the youth get it worse and so it just goes on . . . .

Staff members reported that not feeling safe affected them in negative ways, both at work and at home. One participant commented, "I sense that I am becoming a worse therapist . . . I think differently if I feel that something is not safe." The participants expressed concern about spending time at home dreading going back to work. " . . . [I]f you do that, then it will wear you out over time," one of them said.

Although most of the informants considered feedback to be useful in developing skills and correcting undesirable staff behavior, some said that they feel insecure in feedback situations. For example, as one staff member expressed it,

> If we have scenario-training, it can be a little uncomfortable for me, if it is a situation that I haven't handled well before and then I have to play it out in front of my colleagues . . . .I have found it helpful if someone can put a finger on it; can it be this? And they reflect a little together with me, and so I feel safer . . . .

Despite feeling somewhat uncomfortable in such training situations, some said that figuring out with others how to resolve different situations increases the likelihood that the plans will actually be carried out.

Communication Influence Staff Members' Perception of Safety

If feedback and training are to having the desired outcome, open and honest communication among colleagues and leaders is crucial. Only then will staff members feel comfortable raising uncertainties and concerns. One participant expressed it this way:

> To dare to say if you are feeling unsafe, what it is that makes you feel unsafe, and to work on those things. Work with the basics, and then it gets a little more advanced over time, and it creates safety in the workplace.

Several informants pointed out that it is necessary, but not easy, to admit to feeling unsafe or incapable of doing one's job. As one staff member said,

> One can talk about things instead of going and dreading it and thinking no one else feels this way. That it is only me who doesn`t manage it. It is the worst feeling one can have in a job like this.

Another staff member stated that safety is knowing their colleagues' capabilities at all times, instead of walking around and being unsure whether or not colleagues dare to do their jobs. If some staff members are not up to doing their jobs, this needs to be taken into account when planning and assessing risk, to ensure predictability. The key thing, as another participant stated, is "having permission to bring up something that you feel insecure about and rather to be honest about it . . . . Because then you can plan everything."

Staff Perceptions of Safety on an Organizational Level (Code Group 2)

Participants underscored that safety has organizational dimensions as well (see Table 5).

Leadership Influences Staff Members` Perceptions of Safety

Staff members regard active and supportive leadership as important to perceptions of greater safety. Active leadership comprises leaders who co-ordinate and set the course for the department. As one participant expressed it, active leadership makes it clear " . . . that one isn't driving his own boat but that all are sitting in the same one." Leaders need to have an overview, a clear focus and goals, to be vigorous, dynamic, and to get things done. One participant said:

> an important bit for me is that I have clear leadership also when there are ambiguities . . . [N]ow and then if I myself become confused, where is the ship going now? What do we decide? That I have someone, team leaders in the first place, who are clear about what the plan is . . . and who must be able to act decisively.

Underpinning such leadership are predictable organizational structures and routines put in place by the leaders. Further, building supportive relationships between a leader and staff helps ensure that staff members are seen, heard, and

Table 5. Themes and subthemes included in Code Group 2.

Theme	Subthemes
Leadership influences staff members' perceptions of safety	Support
	Facilitation
	Leadership
Routines and structures influence staff members' perceptions of safety	Stability
	Credibility
	Physical environment
	Structured information
	Education and training

taken into consideration in their daily work. "It is important with leadership support that one experiences it as someone having your back." This specifically includes support in preventing difficult situations – those involving aggression, conflict, and violence – and debriefing and following up on them when they do occur. To re-create safety after disruptions, participants considered it important that the staff be taken care of afterward, especially by leadership and through formal organizational systems. Staff members prefer leaders to contact them to initiate the processing of traumatic or stressful situations, in a structural way, and stated that receiving support and treatment after difficult incidents should not be optional. Several said that leaders had allowed them to choose. In the words of one,

> It is very easy after an episode that has been difficult, when you get asked if you need follow-up, it is very easy to answer "No, it's fine" . . . .But it isn't so certain that it is . . . .I believe it is really important what happens afterwards.

Some have regretted saying "no" to avoid being bothersome, later recognizing that they had suffered negative effects from the incident. As one participant put it,

> I have myself said "no thanks" to a psychologist that I regretted many years later, after incidents at work. And it was because I was asked "If you need . . . maybe we can arrange it." Then you feel you are a bother.

Some mentioned anxiety and stress as reactions to exposure to aggression and violence, and said that, as a result, they could react strongly to small things. They described feeling activated in their body and getting scared of nothing. One staff member described it as

> . . . one walks a little on one's toes and is a bit activated in one's body, reacting to small things, that maybe usually one wouldn't react to. Jumping if a door is slammed or someone shuts a kitchen cabinet a little hard.

To avoid such consequences, leadership support and debriefing are essential.

Routines and Structures Influence Staff Members' Perceptions of Safety

Staff members indicate that high degrees of predictability and stability in the organization leads to a higher degree of perceived safety. Predictability and safety are enhanced if risk assessments are done ahead of time and are then used to plan what to do and to determine who should do what. These plans should take into consideration the number of available staff members, so that no one has to stand alone in difficult situations. In addition to risk assessments and planning, coordination was also seen as important. "It is all

the more important that things are well systematized and that there are good routines for things, so that we are coordinated," as one participant stated.

Sticking to plans made at the outset can increase the perception of safety. Participants said that predictability depends on a stable group of staff members that persists over time and carries out plans that they have agreed on. In the words of one, it is important " … that structures exist so that we know what we should do when there is commotion or trouble, so we have systems that we follow." One staff member described the positive results of an overlap between when one team leaves and another team starts its shift. This helps ensure " … that one gets enough and structured information about how things have been, so that one can be prepared, be ready and detect signals." On the other hand, if the departing team conveys negative feelings to the incoming team, these feelings can contribute to unsafety. According to one staff member,

> Greater uncertainty comes when overlaps contain lot of emotion and little professionalism; one says how it has been for oneself, one doesn't say what has happened and this creates more insecurity. This doesn't give me huge motivation to get started with my shift.

These expressed feelings can create expectations among the staff starting the new shift that the work will be challenging and heavy. The physical environment should also be considered; it is important, for example, to be aware of possible escape routes and to make inaccessible objects that could be used as weapons.

In general, staff members reported that having sufficient education and training increased their confidence in their own competence, which led to a sense being able to cope and increased perceived safety. Some pointed out that the amount of systematic training affected whether they felt safe and could depend on structures and routines in the organization. Several staff members indicated that knowledge of youth rights is important to feel secure about the regulations and to avert unwanted situations. Others

Table 6. Themes and subthemes included in Code Group 3.

More unity and coordination among team members	Better understanding of one another Shared skills, knowledge, focus
More transparency among and consideration for colleagues	Improved communication More acceptance and recognition Attention to risks
More systematic work processes	Systematic risk assessments, planning, and prevention Prevention of physical restraint More attention to goals
More awareness and consciousness in conflict situations	Basic safety attitude More self-consciousness among staff More openness, slower tempo, and use of defensive communication
More reflection after conflict situations	More self-evaluation

said that they had taken different classes on youth rights before attending the training program, and that they felt confident in their knowledge about the subject.

Staff Experiences with "Basic Training Program in Safety and Security" (Code Group 3)

Five themes comprise staff members' experience with the training program (see Table 6).

More Unity and Coordination among Team Members

As a result of the program, most staff members reported knowing and understanding each other better. As one said, "We have been in some situations [after the training course] that we have handled much better, because we have come to know each other better and work more alike. This has made us feel more coordinated." Several participants stated that they generally feel more confident in their colleagues since attending the program because they know that their colleagues have the same knowledge and skills as they do. In situations in which they have had to perform physical restraint, the training has contributed to more confidence. One participant stated:

> … [I]t happens now and then that we do not manage to prevent, and so we must practice and then we can all practice, and then we feel confident about it. It is much easier to know what all the others are able to do than it was before.

Developing a common focus, language and understanding, including more comprehensive and adjusted goals, has contributed to a more integrated practice in the facility, according to participants. One stated, " … .This course we have taken, which has been a kind of 'now we go in step.' creates a feeling of security that makes it totally alright to come to work." Staff members pointed out that they also are more aware of the goals they had already set. As one participant commented, "One thing that I think a lot about is 'what is the goal?' I believe one becomes a little more solution-oriented when one also sees it."

Participants from two of the three facilities had been training systematically over time and referred frequently to the training program's models and terminology. This is illustrated by the comments of one: "It is pointless to talk to someone who is deep down in the stress-cone or on the top of the aggression-curve." Participants also referred to different communication strategies learned in the training program. As one said, "I think that my communication quickly can turn a bit red [giving orders, issuing warnings, moralizing, and arguing]."

More Honesty, Openness, and Consideration among Colleagues

Several staff members mentioned that the training program influenced and changed the way they communicate with colleagues and leaders. They consider themselves now to be more open and honest with each other about how they feel about their work with youth. As a consequence, they have developed an acceptance to, as one participant said,

> . . . know how one feels today and what type of consideration one must take. That we have gained an acceptance of it and talk about where we are in the stress-cone [a model used in the program]. Feel it in the body, what do the youth do to us? What can influence the relationship? . . . Feel the alarm . . . .It all benefits. You have to dig deep to achieve this.

Some participants said they found it difficult to share, but at the same time, they acknowledged that they experienced more support and feedback from colleagues. They saw this as improving the quality of risk assessments and enabling everyone to cope better in their roles as providers of care and therapy.

Staff reported that they had come to understand that they had tolerated too much risk-taking and too many dangerous situations previously. One expressed it this way:

> . . . .One thinks that one must take so much, and grit one's teeth, and this is what you should tackle, but after it [the training program) we developed a little more of a threshold for . . . .no, we are in fact not going to do that.

Several staff members reported a great upheaval after the training program. Now, they take fewer risks and do not put up with everything as they had previously.

More Systematic Work Processes

Staff at all three facilities reported that attending the program had led to an increased focus on preventing conflicts. They had created arenas of risk assessment and changed the way they prepared for difficult and risk-filled situations. One participant explained,

> I do much more now than before because one must do things before and afterwards. Even if one maybe doesn't do that much in the situation, then one does more before and after. It also helps to prevent much more, that we manage to plan in a completely different way than before.

Staff members pointed out that now, before they handle a difficult situation, they prepare, assess risks more frequently than before, consider what is needed to resolve the situation satisfactorily, and plan how to do it. Some said that they did these same things prior to attending the program, but that they now do them more systematically, following specific forms and structures. One participant said,

> We became more aware after the implementation of safety and security [the training program]. There are maybe things I have done before or during conflicts, but now we have visualized it better and put it into practice more.

Staff members were concerned about the use of physical restraints and how to prevent using them. Since participating in the training program, one staff member noted, regarding physical restraint, " … you need to be better at avoiding it than performing it."

More Awareness and Consciousness in Conflict Situations

Staff members reported a greater awareness in general regarding how their thinking and behavior affect both themself and others. They reported that, since the training program, they reflected more critically on their own way of working, considering particularly the roles they played in conflict situations. As one participant commented, "It can often be the adult who maintains the conflict." Staff members agreed that they play a role in conflicts and that their actions can escalate matters. "One can actually become a trigger, if one just keeps standing there." Participants stated that they are now more conscious of the signals they are sending to youth when they remain in a conflict situation. In the words of one,

> [Y]es, I maybe show that I can tolerate you, but I show too that it is completely fine if you just continue … .Before, maybe I just stood there and did not think anything about why I was just standing there … .that I should just tolerate it. But now I believe that maybe there is more that connects with me and that, okay, what is my limit? What do I teach you now? In some situations, maybe it is right to pull away a little … .I am here for you, but now it is enough for a while. The boundaries become a little clearer. More conscious.

Staff members said that reflecting on and being aware of the behaviors that would not be acceptable in a specific situation and taking a firm stance against them made them feel safer. Some said that they had changed their thinking about conflicts, moving from viewing them as power-struggles to focusing instead on resolving and de-escalating them.

> Before, you were so much more like "Now I have started it and so I will stick with it until the bitter end, or I lose face" … .I felt that I could not show the others that I was losing in the situation. And this [the training program] has made me much more aware of it, that it actually doesn't matter to me anymore.

Some participants mentioned that they have used this approach more frequently since participating in the program and that it has had a calming effect. A few had different opinions and preferred to remain involved in situations or conflicts until they had resolved them, so that they did not show weakness in front of the youth.

In general, since participating in the training program, staff members said that they experienced a change in their communication strategies and behaviors in response to escalating situations. As one described:

> I have become much more aware of speaking slowly, at a calm tempo and just breathing out, and maintaining distance. One is aware of in a completely different way, and I believe that it helps that the situations that before ended up in complete chaos, it is longer between them. It is much, much, much longer between them.

Low affective/green communication strategies, such as being open, honest and calm, demonstrating interest, and engaging in active listening, were used more frequently and helped staff members both prevent situations from escalating or getting out of control and stop them if they did. Several staff members said they found a common way to de-escalate conflicts and aggression as early as possible, mentioning trying "to be a step ahead." To do this requires assessing the situation early, and said that they now perform risk-assessment more regularly and often in writing. They stressed the importance of early observation of an incipient conflict, followed by strategic and thoughtful action in accordance with pre-agreed-upon methods. Staff members reported more use and greater awareness of basic safety measures, such as adopting a defensive posture, removing objects that could be used as weapons, and maintaining appropriate distance from others.

Some of the interviewed staff members pointed out that situations that, prior to participation in the training program, could get out of control and become chaotic, are now rarer and that engagement in physical conflict had decreased. One participant thought that physical conflict had actually increased in recent years. He believed that about 15 years ago, staff had the ability to use authoritarian methods, such as forcing youth to take long hikes in the woods or applying other sanctions, but that these are no longer options due to legal regulations and control.

Staff members also focused on their increased awareness and consciousness when they experienced difficult situations, such as when exercising physical restraint. One commented: " . . . .I am more conscious of different things that we have learned and pay attention to the breathing when we are sitting down on the floor." An awareness of how a youth breathes when restrained can be lifesaving for the youth involved. Managing conflict well also requires staff members to be aware of how they are positioned within the conflict vis-à-vis the involved youths as well as of their communication strategies.

More Reflection after Conflict Situations

Some staff members indicated that the focus on prevention had also improved their ability to evaluate incidents after the fact, allowing them to learn from experiences and be better prepared for the next conflict. Staff stated that they now evaluate and reflect more fully on situations and their own actions than

they did prior to attending the training program. One informant said that, in the aftermath of situations, she looks at the poster that depicts the training program models and asks herself, "What could I have done differently? Where was I?" She also believes that she has become even better at assessing herself and reflecting on her behavior.

Participants also pointed out that talking to youths after a conflict is essential. In such situations, timing is important. In the words of one: "We see that one becomes better at holding a conversation afterwards, that one gives the youth a little time, rather … not running after them." Staff members now give themselves and the youths they interact with more space and time to calm down before talking about what happened and planning what to do next time.

Discussion

The findings of this study contribute to the knowledge of how staff members perceive safety in their workplace. The analysis reveals significant factors, both on the individual and organizational levels. The study also reveals that staff members understand their work practices and attitudes as having been influenced by the training program in which they participated. In what follows, we will discuss the main findings of our study.

Safety Matters

This study shows the vital role of safety for the staff members that participated in the study. Open, honest, and supportive relationships among colleagues and between colleagues and leaders were of most importance to staff perceptions of safety at work. One staff member stood out and leaned toward the relationship with youth rather than relationships with colleagues. This study also contributes to an understanding of the importance of organizational factors that affect individuals and their relationships with one another. Organizational structures, routines, and predictability appear crucial to staff members' sense of safety. A stable staff group over time is also perceived to be essential to staff safety. This finding accords with the study by Pelto-Piri et al. (2020), which indicates that external factors – organizational, situational, and relational – play important roles in violence prevention. Such factors may be easier to modify than internal youth factors. On a relational level, Pelto-Piri et al. (2020) find that part of violence prevention includes regular management follow-up with staff after violent incidents and increased psychological support.

Staff members' stated desire for clear leadership and standard routines implies that current methods and routines of staff support and debriefing after difficult and unwanted situations are insufficiently developed. Leadership in these areas requires improvement to increase staff perceptions of safety.

Leadership support also critically influences factors such as retention, job stress, and burnout, that can affect residential youth-care outcomes (B. D. Smith, 2005; Del Valle et al., 2007). Reviews of strategies for reducing the use of R&S have concluded that clear and predictable leadership, coupled with staff training and preventive interventions, can yield promising outcomes (LeBel et al., 2010; Scanlan, 2010).

The participants in our study stressed that receiving sufficient and uniform education and training in preventing aggression and conflict was important to their sense of safety. This corresponds with the finding of Pelto-Piri et al. (2020) that improving staff competence in the use of de-escalation techniques can help prevent aggression and violence. Smith et al. (2017) conclude that client violence can be reduced if de-escalation and behavior-management techniques are used properly. Our findings support this conclusion.

