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Staff Profiles and Caregiving Attitudes in Residential Agencies Implementing the CARE Model: A Cross-National Comparison

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Abstract

Despite being considered a "last resort," residential care constitutes an essential component of the child welfare system, providing support to children with life trajectories marked by significant adversity. In this context, the implementation of trauma-informed and evidence-based models is crucial to ensuring quality care. The Children and Residential Experiences (CARE) model is situated within this approach, guiding staff interventions. This study aims to conduct a comparative analysis of staff profile and their caregiving attitudes in residential care homes in Australia, Canada, Spain and the United States, using the CARE model as a reference framework. The sample consisted of 4,548 professionals from 47 agencies that have expressed the intention to implement CARE across the four countries. Data were collected at different time points between 2017 and 2025, prior to the model's implementation. The Staff Survey was used to assess baseline beliefs and knowledge about caregiving practices aligned with the CARE principles. Sociodemographic and occupational variables were also included. A common pattern emerged across countries, with the same domains consistently rated as strengths (Family Involvement and Promote Competence) and challenges (Flexibility). High staff turnover also emerged as a cross-cutting weakness. Australia and Canada showed higher levels of alignment with CARE, even with a lower proportion of staff holding university degrees, underscoring the importance of practice-oriented internal training. Overall, the findings highlight the importance of implementing trauma-informed and evidence-based models, as well as strengthening ongoing training, supervision, working conditions and organizational support to improve the quality of residential care.

Keywords Residential care · CARE model · Care practices · Child welfare · Trauma-informed care · Evidence-based program

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Introduction

Theoretical Framework

Residential care is a key resource within child welfare systems that provides care for children who have had to be separated from their families due to situations of violence, neglect, lack of safety, as well as physical, emotional, and sexual abuse (Ames & Loebach, 2023; Turner et al., 2019). Although terminology varies widely across different countries, the international work group on Therapeutic Residential Care (TRC) has referred to this concept as (1) any residential group setting where children spend the night, (2) where settings may vary in size and function and where the auspice of service may be child welfare, juvenile corrections, or mental health, and (3) where the focus will be on how each country views residential care (Whittaker et al., 2022). This variety of resources and approaches reflects the

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historical struggle to establish an international conceptualization of what should characterize a residential care program that ensures effective, safe, and high-quality care. In this regard, consensus has been reached on the notion of "therapeutic residential care", which refers to:

The planful use of a purposefully constructed, multidimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources (Whittaker et al., 2015, p. 24).

Despite the international advances achieved in the field of residential care, much of the literature, particularly in Anglophone contexts, continues to frame residential care as a "last resort," viewing it as a temporary placement associated with the failure of other family-based alternatives (Dozier et al., 2014). This perception has contributed to the overrepresentation of youth with complex emotional, behavioral, and psychosocial needs in such settings. Studies conducted in Spain have shown that approximately 61% of children in residential care present emotional and behavioral problems (González-García et al., 2017), while figures as high as 88.6% have been reported in the United States (Burns et al., 2004). It is noteworthy that children and youth in residential environments are even more likely to have experienced childhoods marked by complex trauma (including emotional, physical, and sexual abuse and neglect), as well as multiple placement changes (Holden & Sellers, 2019). These experiences often give rise to what Anglin (2002) termed pain-based behavior, referring to outwardly disruptive or challenging actions that reflect underlying emotional distress resulting from exposure to traumatic events and prolonged adverse experiences. Therefore, residential care is not only an alternative measure to family care but must also fulfill an important treatment function (Del