Further, our results show that staff members believe that feeling unsafe at work increases the fatigue, stress, and fear that several have experienced. The consequences can be serious and undesirable, including staff burn-out and staff turnover (Colton & Roberts, 2007; Conrad & Kellar-Guenther, 2006; Maslach et al., 2001; Seti, 2008). Additionally, the care and treatment of youth can be affected adversely. Staff who feel unsafe may act and communicate with greater strictness and severity, which may in turn increase conflict, with negative effects for both staff and youth. Winstanley and Hales (2014) advocate interventions that promote staff members' awareness of their emotional state and the effect of their behaviors on others, thus helping staff to withdraw from escalating situations and to rely on colleagues who are not displaying emotional exhaustion.

The Influence of the Basic Training Program on Perceptions of Safety

Our findings indicate that staff believed that the training program had made them more aware of and competent in preventing and managing, incidents of aggression and conflict and engaging in reflection after them. As a result, staff felt better prepared for possible undesirable situations. Changing practice and focusing on staff understanding and team management of conflict may be fruitful for managing conflict and intervening early.

Recognizing that aggression is often a result of powerlessness, the attitudes and actions of staff could influence incident outcomes for both staff and youth. Our impression is that staff intend to employ de-escalating techniques when dealing with frustrated youth, and that they try not to become, or to show that they have become, unregulated or stressed. This does not necessarily mean that staff act passively or withdraw from uncomfortable situations, but could be that they address situations actively, in ways that are perceived as nonaggressive and lacking in emotionality. Staff indicate that these approaches and actions have been influenced by the training program, and in particular, by the

training of staff in communication techniques and defensive attitudes. The education in powerlessness theory that staff have received as well as their training to reflect on power disparities may also have been influential.

Staff members report that, since the training, they are more aware of their own safety, take fewer risks, and adopt a defensive approach to conflicts and aggression. One result of this change could be that fewer conflict situations arise. Another could be that staff believe intervention is unsafe and they thus act too defensively, taking no action in situations where action is needed, with the consequences being that involved youths do not receive needed care. One risk is that staff have an excuse not to say "no" or "stop" to the youths in their care, in order to avoid disagreement or conflict, when these responses are in fact the proper answers.

According to study participants, predictability and stability, including shared focus, goals, plans and expectations, increase their perceptions of safety. They report that uniform competence and training contribute to increased safety. Since the training program, staff members indicate being more coordinated as a team, more confident at work, and possibly better regulated and calmer in handling difficult and escalating situations without being overwhelmed by their own fear or anger. These findings indicate that staff may be better able to show the youth in their care an attitude of recognition and help them feel more empowered, thereby reducing displays of frustration and anger that are caused by feelings of powerlessness.

The program " non-violence resistance" (NVR) for residential settings has some similarities to the Basic Training Program in Safety and Security; it aims to make staff members feel more confident in their daily work, improve team functioning, develop organizational vision and behavior, and decrease the number of aggressive incidents through various measures including presence, de-escalation and reflection (Van Gink et al., 2018). Multilevel analysis of NVR shows significant positive effects on team functioning, team satisfaction, and shared vision and commitment (Van Gink et al., 2018). Supportive teams of staff members who share common beliefs is vital to violence prevention (Pelto-Piri et al., 2017). Our findings are in line with these results. They indicate that teams that are better coordinated, more supportive and share a vision help reduce staff stress and enhance staff perceptions of safety. Thus, the basic training program appears to have potential to furnish staff with appropriate skills and knowledge to identify, prevent, and de-escalate conflict in residential youth facilities.

Our study shows that many goals of the training program were perceived achieved by the participants, such as increasing conscious thought before applying physical restraint, improving communication skills, increasing reflection, preventing aggression and conflict, enhancing team coordination and unity, and increasing awareness of self and others.

Limitations and Suggestions for Future Research

There are several possible limitations to this study. First, we do not have information to compare the facilities that consented to participate in the study with those who did not, so there might be similarities or differences that we are not aware of. Although we did not seek to limit participation beyond our two imposed criteria, we relied on staff managers to communicate with potential participants and staff members' willingness to participate, potentially biasing the findings. Staff members who were unwilling to participate may have opinions other than those uncovered in this study and a different sample might have generated other descriptive codes and code groups.

Second, those staff members who did take part in the study may have felt obliged to participate because their manager presented the invitation to them. To avert this bias, participants were told to contact the researchers directly, rather than their supervisors, if they wished to participate. Given the varied responses in our sample, we believe that sampling bias was minimal.

Third, participants may have been influenced by the presence of team leaders in two of the focus groups. To counteract possible influence, we raised the matter in the focus-group interviews. Participants described the team leaders as equals part of the team, who worked under the same conditions and the same hours with youth as did staff members. The interviewers did not perceive any reluctance or hesitation among participants with respect to this issue.

Fourth, the study's categories and codes are based on participants' descriptions of practice and therefore were not tested empirically. Systematic studies of similar programs in the same area of research conclude that it is unclear if such training programs work or lead to desired results (Price et al., 2015). We cannot determine if attending the training program has reduced the incidences of conflict and aggression, or has improved youth safety and care. However, Marton (2014) argues for a strong link between people's descriptions of practice and actual practice.

Fifth, we do not know if staff members' enhanced perceptions of safety are the result of staff having attended this particular training program. We also do not know if particular aspects of the training program or its content were responsible for the reported changes, such as staff members becoming better acquainted during training or gaining shared understanding, direction, focus and an enhanced ability to reflect. There could also be a possibility that staff perceptions could have been influenced by other programs, such as a trauma-based care approach.

A sixth potential limitation concerns methodology. We cannot guarantee that the study participants did not experience the interview as similar to an evaluation, and that they did not adjust their responses according to what they assumed to be the expected or ideal/correct answers from the interviewers or colleagues. We chose focus-group interviews to be able to create a group dynamic interaction process where the participants respond to each other's statements. This cannot be created in individual interviews. To reduce possible participant reluctance to reveal difficulties, we used open-ended questions to encourage participants to engage in self-driven, free narratives. We also emphasized that we are not experts in the training program and that our aim was not to investigate how successfully they were following the program.

Finally, a possible limitation is the empirical foundation of our discussion, which rests on research from different types of inpatient youth facilities, mainly because of the dearth of research on safety, conflict, and aggression in comparable residential care facilities. However, due to the significant similarities between inpatient psychiatric wards and residential care facilities, we argue that the findings from studies of the latter can help illuminate issues related to the former, at least until a more solid empirical foundation has been established for services in residential care facilities.

Our study suggests that development of personal skills, as well as a targeted, team approach to help staff members gain awareness of their own roles and how they affect youth and difficult situations, are vital in residential facilities as well as other sectors providing care. However, more knowledge about how staff can contribute to increased safety for both themselves and the youth living in residential settings is urgently needed. In particular, research is needed on staff awareness of and efforts to prevent and manage aggression, violence, and conflict, as this is fundamental to the relational connections between staff and youth and to the well-being of both. Research should also include the perspectives and experiences of the youth who are receiving care, to ensure development of a comprehensive and credible foundation for knowledge-based practice related to safety and conflict prevention and management in residential care facilities. Educational and training programs ought to be tailored to enhancing safety and preventing/managing conflict and aggression. The search for effective training programs and approaches should continue and would benefit from further research, especially to determine if, after staff attend training, conflict and aggression actually decrease and staff treat youth differently. Such research requires methods other than staff self-reporting. Also important are comparisons of different training programs that produce similar results, to discover which aspects of the programs produce the best practice.

Conclusion

This study investigated staff perceptions of safety and their experiences with the Basic Training Program in Safety and Security. We found that staff members believed that the program increased their perceptions of safety, knowledge, and awareness of approaches to dealing with conflict and aggression. We found that staff regard safety as essential. Participants' perceptions of enhanced safety were linked to predictability, stability, team coordination, education and training, and organizational support. Trusting and supportive collegial relationships appear to be the most important factor in increasing perceptions of safety. Staff members reported that their well-being and their ability to provide proper care for youth living in residential facilities are connected to perceived safety.

Staff who attended the training program reported enhanced awareness and more systematic implementation of work processes in cooperative and coordinated teams to prevent, manage, and evaluate conflicts. Teamwork is based on a common language, focus, goals, and expectations. Staff also reported improvement of their communication skills and ability to offer collegial support in an open and honest climate, compared to before attending the program. By attending the program staff members felt that they got to know each other and themselves better, developed more self-control, and to increased self-reflection. Our findings suggest that several of the training program's aims were reported met. Also, staff members' prerequisites for safety increased after attending the program. Even if we cannot generalize this study to the population, the study indicates that training, both individually and in teams, in prevention and management of conflict and aggression may be crucial in increasing perceptions of safety of staff working in youth residential facilities.

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References

Bath, H. (2015). The three pillars of traumawise care: Healing in the other 23 hours. *Reclaiming Children & Youth*, *23*(4), 5–11. https://doi.org/10.1007/BF02629766

Bath, H. I. (2008). Calming together: The pathway to self-control [Article]. *Reclaiming Children & Youth*, *16*(4), 44–46. https://login.ezproxy.oslomet.no/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=eue&AN=508025714&site=ehost-live&scope=site

Bogo, M., Shlonsky, A., Lee, B., & Serbinski, S. (2014). Acting like it matters: A scoping review of simulation in child welfare training. *Journal of Public Child Welfare*, *8*(1), 70–93. https://doi.org/10.1080/15548732.2013.818610

Colton, M., & Roberts, S. (2007). Factors that contribute to high turnover among residential child care staff. *Child & Family Social Work*, *12*(2), 133–142. https://doi.org/10.1111/j.1365-2206.2006.00451.x

Connor, D. F., McIntyre, E. K., Miller, K., Brown, C., Bluestone, H., Daunais, D., & Lebeau, S. (2003). Staff retention and turnover in a residential treatment center. *Residential Treatment for Children & Youth*, *20*(3), 43–53. https://doi.org/10.1300/J007v20n03_04

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse Negl*, *30*(10), 1071–1080. https://doi.org/10.1016/j.chiabu.2006.03.009

Dean, A. J., Duke, S. G., George, M., & Scott, J. (2007). Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(6), 711–720. https://www.jaacap.org/article/S0890-8567(09)62150-X/fulltext

Dean, A. J., Gibbon, P., McDermott, B. M., Davidson, T., & Scott, J. (2010). Exposure to aggression and the impact on staff in a child and adolescent inpatient unit. *Archives of Psychiatric Nursing*, *24*(1), 15–26. https://www.psychiatricnursing.org/article/S0883-9417(09)00002-8/fulltext

Del Valle, J. F., López, M., & Bravo, A. (2007). Job stress and burnout in residential child care workers in Spain. *Psicothema*, *19*(Número4), 610–615. https://reunido.uniovi.es/index.php/PST/article/view/8524

Fraser, S. L., Archambault, I., & Parent, V. (2016). Staff intervention and youth behaviors in a child welfare residence. *Journal of Child and Family Studies*, *25*(4), 1188–1199. https://doi.org/10.1007/s10826-015-0312-6

Furnivall, J. (2018). Reclaiming complexity: Beneath the surface in residential child care. *Journal of Social Work Practice*, *32*(4), 373–390. https://doi.org/10.1080/02650533.2018.1503164

Hagen, I. M., & Svalund, J. (2019). Vold, trusler og trakassering i helse- og sosialsektore. (Violence, threats and harassment in the health and social sector)

Knorth, E. J., Harder, A. T., Huyghen, A. M. N., Kalverboer, M. E., & Zandberg, T. (2010). Residential youth care and treatment research. *International Journal of Child & Family Welfare*, *13*(1/2), 49–67. http://hdl.handle.net/1765/115858

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, *45*(3), 214–222. https://doi.org/10.5014/ajot.45.3.214

LeBel, J., Huckshorn, K. A., & Caldwell, B. (2010). Restraint use in residential programs: Why are best practices ignored? *Child Welfare*, *89*(2), 169–187. https://www.researchgate.net/profile/Janice-Lebel-2/publication/46392296_Restraint_use_in_residential_programs_Why_are_best_practices_ignored/links/004635390bdeaa3add000000/Restraint-use-in-residential-programs-Why-are-best-practices-ignored.pdf

Lombart, B., De Stefano, C., Dupont, D., Nadji, L., & Galinski, M. (2020). Caregivers blinded by the care: A qualitative study of physical restraint in pediatric care. *Nursing Ethics*, *27*(1), 230–246. https://doi.org/10.1177/0969733019833128

Lynch, M. F., Jr, Plant, R. W., & Ryan, R. M. (2005). Psychological needs and threat to safety: Implications for staff and patients in a psychiatric hospital for youth. *Professional Psychology: Research and Practice*, *36*(4), 415–425. https://doi.org/10.1037/0735-7028.36.4.415

MacRae, R., & Skinner, K. (2011). Learning for the twenty-first century: Maximising learning transfer from learning and development activity. *Social Work Education*, *30*(8), 981–994. https://doi.org/10.1080/02615479.2010.520118

Marton, F. (2014). *Necessary conditions of learning*. Taylor & Francis. https://books.google.se/books?id=bbzcAwAAQBAJ

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, *52*(1), 397–422. https://doi.org/10.1146/annurev.psych.52.1.397

Miller, D. E. (1986). The management of misbehavior by seclusion. *Residential Treatment for Children & Youth*, *4*(1), 63–73. https://doi.org/10.1300/J007v04n01_09

Moore, T., McArthur, M., Death, J., Tilbury, C., & Roche, S. (2017). Young people's views on safety and preventing abuse and harm in residential care: "It's got to be better than home." *Children and Youth Services Review 81*(October), 212–219. https://www.sciencedirect.com/science/article/abs/pii/S019074091730316X?via%3Dihub

Nunno, M. A., Holden, M. J., & Leidy, B. (2003). Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility. *Children and Youth Services Review*, *25*(4), 295–315. https://doi.org/10.1016/S0190-7409(03)00013-6

Nyttingnes, O., Ruud, T., Norvoll, R., Rugkasa, J., & Hanssen-Bauer, K. (2018). A cross-sectional study of experienced coercion in adolescent mental health inpatients. *BMC Health Services Research*, *18*(1), 389. Article. https://doi.org/https://doi.org/10.1186/s12913-018-3208-5

Pelto-Piri, V., Engström, I., Sandèn, P., Warg, L.-E., & Kjellin, L. (2017). *Hantering av hot och våld. Personalens syn på etik, bemötande och säkerhet i mötet med ungdomar på institutioner (Handling threats and violence. Staffs view at ethics, treatment and security with young people at institutions)* 978-91-87053-54-2. S. institutionsstryelse. Statens institutionsstyrelse (SIS) Report number 12.

Pelto-Piri, V., Warg, L. E., & Kjellin, L. (2020). Violence and aggression in psychiatric inpatient care in Sweden: A critical incident technique analysis of staff descriptions. *BMC Health Serv Res*, *20*(1), 362. https://doi.org/10.1186/s12913-020-05239-w

Price, O., Baker, J., Bee, P., & Lovell, K. (2015). Learning and performance outcomes of mental health staff training in de-escalation techniques for the management of violence and aggression. *British Journal of Psychiatry*, *206*(6), 447–455. https://doi.org/10.1192/bjp.bp.114.144576

Scanlan, J. N. (2010). Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: What we know so far a review of the literature. *International Journal of Social Psychiatry*, *56*(4), 412–423. https://doi.org/10.1177/0020764009106630

Scaramella, L. V., & Leve, L. D. (2004). Clarifying parent–child reciprocities during early childhood: The early childhood coercion model. *Clinical Child and Family Psychology Review*, *7*(2), 89–107. https://doi.org/10.1023/B:CCFP.0000030287.13160.a3

Seti, C. L. (2008). Causes and treatment of burnout in residential child care workers: A review of the research. *Residential Treatment for Children & Youth*, *24*(3), 197–229. https://doi.org/10.1080/08865710802111972

Slaatto, A., Mellblom, A. V., Kleppe, L. C., Baugerud, G. A., & Kjøbli, J. (2021). Conflict prevention, de-escalation and restraint in children/youth inpatient and residential facilities: A systematic mapping review. *Children and Youth Services Review*, *127*(May), 106069. https://doi.org/10.1016/j.childyouth.2021.106069

Smith, B. D. (2005). Job retention in child welfare: Effects of perceived organizational support, supervisor support, and intrinsic job value. *Children and Youth Services Review*, *27*(2), 153–169. https://doi.org/10.1016/j.childyouth.2004.08.013

Smith, Y. (2014). Rethinking decision making: An ethnographic study of worker agency in crisis intervention. *Social Service Review*, *88*(3), 407–442. https://doi.org/10.1086/677846

Smith, Y., Colletta, L., & Bender, A. E. (2017). Client violence against youth care workers: Findings of an exploratory study of workforce issues in residential treatment. *Journal of Interpersonal Violence*, *36*(5-6), 886260517743551. https://journals.sagepub.com/doi/10.1177/0886260517743551

Steckley, L. (2018). Catharsis, containment and physical restraint in residential child care. *British Journal of Social Work*, *48*(6), 1645–1663. https://doi.org/10.1093/bjsw/bcx131

Steele, W., & Kuban, V. (2013). *Working with grieving and traumatized children and adolescents: Discovering what matters most through evidence-based sensory interventions*. Routledge.

Tjora, A. H. (2019). *Qualitative research as stepwise-deductive induction* (Vol. 26). Routledge.

van Gink, K., Vermeiren, R., Goddard, N., van Domburgh, L., van der Stegen, B., Twisk, J., Popma, A., & Jansen, L. (2018). The influence of non-violent resistance on work climate, living group climate and aggression in child and adolescent residential care. *Children and Youth Services Review*, *94*(C), 456–465. https://doi.org/10.1016/j.childyouth.2018.08.009

Visser, K. M., Jansen, L. M. C., Popma, A., Vermeiren, R. R. J. M., & Kasius, M. C. (2020). Addressing aggression in the residential setting for juveniles with mild intellectual disability through training in non-violent resistance. *Child & Youth Care Forum, 50*(2021), 333–349. https://doi.org/10.1007/s10566-020-09576-z

Winstanley, S., & Hales, L. (2014). A preliminary study of burnout in residential social workers experiencing workplace aggression: Might it be cyclical? *The British Journal of Social Work*, *45*(1), 24–33. https://doi.org/10.1093/bjsw/bcu036

Woodcock, K., & Fisher, S. L. (2008). *Occupational health and safety for sign language interpreters*. Ryerson University, Toronto. https://www.ryerson.ca/content/dam/woodcock/pdfs/OHSGuideforSLI.pdf

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Youth in Residential Facilities: "Am I Safe?," "Do I Matter?," and "Do You Care?"

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ABSTRACT

Youth in residential facilities need to perceive that they are safe. Their perceptions of the quality of treatment and care they receive are affected by how staff behave toward and communication with them as well as by the extent to which they can participate in decisions about their daily lives and futures. To better understand how youth perceive safety and experience residential facilities, we conducted a qualitative study involving eight youths between 16 and 18 years of age living in Norwegian public residential facilities. We investigated 1) their perceptions of safety and 2) their experiences of and reaction to staff behaviors and attitudes. Our findings show that these youths perceive safety as related to their own room and to the people around them. They also indicate that the everyday life of youths can vary: it may be characterized by passivity and by waiting for the start of life or of daily activities, such as school. Our findings about staff attitude and behavior point to the need for youth care services to focus on the communication abilities of staff rather than on the problematic behaviors of youth. These findings have implications for facilities that provide care and treatment to youth.

KEYWORDS

Youth perspectives and experiences; residential facility; safety; staff behavior and attitude; powerlessness

Implications for Practice

- Youths' feelings of safety in residential facilities are linked to their rooms and the people around them
- Staff behaviors, attitudes, and communication matter to youth
- Youth want staff to appreciate their perspectives and allow them to calm down, participate in activities, and share their thoughts and feelings
- There is a need for residential facilities to maintain focus on the communication abilities of staff
- Further research is needed and should include youths' perspectives on and experiences of living in residential facilities

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Introduction

Safety is often referred to as one of the most fundamental needs of youth in residential care facilities (Bath, 2015; Furnivall, 2018; Moore et al., 2017). From a youth perspective, safety has both emotional (feeling safe) and interpersonal (being safe) dimensions. Being safe can be understood as the state of being protected from harm or other non-desirable outcomes. Feeling safe means being confident that one is not in danger. Youth often live in residential facilities as a result of harmful and disrupted relationships with caregivers upon whom they depended; they have thus suffered trauma, disappointment, and abandonment (Braxton, 1995; Briggs et al., 2012; Carr et al., 2020; Collin-Vézina et al., 2011; Gharabaghi, 2019). In many cases, they experience considerable turbulence, fear, and disrupted attachment as a result of the abuse and neglect they were subject to (Collin-Vézina et al., 2011; Greger et al., 2015). If a youth does not feel safe, s/he may exhibit behaviors and experience emotions that are shaped by a survival instinct. Safety is a core dimension of quality in residential settings and needs to include youth`s own assessment of the settings safety (Farmer et al., 2017). It is essential that residential care provide an environment where youths can feel both calm and safe, so that they can overcome the effects of past abuse, heal, and attend to developmental tasks (Bath, 2015; Hawkins-Rodgers, 2007; Holden et al., 2010; Moore et al., 2017).

The issue of safety is fundamental to well-being. It is therefore closely related to the quality of interpersonal connections, as only in relationships with others can youth begin to feel safe and to heal (Bath, 2015). Safety is the first pillar of trauma-informed care. Youth’s sense of safety is strongly linked to staff quality, which include the ability of staff to relate effectively to youth and to maintain control of care environments (Freundlich et al., 2007). In addition, feeling safe contributes to youths` perceptions of a healthy social climate (Leipoldt et al., 2019; Pérez-García et al., 2019). The second and third pillars are Connections and Coping (Bath, 2015). Staff should be committed to building and maintaining appropriate therapeutic relationships with youth; according to some scholars, “relationship is the intervention” (Stuart, 2009). They need to build trusting relationships that both allow youth to participate and provide enough structure to help them succeed (Ungar & Ikeda, 2017). The main moderating factors for feeling cared for and loved are feeling safe and enjoying social support (Lausten & Frederiksen, 2016).

Staff members are responsible for how they form relationships with youth; these relationships greatly influence whether youth perceive themselves as subjects in inter-subjective meetings (Pelto-Piri et al., 2014), or as merely objects of routine-based care. A variety of research and training has focused on the essential roles of staff and organizational leadership to determine how

best to keep youth in residential care safe (James, 2011). Youth report better psychological and behavioral outcomes when they experience staff as available, reliable, respectful, and honest (Bell, 2002; Manso et al., 2008; McLeod, 2010).

An open environment that supports youth's opportunity for personal growth and safety is of central importance (Connor et al., 2003; Winstanley & Hales, 2014) both to youth outcomes and the reduction of aggression within the institution (Fraser et al., 2016). Additionally, fewer aggressive incidents is associated with a better care and treatment environment for youth and with a better working environment for staff, both of which should be goals of residential care facilities (Visser et al., 2020). Thus, the first imperative in working with traumatized youth is to create a safe place for them (Bath, 2015). Safety itself may depend on one of the pillars of trauma-informed care: comfortable connections between traumatized youths and their care providers, such as staff in residential facilities.

Even though some studies conclude with high youth perception of safety (Huefner et al., 2020), several other studies reveal that the residential-care experience of many youths is marked by a lack of safety, by sustained violence, and by continual threats of physical, emotional, and sexual abuse (Attar-Schwartz, 2014; Attar-Schwartz & Khoury-Kassabri, 2015; Freundlich et al., 2007; Gibbs & Sinclair, 1998; Mazzone et al., 2018; Sekol, 2013). Youths` perception of an unsafe environment has been associated with having experienced peer aggression (Lanctôt et al., 2016; Leipoldt et al., 2019), and has itself led to higher levels of aggressive behavior on the part of youth who have experienced aggression (Martinelli et al., 2018; Strijbosch et al., 2019).

Additionally, several studies reported in a review by Ten Brummelaar et al. (2018) suggest that youth have limited opportunities to participate in decision-making while in residential care, even though participation is a fundamental right for all youth growing up in residential care. Such participation is considered a key factor affecting youths' current or future living circumstances and it may improve the quality of their experiences living in residential care facilities (Ten Brummelaar et al., 2018). Youth wish to be included in a meaningful manner during every stage of care, from pre-admission (Roesch-Marsh, 2012) to transition-out-of-care phases (Fudge Schormans & Rooke, 2008). A review by Van Bijleveld et al. (2015) identified the personal relationship between youth and social workers as one of the most important facilitators of participation. A positive relationship with good communication between youth and staff, which focuses on understanding, closeness, respect, and reciprocity, is essential to promoting participation (Brown et al., 2010; Cousins & Milner, 2006; Henriksen et al., 2008).

Several studies suggest that a lack of youth participation during residential care can lead to outcomes seen as negative. A study by Roesch-Marsh (2012) reported youth emotional and behavioral problems. However, the behavior described as 'difficult' or 'manipulative' could also be understood as

reflecting youths' efforts to exercise some influence in a situation that did not offer other ways to do so (Tew, 2006). Another study reports passivity – youths declining or ceasing to ask questions or challenging decisions – as an outcome of lack of participation (Fudge Schormans & Rooke, 2008). Unless people feel able to exert some control over their lives, they cease trying to do so, according to the theory of learned helplessness (Maier & Seligman, 2016; Seligman, 1974). Among youths in residential facilities, learned helplessness can manifest itself as the inability to express their will and the belief that they have no influence over their own lives. Some studies of youth's experiences of decision-making procedures report feelings of helplessness, a lack of knowledge, and low self-confidence among youths as a result of their lack of opportunities to make decisions about their own lives (Bessell, 2011; Leeson, 2007). People who feel unable to solve problems for themselves become more dependent on others or withdraw into themselves. Powerlessness derives from a lack of decision-making power, the inability to make choices, and exposure to disrespectful treatment (Young, 2011). People are most likely to experience powerlessness when they occupy a clearly subordinate status, as do youth in residential facilities, and when others – in this instance, professional staff – wield power and decision-making authority over them (Barnes & Mercer, 2005). Powerlessness is experienced as a loss of control and a belief that, regardless of what one does, the present situation will not change (Maier & Seligman, 2016). It may also be described as an overwhelming feeling of helplessness. This feeling may result from a lack of free will or the inability to express freely one's needs, opinions, thoughts, and feelings (Young, 2011). Youth in residential care tend to have more intense feelings of powerlessness than do youth as a whole due to their unmet dependency needs and the high degree of structure required by the therapeutic environment (Braxton, 1995).

The aim of residential-youth care facilities is to care for, protect, and prepare youth for independent life in society (Ten Brummelaar et al., 2018; Whittaker et al., 2016). The environment and structure in these facilities, such as personal involvement by staff and a predictable set of rules, can affect how youth understand the reason for decisions and their ability to gain the experiences and skills needed for subsequent life in society (Henriksen et al., 2008). Placement in Norwegian residential-care facilities may occur after a court order or a municipal decision that has itself been made in response to troublesome behavior, substance abuse, or difficult home conditions. The Norwegian Directorate of Children, Youth, and Family Affairs is responsible for ensuring that public residential-youth facilities in Norway provide quality care, protection, and safety to youth. Staff in these facilities have undergone a training program – "The Basic Training Program in Safety and Security" (see, Slaatto, Mellblom, Kleppe,

Baugerud et al. (2021)) – and have been introduced to trauma-informed care as part of the framework for understanding youth living in these facilities.

The Current Study

Several youth facilities have devoted considerable resources to improving the quality of practice (Slaatto, Mellblom, Kleppe, Baugerud et al., 2021) and the interest in understanding the safety needs of youth in residential care has grown. However, there is limited research that considers how youth in residential facilities themselves define and experience safety, what their safety concerns are, and how they would like systems and staff to respond to their needs. Therefore, this current study investigated 1) youth perceptions of safety in residential facilities and 2) their experiences of and reaction to staff behaviors and attitudes.

Method

The plan for this study was to conduct qualitative focus-group interviews with youths at three different state-run residential facilities, including those with youth in long-term placements for substance and behavioral problems and those with youth in placements due to difficult home conditions. After ethical considerations, we found focus-group interviews to be an appropriate method since they could offer vulnerable individuals a feeling of safety that they might lack if interviewed individually. Although the first interview at one of the facilities was planned as a focus-group interview, it became instead a group interview as we were unable to foster discussion among the three youth participants, who individually directed their answers to the interviewer and did not speak directly to each other. Covid-19 restrictions then prevented us from conducting further in-person and group interviews. Thus, we conducted three additional interviews by telephone, with one individual at a time from the same facility. In January 2022, we conducted two more interviews to increase the number of respondents. Although the interviews did not proceed as originally planned, the resulting data is rich and potentially valuable and thus worth sharing.

Sample

The first author approached managers of three residential facilities that had previously permitted focus-group-interviews with staff members (see, Slaatto, Mellblom, Kleppe, Baugerud et al. (2021)). Each facility was given written information about the study and our request to recruit youth. The inclusion

criteria for participating youth were 1) currently living at the residential facility and 2) age 16 or older. Youths fitting these criteria at the three selected facilities were then given oral and written information about the study by staff. One facility was able to recruit three out of six qualified youths, and another recruited three out of ten youths. The third facility did not recruit anyone. In December 2021, the first author reached out to two of these facilities to recruit more youths to extend the sample. One of the facilities recruited two more youths. Each of the eight participating youths signed an informed-consent letter. Of the eight participants, six were male and two were female. All ranged in age from 16 to 18. One facility was a drug-and-behavior treatment facility and the other a care facility; each housed from six to eighteen youths ranging in age from 12 to 19. Even though the facilities are different and specialized in order to cover specific youth needs, all staff members have attended the same education and training program regarding safety and security. We could not find any differences between the facilities regarding these issues when analyzing the interviews.

Data Collection and Analysis

The first interviews took place from February 2020 to May 2020. The group interview was conducted by two of the study authors. To supplement the data material, two additional phone interviews were conducted in January 2022. The interview guide was based on two themes: youth perceptions of safety at the facility and youth perceptions of staff behavior, communication and attitude. The themes were presented to the participants, and the interviewer asked several questions related to each theme (see, Table 1). To establish rapport, the interviewer first talked about the project and then started the interview by asking the participant to "tell me about what a regular day is like for you." The interviews were conducted by the first author and ranged from 13 to 56 minutes. The interviews were digitally recorded and transcribed verbatim by the first author.

Inspired by the Stepwise-Deductive Induction (SDI) method (Tjora, 2019), we strove to represent the responses of the youths truthfully and empirically grounded by reproducing accurate quotes (Krefting, 1991). The only alteration to the quotes involved omitting "filler" words, such as "um" or "uh," that perform a function in oral communication but lack meaning when written.

Table 1. Themes and questions from the interview guide.

Main theme:	Questions:
Safety	What does safety mean to you? What do you see as safe and unsafe?
Conflicts with staff – staff behavior and attitude	What do staff do when a conflict arises between youth and staff? How do you feel treated by staff in such situations? Do you feel heard, seen, understood, and taken into consideration? What happens after conflicts? How do you wish to be treated by staff?

Additionally, we write “he” or “him” to refer to the participants, to mask their gender. The first author developed a list of initial codes to extract the essence of the material. The software package NVivo was used to keep track of the many codes demanded by the high degree of analytical detail. To ensure quality, the codes were not produced prior to the coding, which would have led to replication rather than systematization of the empirical content (Tjora, 2019). To increase reliability and ensure that no information was lost or coded inconsistently, the second author also coded the interviews. Similar codes were then collapsed, and new codes were added to the list created by the first author until the authors reached consensus. The final list served as a codebook and foundation for the next step: grouping the codes. The last step was to analyze and interpret the content in the code groups to capture the essence of the youths’ responses.

Ethical Considerations

The project was granted approval by the Norwegian Center for Research Data (ref. 339013). We administered the study in accordance with the principles for ethical research of the Norwegian National Committee for Research Ethics. Confidentiality was very important, particularly since one interview was conducted at the youths’ residential facility and the staff were aware of the youths’ participation. When writing up the findings, we removed all potentially identifying characteristics from the material.

Findings

We identified three code groups corresponding to youth perceptions and experiences (see, Table 2). We also selected quotes (which we translated from Norwegian to English) that exemplify the youths’ shared views as well as the differences in their experiences that emerged during our analysis. The three code groups fit together under the overarching theme of safety conditions. The first was the importance of safe private space with caring staff around. The second main is the perception that the stay at residential facility involved waiting for life to resume. The third main is the importance and complexity of relations and connections to staff, including interpretations of staff behavior and attitudes.

Table 2. Code groups.

Code group 1: Am I safe?	Feeling safe in my own room
	Feeling safe with people around me
	A lack of safety
Code group 2: Do I matter?	Staying in my room all day and night, waiting
	I have a plan for my day
Code group 3: Do you care?	Staff behavior in conflict situations
	Desirable staff behavior

"Am I Safe?" (Code Group 1)

Feeling Safe in My Own Room

When asked where they feel safe, several youths agreed that their rooms are safe spaces for them. As one put it, "My safety is my own room." Another said, "To live on the second floor. Always lived on the second floor. In residential facilities I have not lived on the second floor. Then I feel a little vulnerable because right outside my window is the street." One answered, "No, not as long as I`m in my room all the time" to the question, "Is there something that makes you feel unsafe at the facility?"

Feeling Safe with People around Me

The participants stressed that the people around them, both other youth and staff, are central to their sense of safety. As one participant stated, " … that I have people around me all the time … is safety for me … I feel very uncomfortable being alone." Another participant also said that knowing the people around him is important: "My safety is the other youths that live here. I know most of them well. And then there are some staff members that I feel pretty safe around, and others that I am not so completely safe around." Some of the youths said that feeling that the staff care about them is important to their sense of safety. One participant noted, "When there are staff who care, then it feels pretty safe." Another youth stated that " … I know that there is always someone I can talk to if I need to and that they [the staff] themselves come and knock on the door just to stop by." He continued, "I have been in a very bad mood towards most of them [staff] and they have handled it very well."

In contrast, one participant said, "I am actually involved with adults as little as possible because I do not like people knowing so much about or interfering in my things." Another youth said he tried "to keep emotions out of it … because it is a professional workplace. So I feel that I also have to be professional." When talking about the facility, one youth said, " … Adults … a bit annoying that they come and go … .For them it is just a job."

A Lack of Safety

Regarding any lack of safety, one youth commented, "There is nothing that is scary or makes me afraid here." Another said, "I think the only thing that can be unsafe for me can be myself. I know I can be a danger to myself. Unsafe … is that if I actually do something that is not good for me, it is just me, not because of the others or that I live here." One participant expressed it this way: "If I am not safe, it is due surely to some problems I have gotten myself into that I have to fix."

Another participant said, "I have heard other youths that have screamed and shouted that they (staff) should not hold so hard … does not sound very good." He continued, "I struggle with loud conflicts. It sends me easily into an anxiety attack." Another participant talked about other youths living at the facility who were threatening him. He put it this way:

> I have heard a lot the time I have spent here. As I have told those who have threatened me, I have just given them a knife and said, "you can do it or you can shut up." Mostly it's just words. They only have a façade as gangster, when they actually are not . . . so I don't care so much. I know that the threats are not real . . . I can look at them and see that . . . they say it, but immediately when you give them a weapon, and say that "okay, come and stab me then," then . . . they do not dare, they just shake . . . and I got my friends so I can just . . . say their names and then I get to know what they have done and where they are in relation to the street . . . Most of them are just 15-year-olds with attitude problems . . . .

"Do I Matter?" (Code Group 2)

Staying in My Room All Day and Night, Waiting

Four of the eight participating youths had no organized daily activities. As one described a typical day: "I sleep a lot during the day since I don't go to school anymore . . . When I feel like eating, I do that, but really, I am just in my room." He continued that sometimes, he "does something at the residence with the adults. They help me a little with finding something that I can do to fill my days." Another participant offered a similar description: "I wake up, then I fall asleep, and then I do that five more times, and then I actually wake up, go to the computer, talk to my girlfriend, and then I go to bed again. I don't do much. I just sit in my room 24/7." He continued,

> I'm pretty much on hold. I'm just waiting with everything. It is pretty boring. I don't do anything with my life right now, I'm just waiting until I have moved out . . . then I will get a job, I will start exercising, start a family.

When asked the reason for staying in one's room all day, every day, one participant responded, "I feel in my heart that there is nothing out there needing me or that I need." Another said, "I understand that a person sits in the room because . . . there is nothing to get up for." Unpredictability and lack of control over one's life were cited by one participant as the reason he was not looking for a job. "Suddenly I get a job, and then the next day: Hey, you are moving out now!"

I Have a Plan for My Day

Two of the youths interviewed attend school as part of their daily routine. According to one, "I wake up and go to school and I stay at school until it ends. Then a staff member calls me between three and four o'clock and asks what my plans are and if I need help with anything."

Another stated that, "I don't do much, I do what I'm supposed to, wake up, go to school, come home, eat dinner, maybe play a little, nothing more than that." Another described setting a routine:

> I usually have a week plan, so I get up, eat breakfast, talk a little with the others. After I have eaten, then I take some tobacco and a coffee, and after that I start on my week plan that we have written . . . and after that I usually watch Netflix or play with the others or hang out with the other teens.

One of the youths said he was preparing to move out of the residential facility. "My day consists of looking for apartments and a possible job."

Participants were then asked if they knew of plans for their future and whether they had participated in developing them. One youth answered, " . . . Most [of the youths] have some difficulties with themselves, so I don't believe that they really think about what they want to do going forward. So, it is actually more about . . . what do we do now . . . ."

"Do You Care?" (Code Group 3)

Staff Behavior in Conflict Situations

In response to a question about what staff do when a conflict arises, one participant answered, "I can't register what they are doing, I'm angry and don't understand what is going on . . . " In contrast, another youth said, "very calm (staff), they don't get angry . . . controlled . . . sometimes they get stressed, but that is human. You can trust them." Another commented, "Staff care about us. They talk and try to solve the problem . . . . They talk to you and ask, "what do you want us to do to make it better for you?" They don't get so stressed . . . . They try to be normal and show us patience." He continued, "sometimes they (staff) support me . . . it depends on who is working." Similarly, another youth said, "Person-dependent. Some are very nice, but others have grumpy voices. The nice ones come and talk to me and try to calm me down. Depends on who, if I feel understood." Another one offered, "Some of them try to explain, but others just say, 'no, this is how it is, you are not allowed therefore.'"

As shown, some of the youths reported that staff are open to talking about things, other youths reported that even if they present good arguments, staff will not change their opinions about something. As one participant stated, "One can argue and come up with all the good points there are. But they go strictly by the rules. I usually have the best points, but I never win." Another said, "They [the staff] understood why I became irritated, but at the same time, they won't change their minds . . . . In the end, I just give up." One youth stated,

> I feel that they [staff] are . . . a bit too "into" the rules. Sometimes they should bend the rules a bit . . . . It doesn't really help, it is just more annoying. They could have left the rule, not thought about it, because that would have done us both good. And I don't mean that they should let us smoke or something, but give us a little space, let us calm down. Not just go straight into a meeting to talk about it and stuff. Let us calm down, let us go for a walk, let us let out some anger.

He continued, “Because I would rather go for a drive and listen to hip-hop and curse in the car instead of punching someone. I feel that’s better.” Another youth said about staff reactions to conflicts, “Sometimes they back off and other times they get to the level as me, for example, both of us get pissed off at each other.” Another youth stated that staff “ . . . say themselves that they like to push youths’ buttons, just to irritate us and . . . to see how we react . . . . It is not fun. It is not okay either.” He continued,

> Some of us don’t think twice before we just hit you. It is your fault, because when staff put pressure on youth who have problems with anger or other things. If you get punched, I don’t care. He said that he needed some time, and that you shouldn’t talk about it so much, and you keep doing it . . . and push those buttons, then . . . they deserve it. He warned you . . . . I think it is more that the facility wants to test if kids are going to do something. But if you test that way then . . . even the staff have said they like to push the buttons to see the reaction, but is it useful? Because if he gets really pissed and punches you, then he lost control because you pushed his buttons, then he will get punished and have problems because you were an idiot and fucked with him. Is that okay?

If the conflicts escalate, some of the youth mentioned that it can result in staff writing a restraint protocol.” As one explained “ . . . they write reports, they can misunderstand what I have said. Maybe I have said something I didn't mean, for example, “I will kill you.” I don’t mean it, but they take it seriously.” Complaining about the treatment is reported pointless, according to this youth, “I get thrown in my face almost every day that I can complain to my appointed county representative but that doesn’t do shit.”

Desirable Staff Behavior

Although one participant said simply, “You can’t like everybody,” several others reflected on the qualities, behaviors, or virtues they wished to see in staff. “Showing that he cares,” as one participant put it, is important. Staff can demonstrate caring in simple ways. For example, they can “ . . . ask if everything is okay . . . say that they can talk about it with them,” in the words of one youth. Another wished that staff would “participate in activities.”

One youth wished staff expressed personality and genuineness and “would not be so exacting about following the rules all the time, that they would be a bit more themselves too so that they don’t seem just like they are only employees, that I feel that they are people too.” Similarly, one youth said, “They can listen to what I have to say, instead of just following the rules. They need to put themselves in my situation and listen to what I have to say.” Another wanted reciprocity. As he explained, staff should be

> pretty open and share. For example, if I want to talk about something, then I want to feel that I am not just talking to a stone, you know, that they also are putting something into the conversation. So, for example, if I’m talking about my feelings, so at least try to talk about what they are experiencing, you know, not just give, but also get a little too.

With respect to conflicts, one participant said, "If I am having a conflict, then I really want to know the reason why I am being told 'no.' Talk about in a proper way; then it's easier for me to accept it. If someone doesn't do that, I get pretty upset." Another youth said that, after a conflict, "I don't want them [the staff] to pick on me and take it up in a bad way . . . that it has all been my fault, that they instead see it from both perspectives." Several youths pointed out that staff need to be patient, flexible, and good at handling stress.

Discussion

"Am I Safe?"

According to most of the participating youths, being around other youths and staff who care and who they know is essential to feeling safe. Although the importance of positive relationships has long been recognized, there is now good scientific evidence from human services that safety and connections with others are critical ingredients in healing and growth (Bath, 2015). The fact that only one of the youths reported hearing loud conflicts between staff and youth living in the facility that made him uncomfortable could be interpreted to mean that the facility is perceived to be safe by most of the youth.

The participant who stated that he had been threatened by other youths but was unafraid of the threats, can indicate that there could be a competition among peers, which demands specific coping skills of the youth. One needs to show toughness in order not to be taken advantage of by others (Anderson, 2000). Peer status, and thereby protection from others, is attained by defying authority and repressing peers (Van der Helm et al., 2018). Social problem behavior may therefore hamper the development of a therapeutic group climate and may even result in repression and unsafety.

The participant who had been threatened also said he wanted to be as little involved as possible with staff. This could indicate that he is assuming responsibility for the situation and/or that he lacks confidence in the staff. It is also possible that he did not want to admit that the threats made him feel unsafe or to offer evidence of an unsafe situation. Although he said he did not feel unsafe, other youths, hearing about the threats, could feel that their facility is not safe, in the same way that overhearing loud conflicts between staff and youths caused one youth to experience anxiety, as he told us. The participant also said staff rarely talked to him about what he had heard and did not ask him if he was okay afterward. This participant's comments, as well as the comment by another youth that he is safe as long as he stays in his room, raise the possibility that the living environment is perceived as unsafe. Such perceptions can make it difficult for youth to heal, overcome the effects of past abuse and neglect, and attend to developmental tasks (Bath, 2015; Hawkins-Rodgers,

2007; Holden et al., 2010; Moore et al., 2017). As Bath (2015) asserts, the first imperative in working with traumatized children is creating a safe place for them.

Two of the youths said that they posed the only potential threat to their own safety. Their statements could be interpreted as specific to these individuals' own behavioral issues or situations and as indicating that they perceive other residents, staff, and the facility itself as safe. Or it could be that these youths take responsibility for unsafe situations and blame themselves. We can assume that many youths placed in residential facilities have experiences of taking care of themselves and that being removed from their original home does not easily change their behaviors and attitudes. As some of them stated, they are involved with staff as little as possible and fix their problem themselves. This may suggest that they feel alone and/or cannot depend on staff to help them, which in turn, could generate feelings of being unsafe. The quotes regarding professionalism – "it's just a job" and "feeling investigated" – underline a possible distance between staff and youth. Whereas studies have focused on the importance of connections and relationships in enhancing youths' feelings of safety (Bath, 2015; Gharabaghi, 2019; Stuart, 2009), research is lacking on how physical facilities themselves affect feelings of safety. This study suggests that youths' private rooms and these rooms' locations can be important to youths' perceptions of safety.

Do I Matter?

Only half of the interviewed youths engaged in any organized daily activities, such as school, or followed a weekly plan. The others described days of staying mainly in their rooms, sleeping and gaming, waiting for their lives to resume. Two of the youths expressed the feeling that no one needs them, they have no purpose; they do not need anyone or anything, and thus there is nothing to get up for. They voiced feelings of being on hold, just waiting, not knowing how to occupy their time or where they would be going next. These expressions could suggest that these youths feel that they do not matter. In contrast, the youths who had plans and was attending school did not describe their life this way.

One youth said, in explanation for why he did not bother to look for a job, that he might be moving the next day. This could mean that this youth suffers from a lack of predictability, control, and influence over his life and future due to uncertainty about the duration of his stay in the facility. As another youth pointed out, the youths had some difficulties with themselves; he believes that they mostly think about the present, and really do not think about what they want to do going forward. It can be challenging to focus on the future if the present feels problematic or meaningless. This perspective may influence how some youth relate to their future decisions. The lack of predictability and influence in one's own life can create passivity (Fudge Schormans & Rooke,

2008), feelings of powerlessness (Young, 2011), learned helplessness (Maier & Seligman, 2016; Seligman, 1974); it can also trigger escalating frustration (Engström et al., 2020). Additionally, self-confidence can wane, weakening youths' resilience and their ability to solve their own problems. Providing youth with opportunities to understand how they relate to others and to the world, giving them a clear sense that they matter, and strengthening their self-confidence all appear essential (Gharabaghi, 2019).

"Do You Care?"

Several of the participants mentioned that staff care, are available, talk to them, and are trustworthy. This finding is similar to other studies (Harder et al., 2013, 2017). These behaviors fit the care-based staff-interaction style (Engström et al., 2020) and the importance of emotional recognition by staff (Cameron & Maginn, 2008; Lausten & Frederiksen, 2016; Warming, 2015). Several youths shared their thoughts about what a good staff member would say and do. Such a staff member would demonstrate caring, be present and patient, spend time with youth, and participate in activities. Youths also wished for staff members to be open, to share, to explain the rules, to take youths' perspectives into consideration, and to allow youths time and space to calm down. Such a staff member, described as the "Caregiver" by Ungar and Ikeda (2017), is someone who has reasonable expectations and imposes structures but is also flexible in negotiations with youth when rules are broken.

If staff fail to explain a youth's question, such as why a particular activity is not permitted, the youth may become upset, as in the case described by one participant in our study. Engström et al. (2020) offered similar findings of youth reporting difficulty understanding rules, which triggered escalating feelings of frustration which, if unaddressed by staff in discussions with the youth, often led to youth threats of violence. Berg et al. (2011) emphasize the importance of staff staying calm and talking to youth in a supportive way to prevent aggressive situations. Staff should strive to maintain open, respectful, and co-operative relationships to maximize youth's potential to regain self-control. As Cashmore (2002) found, youth want to be informed, have options, and be given opportunities to voice their opinions. Bessell and Gal (2009) suggest that youth should be invited to be partners with the staff who care for them. The youth in our study also pointed out that the care and treatment they receive from staff are person-dependent. When asked about how they perceive and experience communication and contact with staff, several of the youth we interviewed responded, "it depends who . . .,"

The comment by one youth that staff like to push residents' buttons to see how they will react could be interpreted to mean that staff are exercising their power. Deployment of protective power may be perceived as oppressive and disempowering by those – in this case, the youth – subjected to this power

(Tew, 2006). This perception may be enhanced if past experiences have led youths to assume that adults are untrustworthy. The challenge for staff is to exert the right amount of control over youth in their care, remembering that quality care and treatment require rules and expectations as well as youth engagement. A tendency of staff to rescue rather than to work in partnership with youth may stifle or further undermine the ability of youth residents to mobilize power on their own behalf. The unintended result may be to perpetuate, rather than combat, youths' feelings of powerlessness. As one of the youths said, he assumes that if a conflict between him and staff escalates, it will result in a restraint protocol. The dual nature of social work as providing support/care for as well as exercising control over youth has long been recognized, but it is again a topic of discussion given current interest in responsibilisation and governance (Warming & Fahnøe, 2017). The melding of these two aspects of social work within residential care facilities can create emotional tension for youth and uncertainty about their safety (Furnivall, 2018; Moore et al., 2017).

Another interpretation of the participant's comment that staff like to push youth's buttons is that youths in residential care are easily triggered and affect-dysregulated. As indicated earlier, many youths in residential facilities are traumatized, and the most pervasive and far-reaching impact of complex trauma is the dysregulation of emotions and impulses (Bath, 2015). It stands to reason that a primary focus of work with traumatized youth needs to be on supporting them to learn new ways of effectively managing their emotions and impulses. As Bath (2015) points out, to develop the capacity for self-regulation, youth may need first to be other-regulated through interactions with stable and caring adults.

Regardless of staff intentions, this youth's perception is that staff push buttons just to see the reaction. He questioned the usefulness of what the staff do, which suggests that he does not understand why the staff do what they do. Since he sees their actions as malicious, he expresses that staff deserve to get punched in retaliation. The violence, in his interpretation, is the fault of the staff, who either were focused on their own agenda rather than on the needs of the youth or were failing to respond to the youth's concerns and frustrations. As Roesch-Marsh (2012) suggests, a violent response could be a behavioral and emotional reaction to a lack of participation. Depending on the scenario, staff may switch between deploying co-operative power and protective power. Such a shift may confuse youth and may potentially feel oppressive to them if they perceive staff to have abandoned their previous commitment to mutuality and respect. Protective actions by staff may seem to "come out of the blue" and feel like oppressive betrayals of trust. This suggests the need in social work to always be "upfront" about issues of power and authority, to thereby enable youth to feel better able to trust staff and enter into working relationships with them that they see as partnerships.

Limitations

Several limitations should be noted. A first limitation of the present study is that it is based on relatively small sample. We could have chosen a different method, that might have created a larger sample of youth. The risk of that could be that we missed out on details and nuances that qualitative interviews may capture. Access to youth in such living situations is quite limited and their voices are rarely reflected in research studies. Despite the small sample size, we believe that conveying words and thoughts of these youths is important and valuable. The interviews varied in length. We assume that the shorter interviews also revealed relevant and meaningful information about what mattered to the participants. Second, we have done our best to listen carefully to the youth interviewed and to put their perspective central in this study. An important question is whether the results did indeed reveal the voices of youth and were not prone to selection bias or a prejudiced view of the researchers. The participants may have offered comments that they believed the interviewers wanted to hear. Being asked to talk about their residential facility and its staff may have made the participants feel vulnerable and at risk of sanctions if their comments were not kept confidential. We tried to reduce the likelihood that participants would shape their responses for these reasons by explicitly and clearly saying that no answers were wrong, and that staff would not be told what had been said. Here again, a different method such as for example, survey, that preserve the anonymity when answering, could have been helpful. Third, we approached the participants via the residential facility managers. We thus cannot be sure the managers provided every youth who fit our selection criteria with precise information. We concede that a different sample of youths might have generated different or additional descriptive codes and code groups. We also concede that a different age group could have provided different information. Another issue is that we do not know whether the youth interviewed were representative of all youth in residential care. There is a possibility that we reached youth with more confidence to participate in research or more benevolence to contributing without being paid for example. These sample aspects may have affected the findings of this study. Fourth, after the quality assurance process, we increased the rigor of the research process. We were careful not to apply preexisting theories and own experiences. The second author reviewed and coded the interviews to detect potential coding bias. After discussions between the coders, a small number of coding groups were modified. This modification did not affect the units comprising the theme, however. Finally, due to the nature of this study, the results may not generalize to all adolescents in the population. We are also unable to generalize from our data to other populations or other settings. However, we argue that our findings contribute meaningfully to research concepts related to youth perspectives and experiences of living in residential facilities.

Conclusion

Even though the sample is relatively small, this study makes a contribution to understanding how youth living in residential facilities perceive and experience life in the facility. The findings further illustrate the complexities of everyday life and relationships between staff and youth. Our study indicates that staff behaviors and attitudes toward the youths in their care are crucial to these youths' experiences. Study participants indicated the importance to them of positive relationships with staff and of staff considering their perspectives. Our research highlights significant lessons from the experiences of youth in residential care. First, with respect to youth perceptions of everyday life, it is important to be aware that some youths reported feeling that they were on hold, waiting, not knowing what was going to happen to them. Second, some staff members may behave in a way that increases youth aggression and results in violence and/or passivity and withdrawal. Staff play an important role in these youths' lives, and their interactions with youths profoundly influences how youths perceive the care they receive. Our findings, in conjunction with those of previously mentioned research, point in the direction of maintaining a focus on staff`s relational and communication abilities rather than on youth's problematic behaviors. Overall, the results suggest that education and training for staff should focus on improving those skills that are perceived as important for meeting the needs of youth and yield best practice. More research is needed to gain knowledge about how staff can contribute to enhancing youths' feelings of safety, meaningfulness, and healthy development in their everyday lives and their futures.

Future research is urgently needed about youth's own perspectives on what they require to lead meaningful lives and experience healthy development; such information is fundamental to ensure that residential care and treatment are of high quality and to create a comprehensive and credible foundation for knowledge-based practice. We recommend and will continue to pursue deeper investigation into what youth safety entails in the context of residential care, how youth healing can be enhanced, and how a safe environment can be developed. More consideration should also be given to the importance attributed by youth in this study to their rooms and their location within their facility in relation to improving the quality of youth residential care. Further studies, it is hoped, can lead to enhancement of youth's perceptions of safety, participation, control and their feelings of connectedness and being heard, and can contribute to a reduction in youths' feelings of powerlessness and in incidences of conflict and aggression.

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References

Anderson, E. (2000). *Code of the street. Decency, violence and the moral life of the inner city*. Norton & Company.

Attar-Schwartz, S. (2014). Experiences of sexual victimization by peers among adolescents in residential care settings. *Social Service Review*, *88*(4), 594–629. https://doi.org/10.1086/679194

Attar-Schwartz, S., & Khoury-Kassabri, M. (2015). Indirect and verbal victimization by peers among at-risk youth in residential care. *Child Abuse & Neglect*, *42*(april), 84–98. https://doi.org/10.1016/j.chiabu.2014.12.007

Barnes, C., & Mercer, G. (2005). Disability, work, and welfare: Challenging the social exclusion of disabled people. *Work, Employment & Society*, *19*(3), 527–545. https://doi.org/10.1177/0950017005055669

Bath, H. (2015). The three pillars of traumawise care: Healing in the other 23hours. *Reclaiming Children & Youth*, *23*(4), 5–11. https://www.traumebevisst.no/kompetanseutvikling/filer/23_4_Bath3pillars.pdf

Bell, M. (2002). Promoting children's rights through the use of relationship [Article]. *Child & Family Social Work*, *7*(1), 1–11. https://doi.org/10.1046/j.1365-2206.2002.00225.x

Berg, J., Kaltiala-Heino, R., & Välimäki, M. (2011). Management of aggressive behaviour among adolescents in forensic units: A four-country perspective. *Journal of Psychiatric and Mental Health Nursing*, *18*(9), 776–785. https://doi.org/10.1111/j.1365-2850.2011.01726.x

Bessell, S., & Gal, T. (2009). Forming partnerships: The human rights of children in need of care and protection [Article]. *International Journal of Children's Rights*, *17*(2), 283–298. https://crawford.anu.edu.au/pdf/staff/sharon_bessel/2010/forming_partnerships_IJCR_published_version.pdf

Bessell, S. (2011). Participation in decision-making in out-of-home care in Australia: What do young people say? *Children and Youth Services Review*, *33*(4), 496–501. https://doi.org/10.1016/j.childyouth.2010.05.006

Braxton, E. M. (1995). Angry Children, Frightened Staff. *Residential Treatment for Children & Youth*, *13*(1), 13–28. https://doi.org/10.1300/J007v13n01_03

Briggs, E. C., Greeson, J. K. P., Layne, C. M., Fairbank, J. A., Knoverek, A. M., & Pynoos, R. S. (2012). Trauma exposure, psychosocial functioning, and treatment needs of youth in residential care: Preliminary findings from the NCTSN Core Data Set. *Journal of Child & Adolescent Trauma*, *5*(1), 1–15. https://doi.org/10.1080/19361521.2012.646413

Brown, J. D., Barrett, K., Ireys, H. T., Allen, K., Pires, S. A., & Blau, G. (2010). Family-driven youth-guided practices in residential treatment: Findings from a national survey of residential treatment facilities. *Residential Treatment for Children & Youth*, *27*(3), 149–159. https://doi.org/10.1080/0886571X.2010.500137

Cameron, R. J., & Maginn, C. (2008). The authentic warmth dimension of professional childcare. *The British Journal of Social Work*, *38*(6), 1151–1172. https://doi.org/10.1093/bjsw/bcm044

Carr, A., Duff, H., & Craddock, F. (2020). A systematic review of the outcome of child abuse in long-term care. *Trauma, Violence, & Abuse*, *21*(4), 660–677. https://doi.org/10.1177/1524838018789154

Cashmore, J. (2002). Promoting the participation of children and young people in care. *Child Abuse & Neglect*, *26*(8), 837–847. https://doi.org/10.1016/S0145-2134(02)00353-8

Collin-Vézina, D., Coleman, K., Milne, L., Sell, J., & Daigneault, I. (2011). Trauma experiences, maltreatment-related impairments, and resilience among child welfare youth in residential care. *International Journal of Mental Health and Addiction*, *9*(5), 577–589. https://doi.org/10.1007/s11469-011-9323-8

Connor, D. F., McIntyre, E. K., Miller, K., Brown, C., Bluestone, H., Daunais, D., & Lebeau, S. (2003). Staff retention and turnover in a residential treatment center. *Residential Treatment for Children & Youth*, *20*(3), 43–53. https://doi.org/10.1300/J007v20n03_04

Cousins, W., & Milner, S. (2006). Children's rights: A cross-border study of residential care. *The Irish Journal of Psychology*, *27*(1–2), 88–96. https://doi.org/10.1080/03033910.2006.10446331

Engström, I., Engström, K., & Sellin, T. (2020). Adolescents' experiences of the staff's different interaction styles in coercive youth care in Sweden: A qualitative study. *Issues in Mental Health Nursing*, *41*(11), 1027–1037. https://doi.org/10.1080/01612840.2020.1757794

Farmer, E. M. Z., Murray, M. L., Ballentine, K., Rauktis, M. E., & Burns, B. J. (2017). Would We know it if we saw it? Assessing quality of care in group homes for youth. *Journal of Emotional and Behavioral Disorders*, *25*(1), 28–36. https://doi.org/10.1177/1063426616687363

Fraser, S. L., Archambault, I., & Parent, V. (2016). Staff intervention and youth behaviors in a child welfare residence. *Journal of Child and Family Studies*, *25*(4), 1188–1199. https://doi.org/10.1007/s10826-015-0312-6

Freundlich, M., Avery, R. J., & Padgett, D. (2007). Care or scare: The safety of youth in congregate care in New York City. *Child Abuse & Neglect*, *31*(2), 173–186. https://doi.org/10.1016/j.chiabu.2006.09.002

Fudge Schormans, A., & Rooke, J. (2008). When there are no choices: The consequences of a lack of adult living placements for young adults with intellectual and/or developmental disabilities leaving child welfare care. *Journal of Developmental Disabilities*, *14*(1), 107–126. http://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.620.4389

Furnivall, J. (2018). Reclaiming complexity: Beneath the surface in residential child care. *Journal of Social Work Practice*, *32*(4), 373–390. https://doi.org/10.1080/02650533.2018.1503164

Gharabaghi, K. (2019). *A hard place to call home*. Canadian Scholars.

Gibbs, I., & Sinclair, I. (1998). Private and local authority children's homes: A comparison. *Journal of Adolescence*, *21*(5), 517–527. https://doi.org/10.1006/jado.1998.0175

Greger, H. K., Myhre, A. K., Lydersen, S., & Jozefiak, T. (2015). Previous maltreatment and present mental health in a high-risk adolescent population. *Child Abuse & Neglect*, *45*(July), 122–134. https://doi.org/10.1016/j.chiabu.2015.05.003

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2013). A secure base? The adolescent–staff relationship in secure residential youth care. *Child & Family Social Work*, *18*(3), 305–317. https://doi.org/10.1111/j.1365-2206.2012.00846.x

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2017). The inside out? Views of young people, parents, and professionals regarding successful secure residential care. *Child and Adolescent Social Work Journal*, *34*(5), 431–441. https://doi.org/10.1007/s10560-016-0473-1

Hawkins-Rodgers, Y. (2007). Adolescents adjusting to a group home environment: A residential care model of re-organizing attachment behavior and building resiliency. *Children and Youth Services Review*, *29*(9), 1131–1141. https://doi.org/10.1016/j.childyouth.2007.04.007

Henriksen, A., Degner, J., & Oscarsson, L. (2008). Youths in coercive residential care: Attitudes towards key staff members' personal involvement, from a therapeutic alliance perspective. *European Journal of Social Work*, *11*(2), 145–159. https://doi.org/10.1080/13691450701531976

Holden, M. J., Izzo, C., Nunno, M., Smith, E. G., Endres, T., Holden, J. C., & Kuhn, F. (2010). Children and residential experiences: A comprehensive strategy for implementing a research-informed program model for residential care [Journal article]. *Child Welfare*, *89*(2), 131–149. https://login.ezproxy.oslomet.no/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=eue&AN=105051886&site=ehost-live&scope=site

Huefner, J. C., Ringle, J. L., Gordon, C., & Tyler, P. M. (2020). Impact of perception of safety on outcomes in the context of trauma. *Children and Youth Services Review*, *114*(July), 105060. https://doi.org/10.1016/j.childyouth.2020.105060

James, S. (2011). What works in group care? — A structured review of treatment models for group homes and residential care. *Children and Youth Services Review*, *33*(2), 308–321. https://doi.org/10.1016/j.childyouth.2010.09.014

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, *45*(3), 214–222. https://research.aota.org/ajot/article-abstract/45/3/214/2734/Rigor-in-Qualitative-Research-The-Assessment-of?redirectedFrom=fulltext

Lanctôt, N., Lemieux, A., & Mathys, C. (2016). The value of a safe, connected social climate for adolescent girls in residential care. *Residential Treatment for Children & Youth*, *33*(3–4), 247–269. https://doi.org/10.1080/0886571X.2016.1207218

Lausten, M., & Frederiksen, S. (2016). Do you love me? An empirical analysis of the feeling of love amongst children in out-of-home care. *International Journal of Social Pedagogy*, *5*(1), 90–103. https://doi.org/10.14324/111.444.ijsp.2017.07

Leeson, C. (2007). My life in care: Experiences of non-participation in decision-making processes. *Child & Family Social Work*, *12*(3), 268–277. https://doi.org/10.1111/j.1365-2206.2007.00499.x

Leipoldt, J. D., Harder, A. T., Kayed, N. S., Grietens, H., & Rimehaug, T. (2019). Determinants and outcomes of social climate in therapeutic residential youth care: A systematic review [Nursing homes & residential care 3377]. *Children and Youth Services Review*, *99*(April), 429–440. https://doi.org/10.1016/j.childyouth.2019.02.010

Maier, S. F., & Seligman, M. E. P. (2016). Learned helplessness at fifty: Insights from neuroscience. *Psychological Review*, *123*(4), 349–367. https://doi.org/10.1037/rev0000033

Manso, A., Rauktis, M. E., & Boyd, A. S. (2008). Youth expectations about therapeutic alliance in a residential setting. *Residential Treatment for Children & Youth*, *25*(1), 55–72. https://doi.org/10.1080/08865710802209826

Martinelli, A., Ackermann, K., Bernhard, A., Freitag, C. M., & Schwenck, C. (2018). Hostile attribution bias and aggression in children and adolescents: A systematic literature review on the influence of aggression subtype and gender. *Aggression and Violent Behavior*, *39*(March–April), 25–32. https://doi.org/10.1016/j.avb.2018.01.005

Mazzone, A., Nocentini, A., & Menesini, E. (2018). Bullying and peer violence among children and adolescents in residential care settings: A review of the literature [Nursing homes & residential care 3377]. *Aggression and Violent Behavior*, *38*(January–February), 101–112. https://doi.org/10.1016/j.avb.2017.12.004

McLeod, A. (2010). A friend and an equal': Do young people in care seek the impossible from their social workers? *The British Journal of Social Work*, *40*(3), 772–788. https://doi.org/10.1093/bjsw/bcn143

Moore, T., McArthur, M., Death, J., Tilbury, C., & Roche, S. (2017). Young people's views on safety and preventing abuse and harm in residential care: "It's got to be better than home." *Children and Youth Services Review*, *81*(October), 212–219. https://doi.org/10.1016/j.childyouth.2017.08.010

Pelto-Piri, V., Engström, K., & Engström, I. (2014). Staffs' perceptions of the ethical landscape in psychiatric inpatient care: A qualitative content analysis of ethical diaries [Article]. *Clinical Ethics*, *9*(1), 45–52. https://doi.org/10.1177/1477750914524069

Pérez-García, S., Águila-Otero, A., González-García, C., Santos, I., & Del Valle, J. F. (2019). No one ever asked us. Young people's evaluation of their residential child care facilities in three different programs [Article]. *Nadie nos ha preguntado nunca. La evaluación de los jóvenes sobre sus hogares de acogimiento residencial en tres programas diferentes*, *31*(3), 319–326. https://doi.org/10.7334/psicothema2019.129

Roesch-Marsh, A. (2012). 'Out of control': Making sense of the behaviour of young people referred to secure accommodation. *The British Journal of Social Work*, *44*(2), 197–213. https://doi.org/10.1093/bjsw/bcs102

Sekol, I. (2013). Peer violence in adolescent residential care: A qualitative examination of contextual and peer factors. *Children and Youth Services Review*, *35*(12), 1901–1912. https://doi.org/10.1016/j.childyouth.2013.09.006

Seligman, M. E. (1974). Depression and learned helplessness. In Katz, M. M., Friedman, R. J., Winston, V. H., & Wiley, J. (Eds.),*The psychology of depression: Contemporary theory and research* (pp. xvii, 318–xvii, 318). John Wiley & Sons.

Slaatto, A., Mellblom, A. V., Kleppe, L. C., Baugerud, G. A., & Kjøbli, J. (2021). Conflict prevention, de-escalation and restraint in children/youth inpatient and residential facilities: A systematic mapping review. *Children and Youth Services Review*, *127*(august), 106069. https://doi.org/10.1016/j.childyouth.2021.106069

Slaatto, A., Mellblom, A. V., Kleppe, L. C., & Baugerud, G. A. (2021). Safety in residential youth facilities: staff perceptions of safety and experiences of the "Basic training program in safety and security." *Residential Treatment for Children & Youth*, *39*(2), 1–26. https://doi.org/10.1080/0886571X.2021.1978035

Strijbosch, E. L. L., Wissink, I. B., van der Helm, G. H. P., & Stams, G. J. J. M. (2019). Building a positive group climate together: How monitoring instruments are part of an improvement process in residential care for children. *Children and Youth Services Review*, *96*(January), 266–277. https://doi.org/10.1016/j.childyouth.2018.11.051

Stuart, C. (2009). *Foundations of child and youth care*. Kendall Hunt.

Ten Brummelaar, M., Harder, A. T., Kalverboer, M. E., Post, W. J., & Knorth, E. J. (2018). Participation of youth in decision-making procedures during residential care: A narrative review. *Child & Family Social Work*, *23*(1), 33–44. https://doi.org/10.1111/cfs.12381

Tew, J. (2006). Understanding power and powerlessness: towards a framework for emancipatory practice in social work. *Journal of Social Work*, *6*(1), 33–51. https://doi.org/10.1177/1468017306062222

Tjora, A. H. (2019). *Qualitative research as stepwise-deductive induction* (Vol. 26). Routledge.

Ungar, M., & Ikeda, J. (2017). Rules or no rules? Three strategies for engagement with young people in mandated services. *Child and Adolescent Social Work Journal*, *34*(3), 259–267. https://doi.org/10.1007/s10560-016-0456-2

van Bijleveld, G. G., Dedding, C. W. M., & Bunders-Aelen, J. F. G. (2015). Children's and young people's participation within child welfare and child protection services: A state-of-the-art review. *Child & Family Social Work*, *20*(2), 129–138. https://doi.org/10.1111/cfs.12082

van der Helm, G. H. P., Kuiper, C. H. Z., & Stams, G. J. J. M. (2018). Group climate and treatment motivation in secure residential and forensic youth care from the perspective of self determination theory. *Children and Youth Services Review*, *93*(October), 339–344. https://doi.org/10.1016/j.childyouth.2018.07.028

Visser, K. M., Jansen, L. M. C., Popma, A., Vermeiren, R. R. J. M., & Kasius, M. C. (2020). Addressing aggression in the residential setting for juveniles with mild intellectual disability through training in non-violent resistance. *Child & Youth Care Forum*, *50*(2021), 333–349. https://doi.org/10.1007/s10566-020-09576-z

Warming, H. (2015). The life of children in care in Denmark: A struggle over recognition. *Childhood*, *22*(2), 248–262. https://doi.org/10.1177/0907568214522838

Warming, H., & Fahnøe, K. (2017). Social work and lived citizenship. In H. Warming & K. Fahnøe (Eds.), *Lived citizenship on the edge of society* (pp. 1-22). Rights, Belonging, Intimate Life and Spatiality. Palgrave.

Whittaker, J. K., Holmes, L., Del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J., Bellonci, C., Berridge, D., Bravo, A., Canali, C., Courtney, M., Currey, L., Daly, D., Gilligan, R., Grietens, H., Harder, A., Holden, M., James, S., Kendrick, A., . . . Zeira, A. (2016). Therapeutic residential care for children and youth: a consensus statement of the international work group on therapeutic residential care*. *Residential Treatment for Children & Youth*, *33*(2), 89–106. https://doi.org/10.1080/0886571X.2016.1215755

Winstanley, S., & Hales, L. (2014). A preliminary study of burnout in residential social workers experiencing workplace aggression: Might it be cyclical? *The British Journal of Social Work*, *45*(1), 24–33. https://doi.org/10.1093/bjsw/bcu036

Young, I. M. (2011). *Justice and the politics of difference*. Princeton University Press. https://doi.org/10.1515/9781400839902

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ORIGINAL ARTICLE

'I never win': How children and staff in residential facilities experience meaningful participation

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Abstract

Policymakers increasingly emphasize the importance of achieving meaningful participation of children living in residential care. To achieve the goal of participation, children must be adequately informed, have opportunities to express themselves freely and to be heard, and be given the opportunity to influence decisions about their lives. This study investigated the views and experiences of both children and staff with respect to children's participation in residential facilities in Norway. We conducted both focus-group and individual interviews with 6 children and 18 staff members at different facilities. Qualitative interview data were analysed using the dimensions of meaningful participation: informing, hearing and involving. The study offers three main findings. First, children's initiatives determine if staff inform them of their rights, with two exceptions: children are presented with information by staff when they arrive at a facility and/or after staff use coercion that requires protocols. Second, staff members expressed the importance of listening to children's opinions in a standardized way, following bureaucratic guidelines and structures. Third, several children stated that, no matter what they say, they cannot change the minds of staff members. These findings reveal that the dimensions of meaningful participation (informing, hearing and involving) are not all fully present at these facilities. Further research is needed to determine how to achieve in practice the policy goal of participation of children in residential care.

KEYWORDS
children, influence, participation, residential facilities, staff and children experiences

1 | INTRODUCTION

Worldwide, recognition is growing that children in the care of child protection services should be encouraged to participate in decisions about their lives (Cossar et al., 2016; Doek, 2009; McPherson et al., 2021; van Bijleveld et al., 2014). Policies are increasingly being shaped according to the principles of the United Nations Convention on the Rights of the Child (UNCRC, 1989), which state that acting in the best interests of children is only possible if children are involved in the decisions that affect them. The right to participation, which is addressed in Article 12 of the UNCRC (1989), is seen as a cornerstone of children's rights and should be seen as a prerequisite for making decisions.

Several studies show that professionals generally agree that children's participation is important (Pölkki et al., 2012; Rap et al., 2019). Children are expected to participate both in broad and future-oriented

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contexts and in everyday situations. This is important for three main reasons. First, participation accords children their fundamental rights. This is particular crucial for children in residential care, given that the decisions shaping their lives are often made by strangers and through bureaucratic processes (Bessell, 2011). Second, children's participation can enhance self-confidence and self-esteem (Cashmore, 2002; van Bijleveld et al., 2015; Vis et al., 2011). Further, participation is associated with increased feelings of mastery and control (Bell, 2002; Leeson, 2007), as well as a sense of ownership and responsibility (Cleaver & Kerr, 2006). Allowing children to participate positively affects their overall mental well-being and sense of safety (Vis et al., 2011). Giving children a voice empowers them to be active in their own care and prepares them for the transition to adulthood (Bramsen et al., 2019; Harder et al., 2017). Third, children's participation has instrumental value and positively affects outcomes and other aspect of their lives (Bessell, 2011; Bouma et al., 2018; Dadich, 2010). Considering children's views, wishes and expectations in decision-making fosters their development, makes them feel more connected and committed to decisions and improves the fit between their needs and the care they receive (ten Brummelaar, Harder, et al., 2018; van Bijleveld et al., 2015).

1.1 | Understanding meaningful participation in the context of residential care

The UNCRC General Comment on Article 12 (2009) as well as several studies emphasizes that participation is a dynamic and ongoing process, which includes information-sharing and dialogue based on mutual respect and through which children can learn how their views and those of adults shape the outcome of the process (Archard & Skivenes, 2009; Križ & Skivenes, 2017; Lansdown, 2010; Rap et al., 2019; van Bijleveld et al., 2020). These aspects of participation provide the basis for a three-dimensional approach, presented in Bouma et al. (2018), with respect to meaningful participation by children in out-of-home care settings. The three dimensions were operationalized by Bouma et al. (2018) as informing, hearing and involving.

The first dimension—informing—is a prerequisite to participation (Bessell, 2011; Bouma et al., 2018; UNCRC, 1989). Children need information about their right to and possibilities for participation and about the aims, potential impact and consequences of participation. Staff are responsible for ensuring that children understand the information they are given. Only then can they form views relevant to their circumstances (Cashmore, 2002; UNCRC, 1989). The second dimension—hearing—refers to children expressing their views freely and being heard (Bessell, 2011; Bouma et al., 2018; UNCRC, 1989). Children depend on professionals to ensure safe and supportive relationships and environments that facilitate free expression (Archard & Skivenes, 2009; Bell, 2002; Cashmore, 2002; Cossar et al., 2016; Horwath et al., 2012; Pölkki et al., 2012; van Bijleveld et al., 2015). The third dimension—involving—means that children's expressed views are considered before decisions are made and that the children can affect these decisions (Van Bijleveld et al., 2015).

In this study, we focus on the way the aims of Article 12—participation by the child— have been enacted in residential facilities for children; we then analyse the findings using the three-dimensions framework.

1.2 | Implementing participation in practice

Many studies on children and young people's participation in residential care have confirmed that children wish to have a say in the decisions that are made about their lives (Moore et al., 2017). Several authors have stated that children's participation should become a standard part of formal group processes (Bessell & Gal, 2009; Blakemore et al., 2017; Cashmore, 2002; Daly, 2009; Gal, 2017; Jamieson, 2017; van der Helm et al., 2018). An evaluation of the 'You Matter' project by Strijbosch et al. (2019) found that feedback from the children led to a reduction in aspects of negative group climate over a period of 2 years. Children's answers to open-ended questions indicated the importance of staying focused on creating a safe and positive context for them.

Other studies of residential and foster care find that implementation of child participation has been limited and that children's voices are often unheard or poorly heard (Cahill et al., 2016; Goodkind et al., 2011; Knorth et al., 2008; McCarthy, 2016; Moore et al., 2017; ten Brummelaar, Harder, et al., 2018; van Bijleveld et al., 2015; Vis & Thomas, 2009). Children report that they are not adequately consulted and are not given enough detail to make informed contributions to decision-making (Bessell, 2011; Leeson, 2007). Southwell and Fraser (2010) found that children under the age of 15 were less satisfied than older respondents about several aspects of their lives, including feeling safe, having someone to talk to when they are worried and having a say in what happens to them. In a scoping review, McPherson et al. (2021) reported that several studies showed that youth experienced the setting and space as well as the bureaucratized care planning process as constraints on effective participation. In contrast, when children reported a safe, relational space, usually with a residential care worker, they also indicated that they felt able to voice their opinions (McCarthy, 2016).

One of the reasons that ensuring child participation is challenging is that professionals are greatly influenced by the laws and regulations that dictate the procedures they must follow, their budgets and their workload (Gal, 2017). Limited opportunities for participation can negatively affect children's sense of dignity and self-worth (Bessell, 2011). Consequently, children may try to participate or exercise control in negative ways, such as by rebelling or withdrawing (Leeson, 2007; van Bijleveld et al., 2015).

1.3 | The Norwegian context

The Nordic countries are known for their comprehensive welfare states, which emphasize universalism, solidarity and decommodification (Shanks et al., 2021). Similarities exist in institutional care across

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these countries. Norway has a child-centred policy system that focuses on children's rights and their place in society, in which they are seen and respected as individuals and not just future contributors to the welfare state (Burns et al., 2017). The welfare services are largely publicly funded, and citizens are traditionally granted equal access to the services. In Norway, the welfare state is the framework for residential care and treatment. It is the responsibility of the Directorate of Children's Youth and Family Affairs (Bufdir) to safeguard children's interests and rights and to help them and their families to the extent possible. Children's participation is incorporated into the Norwegian Constitution §104, together with the fundamental best interest principle, the biological principle and the least intrusive intervention principle (TheChildProtectionAct, 1992). Residential care in Norway is funded by the state. Most of the children who are removed from their families are placed in foster care. Approximately 1100 children (9% of the placed children) are put in Norwegian residential facilities run by non-government service organizations or in one of 60 government facilities (StatisticsNorway, 2021). Some of these children are placed because they did not get proper care from their parent and, others, because of their challenging and destructive behaviour. The placement can be voluntary or mandated by civil law. Residential care and treatment are typically provided in suburban houses that accommodate three to eight young people who are cared for by staff. The staffing requirement at the time of data collection was that at least 50% of the staff group had a bachelor's degree in social work, health, child protection or similar field.

1.4 | Aim of the study

In this study, we consulted the staff and children at the same facilities to investigate (1) how children in residential care experience being informed, heard and involved in everyday life and in planning for their futures and (2) how these dimensions of meaningful participation coincide with the way that staff provide information to children, listen to their views and facilitate their involvement.

2 | METHOD

This article draws on three focus-group interviews with 18 staff members (see Table 1) employed at state-run residential facilities in Norway, as well as on one group interview and individual interviews conducted in 2020 with six children between 16 and 18 years old.

A convenience sample was chosen to achieve variety, in both the size and geographical location of the facilities. The first author approached managers of five residential facilities in three of five different regions of Norway, offering written information about the planned study and requesting permission to recruit participants. Three of the five facilities agreed to participate, and two of them were able to recruit both staff and children. The third recruited only staff. The capacities of the facilities ranged from housing 4–20 children between 12 and 18 years of age, including children in long-term placements for substance and behavioural problems and children who had difficult home conditions. Staff shifts range between 7.5 and 24 hours.

TABLE 1 Participants details ($N = 18$).

Participants	$N = 18$ N (%)
Gender	
Female	9 (50)
	Median (range)
Age	35.0 (24 to 50 years old)
Residential work experience	4.5 (8 months to 18 years)
Formal education	
Bachelor's degree in social/health/child-welfare work	16
No relevant education	2

2.1 | Participants

2.1.1 | Children

The first author approached the managers of the three residential facilities whose staff members participated in focus-group interviews (Slaatto et al., 2022). Each facility was given written information about the study and our request to recruit children. The inclusion criteria for participating youth were (1) currently living at the residential facility and (2) age 16 or older. We chose the ages of 16 and older so as not be limited by parents or others who might refuse to allow the child to participate. Residents were given oral and written information about the study by staff. Among the 16 children who met our inclusion criteria, six were recruited. Of the six, five were male and one was female. Three were living in a drug-and-behaviour treatment facility and three were in a residential care facility.

2.1.2 | Staff

Inclusion criteria for staff members were (1) employment involving 50% or more time working directly with youth and (2) participation in the 4-day education and training course known as the Basic Training Program in Safety and Security (Slaatto et al., 2022). We found it important that participant staff members work directly with youth because of our interest in staff-youth interaction. We also considered it important that all participating staff have the same basic educational and training knowledge. Staff members received written information about the study, which was forwarded to them by their managers, who encouraged participation and ensured staff that they would be given the time and opportunity to participate. For practical reasons, we conducted the interviews at the staff members' workplaces.

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2.2 | Data collection and analysis

The interviews took place from February 2020 to September 2020 and were digitally recorded and transcribed verbatim by the first author. The three staff-member focus groups comprised five participants at one facility, six at a second facility and seven at a third. The interviews were conducted by two of the authors together and ranged from 75 to 90 min. We started each interview by giving information about the project and about the focus-group method. We introduced our themes and asked the staff members to describe how they inform the children living at the residential facilities of their rights, how they prevent and handle conflicts with the children and how they listen to them and involve them in decision-making.

After considering the ethics of conducting a focus-group interview with children, we determined it to be an appropriate method, as it could offer vulnerable individuals a feeling of safety that might be lacking in a one-on-one interview. Although the first interview at one of the facilities was planned as a focus-group interview, it became instead a group interview as we were unable to foster discussion among the participants, who each directed their answers at the interviewer rather than speaking to each other. COVID-19 restrictions prevented us from conducting further in-person and group interviews. Thus, we conducted three additional individual interviews by telephone with participants, which ranged from 13 to 56 min. To establish rapport, the interviewer first talked about the project and asked the participant to 'tell me about what a regular day is like for you'. We asked the children what they know about their rights and how they obtained the information. We also asked them how they experience staff listening to them, understanding their perspectives and taking their views into consideration in decision-making.

We used a theory-driven framework in the data analysis. The three dimensions of participation—informing, hearing and involving—provided a guideline. MacFarlane and O'Reilly-de Brún (2012) point out that preexisting concepts or theories in qualitative analyses can provide a powerful lens with which to study data. At this stage of our study, we derived the coding scheme from the three dimensions of meaningful participation (see Table 2). First, one of the transcribed interviews was independently coded using the coding scheme developed by two authors. Any disagreements were resolved through discussion. All interviews were then coded by the first author. We strove to represent staff and youth responses truthfully and empirically by accurately transcribing quotes (Krefting, 1991). The only alteration of quotes involved omitting 'filler' words, such as 'um' or 'uh'. The software package NVivo was used to sort the quotes. To increase reliability, the second author coded a random selection of the interviews. The final step was to analyse and interpret the content of the codes.

2.3 | Ethical considerations

The project was approved by the Norwegian Agency for Shared Services in Education and Research (ref. 339013). We administered the study in accordance with the principles for ethical research of the Norwegian National Committee for Research Ethics. When writing up the findings, we removed any potentially identifying characteristics from the material. We used 'he' or 'him' in referring to participants to mask their gender.

3 | FINDINGS

The three dimensions of youth participation—informing, hearing and involving—are presented in selected quotes (translated from Norwegian into English) that exemplify the views of both staff and children.

3.1 | Participation: Informing

In this section, we present data on how youth experience the provision of information by staff and on staff's perceptions of their provision of this information to the children.

3.1.1 | Children

When asked if staff talk to them about their rights, one child simply said, 'No'. Another said, 'I learned them [the rights] myself'. Several participants from both facilities mentioned receiving a brochure. As one explained, 'When we move into the facility, then we get a brochure with all our rights and stuff …. I have read it a couple of times'. In addition, information was provided by staff when the residents asked for it. One said, 'They [staff] say they can help you; they can talk to you; they can give you the phone number [to the county representative]. They can explain to you about your rights and everything….[Y]ou just need to ask for it, then they will help you …'. Several said that staff differ in how they offer information. In the words of one:

> Some of them try to explain, but others just say 'no, this is how it is' …. If someone does not give it [the explanation] to me, I get really pissed. If someone tries to talk about it … in a proper way, then it is easier for me to accept it.

Regarding children's rights, one child commented that complaining is pointless: 'I get thrown in my face almost every day that I can complain to my appointed county representative but that doesn't do shit'.

Participants were asked if they know what will be happening in their lives. Most said they know what will happen in the next weeks and months. One said, 'No …. Last time they said I was going to move in June, then it was November, then it became February …. Yes, and now all these [dates] have passed already'.

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TABLE 2 Dimensions meaningful participation.

Dimensions	Codes	Examples of selected quotes
Informing	Children: I do not know what will happen in the future I do not know why I am here I know my rights I get the rights thrown at me Nobody talks to me about my rights I have learned my rights on my own I have to ask for information I know what will happen in my life I got the brochure when I moved in Staff: Staff use the brochure with descriptions of rights Giving information depends on the youth Giving information can be forgotten Experiences of youth not getting sufficient and adjusted information Information is given after a situation that requires protocol	Children: 'They [staff] say they can help you; they can talk to you; they can give you the phone number [to the county representative]. They can explain to you about your rights and everything … you just need to ask for it, then they will help you …'. Staff: '[E]ventually, it slips a bit … to remind about the rights … it depends on the young person. Some are very interested and then we have others who simply do not care. So, trying to hold on to it … we forget about it'.
Hearing	Children: It is a professional workplace It is no use complaining There is always someone to talk to Staff do not understand Staff do understand to a certain extent Staff: The children should be heard at all time We work in a standardized way Staff are curious about the youth	Children: 'I have sent in one or two complaints before and it hasn't been taken seriously …. I would rather handle it myself'. Staff: 'To have the feeling of being heard … is an important thing for self-esteem'
Involving	Children: I give up discussions with staff Staff stand strictly by the rules I usually get what I want Youth do not think about the future The youth are not allowed to decide We can decide because it is about us It depends on who I ask Staff: It is important to take into account children's perspectives Staff act in a united, coordinated way to create stability and predictability Staff act person-dependent	Children: 'One can argue and come up with all the good points there are. They go strictly by the rules, and stand firm …. I like to discuss and argue …. I usually have the best points, but I never win'. Another said, '… they [staff] won't change their minds … in the end, I just give up'. Staff: '[B]oth I and the child can sit down and talk about what actually happened. What contributed to the way it turned out this time? What can I do next time to change the outcome? And also focus on maybe what the child could do'.

3.1.2 | Staff

With respect to informing children about their rights, staff participants at all facilities agreed that predictability, overview and knowledge about what is going on are important to children. The majority mentioned that the children receive an informational brochure about their rights when admitted to the facility. One said, '[I]t is very easy for us to have these brochures available, so okay, then we can go through it. "Here is the brochure with your rights and if you are unsure, then you can contact the county representative."' It was also acknowledged that providing information at intake could be bad timing for children as they were coming into a new situation and probably experiencing stress.

> There is an incredible amount of information that the children must take in. And requirements … and there is a new place for them to live, new adults to deal with. So, whether the information about rights is properly perceived and they remember it …. It gets drowned in everything else …. [I]t disappears in a papermill or gets thrown away ….

Another staff member added a comment on the need to remember to inform:

> [E]ventually, it slips a bit … to remind about the rights …. [I]t depends on the young person. Some are very interested and then we have others who simply do not care. So, trying to hold on to it … we forget about it.

Another responded, 'It is often a bit "here and now," so if it is not about "here and now," we deal with it later'.

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Several staff members discussed that youth need to be given correct information and explanations even if they are not interested or claim they know all their rights. One said,

> [I]t is a part of standardized course, then we read their rights and should make sure that they have understood, but … in practice I've experienced that most of the youngsters think they know their rights, or erroneous rights …. My impression is that many have misconceptions of their rights … that they might have heard from others …. It comes from unreliable sources.

They also stressed the importance of both staff and children knowing children's rights so that conflicts and misunderstandings can be avoided. A staff member said,

> I have experienced that they [children] didn't get sufficient information, that they don't know it, and you kind of forget about it, right? … I think there is a point that can avert even more situations if we get better at their rights.

Several participants mentioned staff uncertainty as a possible barrier to providing children information about rights. One commented, '[H]ow far should I go? How far is too far? … I believe we are very unsure about the use of restraint, how far we can pull the strings, right? And what to do when exercising restraint'.

When asked how staff inform children about their rights at times other than at admission, several agreed with one who said, 'Sometimes in house meetings … when applicable, but I don't go and talk to children about the rights, not out of the blue, without something having happened'. Several said that it is easier and more common to give information about rights when it is connected to specific coercive situations, for example, drug testing, searching rooms or use of restraint. About the right to complain one said, '[O]ne must explain that if you experience that I've done something wrong in this situation … it is really important … that you take it properly, convey it, but it is always afterwards, I feel … and that's a bit awkward'.

3.2 | Participation: Hearing

Here, we present data on how youth experience being heard and on how staff perceive their professional practice of listening to children's opinions.

3.2.1 | Children

Several residents said that there is always someone they can talk to if they need to. Others said they try to be involved with the staff as little as possible. About feeling able to express themselves to staff, several said it is person-dependent and that there are some staff members whom they feel safe with and others with whom they do not. In response to the question, 'How can you tell if the staff care?', one of the residents answered, 'When they [staff] actually ask me if I'm okay or say that they can talk to me about it'.

When asked about whether they felt heard and understood by staff, some residents agreed. One commented,

> They do listen to me and understand me to a certain extent, but they can't understand everything …. Most of the staff who work here haven't experienced things that we have, so it's a little hard for them to put themselves in our situation.

Another said, 'There are only some that I feel understand a bit more than the others, and others are more like … they just look at it from one perspective. Others try to see at it from my perspective'.

When asked how they experience conflict with staff, one resident responded, '… I try to hold my emotions in … because it is a professional workplace, right? … [S]o, I feel that I need to be professional as well'. In response to a follow-up question about what happens after a conflict, another said, 'Nothing special; it's just put aside'. Another mentioned complaining to the county representative: 'I have sent in one or two complaints before and it hasn't been taken seriously …. I would rather handle it myself'.

3.2.2 | Staff

The topic mentioned most often was the importance for staff to listen to children. 'To have the feeling of being heard … is an important thing for self-esteem', one explained. Another responded, 'There is something about listening to what they actually are saying'. One commented,

> The children should be heard at all times …. [F]ollow-up with weekly conversations or where user participation is part of our care-conversations …. We work … in a standardized way. It is planned for user participation so it is always quality assured … so that the child shall participate in his or her own process.

About conflict management, one staff member pointed out and several agreed,

> We are curious about what is their frustration … trying to find alternative solutions … so we are listening, we are curious, honest that 'no, you can't have chocolate milk. I understand you want chocolate milk on a Monday, but you know that we only serve that on Saturdays and Sundays …. [I]t is annoying, I know, you probably are tired and blah blah blah'.

The majority also talked about that the importance of ensuring that children's voices are heard after a conflict.

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3.3 | Participation: Involving

In this section, we present data on how children experience being involved and how they perceive staff's consideration of their opinions. Then, we present staff perceptions of their professional practice of involving children.

3.3.1 | Children

Overall, the children in both facilities said they have some influence over everyday activities, being able, for example, to decide when and what to eat and which activities to engage in with staff or other residents. Some also reported some flexibility about internet rules. Others said they had very little or no influence. Most youth participants in this study said that they understand that their residence facilities have rules and limits and that they do not ask to do things that violate those rules. As one explained,

> I don't ask 'You, shall we smoke pot?' …. I ask if we can go to the movies or something like that …. I usually get what I want. Of course, I understand that we live in a residential facility, that we have some things to follow ….

Another said that staff take their opinions into account '… to a certain extent … to the extent that they are allowed to'. Even when admitting that rules are needed, the youth residents questioned why some staff focused on what they consider to be trifles. As one said: 'This is a drug treatment facility. This is not a fashion place. I have my sweater over my boxers, so shut up! These small things piss me off …'.

When asked if they have some influence over plans for their future, several said they did. One answered, 'We are allowed to decide, because it is about us'. He also said, 'They [staff] have asked me, "Do you want to move into an apartment when you turn 18? Would you like us to continue supporting you?" And that they [staff] are always there if I should choose that'. In contrast, one soon-to-be 18-year-old said, 'I don't even get to decide where I want to move next. They have said that I must move back to the municipality where I first got into the child protection system. That is the last thing I want …'.

Several residents from both facilities reported that, even if they present good arguments, staff will not change their opinions. As one stated, 'One can argue and come up with all the good points there are. They go strictly by the rules and stand firm …. I like to discuss and argue …. I usually have the best points, but I never win'. Another said, '… they [staff] won't change their minds … In the end, I just give up'. Another participant stated, 'I feel that they [staff] are … a bit too "into" the rules. Sometimes they should bend the rules a bit'. He continued, 'I would rather go for a drive and listen to hip-hop and curse in the car instead of punching someone. I feel that's better …'.

Whereas some of the participants felt listened to, several also said that their arguments had no effect on decisions. Others described differences among individual staff members: 'Some [staff] are more open to talking about things, others are more, like, "No, it's supposed to be like this and this and this."'

3.3.2 | Staff

Staff participants at all facilities discussed the importance of taking children's perspectives into account and involving children in decisions about their everyday lives and futures. As one explained, staff seek 'to be open and honest and get the children on board in planning their lives for the future, to decrease powerlessness, and to experience control in their own lives … that they participate in and shape their daily lives'. One described using conversation to engage children after a difficult situation:

> [B]oth I and the child can sit down and talk about what actually happened. What contributed to the way it turned out this time? What can I do next time to change the outcome? And also focus on maybe what the child could do.

One staff member said he often hears children say that complaining is useless, that

> It doesn't help anyway. They have very little interest in going through the protocol with me, because there has to be such an enormous feeling of powerlessness that they have … 'My voice doesn't count. Now the staff has done this … and that is that'.

The staff at one facility spoke of wanting to act in a united, coordinated way to create predictability and stability for the children in their care. One commented,

> Structures are there that tell us what to do when there is commotion or unrest, so in a sense we have systems that we follow. And this … is very important, that one doesn't start to wonder just when it starts to burn, 'what to do now?' That it is clear beforehand, right? And it is at least very predictable and very safe.

In contrast, several staff members at the other facility expressed insecurity and uncertainty about person-dependent decisions among staff and about different ways of communicating with residents. One said, 'It becomes very unpredictable for them "if I'm allowed to do that with [a named staff member] but I'm not allowed to that with you."'

As one participant said, 'That's where we often fall into the same traps again. Then you just judge for yourself. Because I know what I'm

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able to do, right? But I don't always … know what my colleague would do in the same situation'. Another voiced similar concerns:

> The insecurity and uncertainty that occur when there is not enough sausage and soda on the table …. If you agree to PlayStation, soda, and pleasant activities, then it is mostly pretty calm and okay. But once you try to frame it a bit and create some adult structure, then the temperature among the children increases …. Then I experience more insecurity, so …. What does my colleague do now? Okay, why didn't my colleague stay within the structure that was decided on, and … what happens next time when I stay within the structure that was actually decided on and not make an individual adaptation but do what the papers tell me to do?

4 | DISCUSSION

Here, we present our analysis of the experiences of children's participation, with the aim of better understanding how meaningful participation is practised.

4.1 | Are children receiving adjusted and sufficient information?

According to the UNCRC (1989), information about rights should be adjusted to the needs of the individual child and provided in a manner sensitive to the child's character, abilities and particular circumstances. Some staff members expressed concern that new residents may have trouble absorbing information provided on admittance, which is often a stressful and overwhelming experience. Additionally, merely providing a brochure at time of admittance can be assumed to be an insufficient way to fully inform children.

Staff shared concerns that children had received incorrect information about their rights, which could cause misunderstanding and conflict. Both children and staff reported that significant responsibility rests on the children to ask staff for information about their rights. This is an important finding because it shows that actual practice is at odds with policy aims. Staff members additionally claimed that the provision of information also depends on children's willingness to listening. However, the challenge and responsibility should lie with the staff to present the information in a way that is interesting and engaging to children.

Staff members from all three facilities focused on informing children about their rights in specific situations, usually those involving the use of restraint or other coercive measures, as such incidents must be documented. Some of the interviewed children said that when they received information about their right to complain to the authorities, they felt it was 'thrown in their face' and that complaining in any case does not help or is not taken seriously. Such statements can be understood as expressions of frustration and powerlessness.

Staff members mentioned that informing children of their right to complain was easiest in here-and-now situations; otherwise, it could be forgotten. This suggests that providing information about this particular right is not a staff priority, a finding supported by other studies showing that caseworkers do not always regard provision of information as integral to fostering children's participation (van Bijleveld et al., 2015; Vis & Thomas, 2009). Another interpretation is that staff are uncertain about children's rights and, as a result, may find it challenging to provide children with appropriate information. A literature review (Toros, 2021) confirms this study's finding regarding the lack of information provided to children. According to the child participants, if staff explain something sufficiently, it is easier to accept. Staff participants indicated that, in situations when they are sure about children's rights and provide enough information, conflicts and misunderstandings can be averted.

4.2 | Are youths' views being heard?

Staff who participated in this study agreed on the importance of allowing children to express themselves and of listening to what they say. They stressed that children need to feel heard at all times, and they described themselves, both during and after conflicts, as mainly interested in the perspectives and views of the children in their care. Many of the children's comments about participation highlighted their relationships with staff, and several pointed out that whether they felt heard and understood depended on which staff member they talked to. Staff have been shown to be crucial in promoting child participation and providing opportunities for children to participate (Archard & Skivenes, 2009; Horwath et al., 2012; Križ & Roundtree-Swain, 2017; McCarthy, 2016; Pölkki et al., 2012).

The power relationship between professional staff and children in residential facilities is obviously asymmetrical. The fact that the children live in the facilities that are the workplaces of the staff can also create challenges to the ideal of children freely expressing themselves. Some children said that they avoid involvement with staff. And one described his home as someone else's workplace and that, therefore, he tried to behave professionally. This suggests that the workplace aspect of residential facilities may diminish or overpower the youth-home aspect. It could be that this particular child experienced the staff's professionalness as an obstacle to sharing his views. In such an environment, residents may not feel free to express opinions, although doing so is part of the dimension of being heard (Bouma et al., 2018). Some staff said that they strive to standardize participation and assure quality by referring to bureaucratic terms and scheduled meetings. The drawback to this approach is that it may create distance between staff and youth, channelling staff energy into task or assessment completion. Another risk is that staff, overidentifying as professionals in a bureaucratic institution, become inflexible or use their autonomy and discretion defensively rather than to address the individual needs of children.

Even if the structural and bureaucratic approach can be helpful in ensuring that children are invited to scheduled conversations and

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meetings, it creates challenges to children's free expression if it has not been adjusted to meet children's needs for spaces and relationships that make them feel comfortable and safe and do not pose a risk of negative consequences.

4.3 | Are children involved in matters concerning them?

Research indicates that children feel that their views are rarely taken into account and that they have limited influence on important decisions (Bell, 2002; Cashmore, 2002; Moore et al., 2017; ten Brummelaar, Harder, et al., 2018; van Bijleveld et al., 2015). The findings of this study largely support this research. Some of the participants said they have little or no influence over big decisions, such as where they will live after leaving the residential facility.

Some of the children at one of the facilities said that their voices do not matter. They described staff as adhering to the rules, unwilling to change their minds, no matter what; these children said that they have given up arguing with staff and trying to have influence. They reported that they were given opportunities to express their views, that staff listen to them and understood their views but that staff still do not alter their decisions. This finding supports the work of de Valk et al. (2019) and McCarthy (2016) who found that children often felt that staff members were not open to changing their minds. Both staff and children stated that there is no point in complaining to the county representative, which is concerning.

If children feel they are not able to influence decisions, they could conclude that there is no point to expressing their views. This could contribute to beliefs that it is futile to stand up for themselves in an argument, voice their concerns or try to protect their interests. Once they establish such a pattern of thinking, they may be less likely to try to change their circumstances. As a result, they may experience prolonged anxiety and display learned helplessness (Seligman, 1974). Unless people feel able to exert some control over their lives, they will cease making the effort to do so (Maier & Seligman, 2016; Seligman, 1974). Feeling powerless can lead to withdrawal (Leeson, 2007; van Bijleveld et al., 2015), to ‘just giving up’ on any effort to influence their own lives. Fudge Schormans and Rooke (2008) ascribe such passivity to a lack of participation. Henriksen et al. (2008) identified the experience of reduced well-being as a result of limited freedom, unexplained decisions and dissatisfaction with the outcome of decisions over which children had no influence. Children who experienced cooperation with staff and who felt their voices were heard reported more positive experiences when living in residential care.

Establishment of clear frameworks and boundaries, and coordination and unity among staff members could enhance predictability and stability for both residents and staff. The study of Moore et al. (2017) supports this. On the other hand, the resulting environment could be perceived as hard to influence. Staff could behave more rigidly and show more concern about doing and saying what they have agreed upon beforehand than about listening to and considering the voices of the involved children. The staff at the facility where children reported feeling that their views did not matter described a high degree of co-ordination and unity among staff and expressed trust that their colleagues would keep their word and act as they had agreed upon beforehand.

In contrast, several staff participants at the other facility said that it is up to them to decide what to do in a particular situation. This could mean that whether children at that facility participate depends on the preferences of individual staff members. In any given situation, some staff members say ‘yes’, perhaps to avoid conflicts, and others say ‘no’, to follow the rules. According to most staff members at this facility, person-dependent professional practice engenders feelings of insecurity. Staff said that they did not know what their colleagues would do in different situations and expressed uncertainty about how much influence the children should have and what they should be allowed to do. They also perceived coordination among staff and teams to be limited. Several previous studies confirm that professionals do not always include children and that, in fact, children's participation does often depend on a professional's personal choice (Archard & Skivenes, 2009; Križ & Roundtree-Swain, 2017; ten Brummelaar, Knorth, et al., 2018; van Bijleveld et al., 2014). Most of the children at this facility also judged staff communication, strategies and attitudes to be person-dependent. Several stated ‘it depends who …’ when talking about their experiences communicating with staff and seeking involvement in decision-making.

Ultimately, staff face a challenge to balance the need to be flexible and supportive with the need to maintain reasonable and predictable boundaries.

4.4 | Limitations

There are several limitations to this study. First, we approached the participants via the residential facility managers. We cannot be sure they provided accurate information to the children and staff who fit our selection criteria. A different sample might have generated other or additional findings. Staff members who participated may have felt obliged to do so because their manager handed them the invitation. To avert this bias, participants were told to contact the researchers directly if they wished to participate. Given the varied responses achieved in our sample, we believe that sampling bias was minimal.

Second, participants may have offered comments that they believed the interviewers wanted to hear. To reduce this likelihood, we explained explicitly and clearly to participants that no answers were wrong and that all the identities and data would be anonymized.

Third, the combination of focus-group interview, group interviews and individual interviews could have resulted in our missing the interaction elements or group effect, which is more easily captured by focus-group interviews.

Fourth, by analysing the data using the three dimensions of participation, we may have missed some perspectives that could have emerged from a data-driven analysis.

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4.5 | Implication for practice and future research

The implications for practice include the need for residential facilities to challenge professional attitudes and to disrupt practices that exclude children from participating and for residential staff to provide information in safe and inclusive spaces to support children in forming and expressing their opinions without concern for negative consequences. We recommend that every child has access to an adult with sufficient knowledge of the child's rights who can act as a representative who has no power to implement negative consequences for the child. Having heard the child's views, staff must then demonstrate that the views have been taken seriously. Staff training regarding how to engage and involve children is needed to ensure that the dimensions of meaningful participation become embedded in residential-care practice.

Further research is needed on children's perspectives, specifically, on how children can participate meaningfully and experience that their voices are heard and taken into consideration. There is also a need for further investigation into how staff can better ensure that youth take in and understand important information that staff provide and have space to freely expressed views. Increased knowledge is also needed about the challenges that staff face when seeking to involve children and about the factors preventing the implementation of full participatory practices.

5 | CONCLUSION

This study's findings, in accordance with the scoping review by McPherson et al. (2021), indicate that, although valued in theory, the three dimensions of meaningful participation—informing, hearing and involving—are not fully implemented in practice.

Our research shows that the model of Bouma et al. (2018) cannot simply be implemented through procedures and policies. Dynamic participation by the staff and the children is also necessary. Establishing the model at the institutional level does not mean that, at the practical level, the desired results will be seen.

Our study shows that even if the policies are consistent across institutions, their practical application is not. One of the biggest lapses in the Norwegian context seems to be with respect to the first dimension—informing—which is a prerequisite to participation. Both children and staff agreed that for a child to be properly informed, the child usually must take the initiative. Significant responsibility rests on children to ask staff for information about their rights. Although children entering residential facilities are usually offered pamphlets that inform them of their rights, this action may fall well short of what is needed to promote and develop a culture of participation that truly includes the voice of the child. Given that informing is the first step in a three-step process, failure to inform adequately puts at risk the whole effort of child participation. Despite Norway's high ambitions when it comes to children's participation, bureaucratic and structural systems, including the asymmetrical power between staff and children in residential facilities, most likely impede children from expressing their views freely in these settings. This is another significant lapse that needs attention. Additionally, we found that some children feel unheard and that whether they felt listened to was staff-dependent.

If the well-being of children matters and if the goal is to consider children's best interests and achieve the best possible outcomes for them, then emphasis must be placed on children's participation. Our findings, in conjunction with those of previous research, point to the need to maintain a focus on how children can participate meaningfully in their own lives. To the best of our knowledge, this study also contributes to the literature by comparing the opinions of staff and children at the same facilities.

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CONFLICT OF INTEREST STATEMENT

The authors report no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available in TSD-system at the University of Oslo.

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REFERENCES

Archard, D., & Skivenes, M. (2009). Hearing the child. *Child & Family Social Work*, *14*(4), 391–399. https://doi.org/10.1111/j.1365-2206.2008.00606.x

Bell, M. (2002). Promoting children's rights through the use of relationship. *Child & Family Social Work*, *7*(1), 1–11. https://doi.org/10.1046/j.1365-2206.2002.00225.x

Bessell, S. (2011). Participation in decision-making in out-of-home care in Australia: What do young people say? *Children and Youth Services Review*, *33*(4), 496–501. https://doi.org/10.1016/j.childyouth.2010.05.006

Bessell, S., & Gal, T. (2009). Forming partnerships: The human rights of children in need of care and protection [article]. *International Journal of Children's Rights*, *17*(2), 283–298. https://doi.org/10.1163/157181808X358258

Blakemore, T., Herbert, J. L., Arney, F., & Parkinson, S. (2017). The impacts of institutional child sexual abuse: A rapid review of the evidence [Behavior Disorders & Antisocial Behavior 3230]. *Child Abuse & Neglect*, *74*, 35–48. https://doi.org/10.1016/j.chiabu.2017.08.006

Bouma, H., López López, M., Knorth, E. J., & Grietens, H. (2018). Meaningful participation for children in the Dutch child protection system: A critical analysis of relevant provisions in policy documents. *Child Abuse & Neglect*, *79*, 279–292. https://doi.org/10.1016/j.chiabu.2018.02.016

Bramsen, I., Kuiper, C., Willemse, K., & Cardol, M. (2019). My path towards living on my own: Voices of youth leaving Dutch secure residential care. *Child and Adolescent Social Work Journal*, *36*(4), 365–380. https://doi.org/10.1007/s10560-018-0564-2

Burns, K., Pösö, T., & Skivenes, M. (2017). *Child welfare removals by the state: A cross-country analysis of decision-making systems*. Oxford University Press. https://books.google.se/books?id=I_jmDAAAQBAJ

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Cahill, O., Holt, S., & Kirwan, G. (2016). Keyworking in residential child care: Lessons from research. *Children and Youth Services Review*, *65*, 216–223. https://doi.org/10.1016/j.childyouth.2016.04.014

Cashmore, J. (2002). Promoting the participation of children and young people in care. *Child Abuse & Neglect*, *26*(8), 837–847. https://doi.org/10.1016/S0145-2134(02)00353-8

Cleaver, E., & Kerr, D. (2006). *Engaging young people in local democracy*. NFER. *Retirado de*. http://nfer.ac.uk/research-areas/pims-data/outlines/engaging-children.cfm

Cossar, J., Brandon, M., & Jordan, P. (2016). 'You've got to trust her and she's got to trust you': Children's views on participation in the child protection system. *Child & Family Social Work*, *21*(1), 103–112. https://doi.org/10.1111/cfs.12115

Dadich, A. (2010). Participation among young people with mental health issues. In B. Percy-Smith & N. Thomas (Eds.), *A handbook of children and young people's participation: Perspectives from theory and practice* (pp. 105–112). Routledge.

Daly, W. (2009). "Adding their flavour to the mix": Involving children and young people in care in research design. *Australian Social Work*, *62*(4), 460–475. https://doi.org/10.1080/03124070903265732

de Valk, S., Kuiper, C., van der Helm, G. H. P., Maas, A. J. J. A., & Stams, G. J. J. M. (2019). Repression in residential youth care: A qualitative study examining the experiences of adolescents in open, secure and forensic institutions. *Journal of Adolescent Research*, *34*(6), 757–782. https://doi.org/10.1177/0743558417719188

Doek, J. E. (2009). The CRC 20 years: An overview of some of the major achievements and remaining challenges. *Child Abuse & Neglect*, *33*(11), 771–782. https://doi.org/10.1016/j.chiabu.2009.08.006

Fudge Schormans, A., & Rooke, J. (2008). When there are no choices: The consequences of a lack of adult living placements for young adults with intellectual and/or developmental disabilities leaving cild welfare care. *Journal of Developmental Disabilities*, *14*(1), 107–126. http://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.620.4389

Gal, T. (2017). An ecological model of child and youth participation. *Children and Youth Services Review*, *79*, 57–64. https://doi.org/10.1016/j.childyouth.2017.05.029

General Comment No. 12. The right of the child to be heard. (2009).

Goodkind, S., Schelbe, L. A., & Shook, J. J. (2011). Why youth leave care: Understandings of adulthood and transition successes and challenges among youth aging out of child welfare. *Children and Youth Services Review*, *33*(6), 1039–1048. https://doi.org/10.1016/j.childyouth.2011.01.010

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2017). The inside out? Views of young people, parents, and professionals regarding successful secure residential care. *Child and Adolescent Social Work Journal*, *34*(5), 431–441. https://doi.org/10.1007/s10560-016-0473-1

Henriksen, A., Degner, J., & Oscarsson, L. (2008). Youths in coercive residential care: Attitudes towards key staff members' personal involvement, from a therapeutic alliance perspective. *European Journal of Social Work*, *11*(2), 145–159. https://doi.org/10.1080/13691450701531976

Horwath, J., Kalyva, E., & Spyru, S. (2012). "I want my experiences to make a difference" promoting participation in policy-making and service development by young people who have experienced violence. *Children and Youth Services Review*, *34*(1), 155–162. https://doi.org/10.1016/j.childyouth.2011.09.012

Jamieson, L. (2017). Children and young people's right to participate in residential care in South Africa. *The International Journal of Human Rights*, *21*(1), 89–102. https://doi.org/10.1080/13642987.2016.1248126

Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. *Children and Youth Services Review*, *30*(2), 123–140. https://doi.org/10.1016/j.childyouth.2007.09.001

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, *45*(3), 214–222. https://doi.org/10.5014/ajot.45.3.214

Križ, K., & Roundtree-Swain, D. (2017). "We are merchandise on a conveyer belt": How young adults in the public child protection system perceive their participation in decisions about their care. *Children and Youth Services Review*, *78*, 32–40. https://doi.org/10.1016/j.childyouth.2017.05.001

Križ, K., & Skivenes, M. (2017). Child welfare workers' perceptions of children's participation: A comparative study of England, Norway and the USA (California). *Child & Family Social Work*, *22*(S2), 11–22. https://doi.org/10.1111/cfs.12224

Lansdown, G. (2010). The realisation of children's participation rights. Critical reflections. In B. Percy-Smith & N. Thomas (Eds.), *A handbook of children and young people's participation: Perspectives from theory and practice*. Routledge. https://doi.org/10.4324/9780203871072

Leeson, C. (2007). My life in care: Experiences of non-participation in decision-making processes. *Child & Family Social Work*, *12*(3), 268–277. https://doi.org/10.1111/j.1365-2206.2007.00499.x

MacFarlane, A., & O'Reilly-de Brún, M. (2012). Using a theory-driven conceptual framework in qualitative Health Research. *Qualitative Health Research*, *22*(5), 607–618. https://doi.org/10.1177/1049732311431898

Maier, S. F., & Seligman, M. E. P. (2016). Learned helplessness at fifty: Insights from neuroscience. *Psychological Review*, *123*(4), 349–367. https://doi.org/10.1037/rev0000033

McCarthy, E. (2016). Young people in residential care, their participation and the influencing factors. *Child Care in Practice*, *22*(4), 368–385. https://doi.org/10.1080/13575279.2016.1188763

McPherson, L., Vosz, M., Gatwiri, K., Parmenter, N., Macnamara, N., Mitchell, J., & Tucci, J. (2021). What does research tell us about young people's participation in decision making in residential care? A systematic scoping review. *Children and Youth Services Review*, *122*, 105899. https://doi.org/10.1016/j.childyouth.2020.105899

Moore, T., McArthur, M., Death, J., Tilbury, C., & Roche, S. (2017). Young people's views on safety and preventing abuse and harm in residential care: "It's got to be better than home". *Children and Youth Services Review*, *81*(October), 212–219. https://doi.org/10.1016/j.childyouth.2017.08.010

Pölkki, P., Vornanen, R., Pursiainen, M., & Riikonen, M. (2012). Children's participation in child-protection processes as experienced by foster children and social workers. *Child Care in Practice*, *18*(2), 107–125. https://doi.org/10.1080/13575279.2011.646954

Rap, S., Verkroost, D., & Bruning, M. (2019). Children's participation in Dutch youth care practice: An exploratory study into the opportunities for child participation in youth care from professionals' perspective. *Child Care in Practice*, *25*(1), 37–50. https://doi.org/10.1080/13575279.2018.1521382

Seligman, M. E. (1974). Depression and learned helplessness. In M. M. Katz, R. J. Friedman, V. H. Winston, & J. Wiley (Eds.), *The psychology of depression: Contemporary theory and research*. (pp. xvii, 318-xvii, 318). John Wiley & Sons.

Shanks, E., Backe-Hansen, E., Eriksson, P., Lausten, M., Lundström, T., Ranta, H., & Sallnäs, M. (2021). Privatisation of residential care for children and youth in Denmark, Finland, Norway, and Sweden. *Nordisk välfärdsforskning|Nordic Welfare Research*, *6*(3), 128–141. https://doi.org/10.18261/issn.2464-4161-2021-03-02

Slaatto, A., Mellblom, A. V., Kleppe, L. C., & Baugerud, G. A. (2022). Safety in residential youth facilities: Staff perceptions of safety and experiences of the "basic training program in safety and security". *Residential Treatment for Children & Youth*, *39*, 212–237. https://doi.org/10.1080/0886571X.2021.1978035

Southwell, J., & Fraser, E. (2010). Young people's satisfaction with residential care: Identifying strengths and weaknesses in service delivery.

13652206, 2024, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/cfs.13090 by Oslomet – Oslo Metropolitan University, Wiley Online Library on [16/01/2025]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License

Child Welfare, *89*(2), 209–228. http://www.jstor.org.ezproxy.oslomet.no/stable/45400462

StatisticsNorway. (2021). https://www.ssb.no/en/statbank/table/11600

Strijbosch, E. L. L., Wissink, I. B., van der Helm, G. H. P., & Stams, G. J. J. M. (2019). Building a positive group climate together: How monitoring instruments are part of an improvement process in residential care for children. *Children and Youth Services Review*, *96*, 266–277. https://doi.org/10.1016/j.childyouth.2018.11.051

ten Brummelaar, M., Harder, A. T., Kalverboer, M. E., Post, W. J., & Knorth, E. J. (2018). Participation of youth in decision-making procedures during residential care: A narrative review. *Child & Family Social Work*, *23*(1), 33–44. https://doi.org/10.1111/cfs.12381

ten Brummelaar, M., Knorth, E. J., Post, W. J., Harder, A. T., & Kalverboer, M. E. (2018). Space between the borders? Perceptions of professionals on the participation in decision-making of young people in coercive care. *Qualitative Social Work*, *17*(5), 692–711. https://doi.org/10.1177/1473325016681661

Toros, K. (2021). Children's participation in decision making from child welfare Workers' perspectives: A systematic review. *Research on Social Work Practice*, *31*(4), 367–374. https://doi.org/10.1177/1049731520984844

UNCRC. (1989). Convention on the rights of the child, Treaty no. 27531. United Nations Human Rights.

van Bijleveld, G. G., Bunders-Aelen, J. F. G., & Dedding, C. W. M. (2020). Exploring the essence of enabling child participation within child protection services. *Child & Family Social Work*, *25*(2), 286–293. https://doi.org/10.1111/cfs.12684

van Bijleveld, G. G., Dedding, C. W. M., & Bunders-Aelen, J. F. G. (2014). Seeing eye to eye or not? Young people's and child protection workers' perspectives on children's participation within the Dutch child protection and welfare services. *Children and Youth Services Review*, *47*, 253–259. https://doi.org/10.1016/j.childyouth.2014.09.018

van Bijleveld, G. G., Dedding, C. W. M., & Bunders-Aelen, J. F. G. (2015). Children's and young people's participation within child welfare and child protection services: A state-of-the-art review. *Child & Family Social Work*, *20*(2), 129–138. https://doi.org/10.1111/cfs.12082

van der Helm, G. H. P., Kuiper, C. H. Z., & Stams, G. J. J. M. (2018). Group climate and treatment motivation in secure residential and forensic youth care from the perspective of self determination theory. *Children and Youth Services Review*, *93*, 339–344. https://doi.org/10.1016/j.childyouth.2018.07.028

Vis, S. A., Strandbu, A., Holtan, A., & Thomas, N. (2011). Participation and health—A research review of child participation in planning and decision-making. *Child & Family Social Work*, *16*(3), 325–335. https://doi.org/10.1111/j.1365-2206.2010.00743.x

Vis, S. A., & Thomas, N. (2009). Beyond talking—Children's participation in Norwegian care and protection cases. *European Journal of Social Work*, *12*(2), 155–168. https://doi.org/10.1080/13691450802567465

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13652206, 2024, 2, Downloaded from https://onlinelibrary.wiley.com/doi/10.1111/cfs.13090 by Oslomet – Oslo Metropolitan University, Wiley Online Library on [16/01/2025]. See the Terms and Conditions (https://onlinelibrary.wiley.com/terms-and-conditions) on Wiley Online Library for rules of use; OA articles are governed by the applicable Creative Commons License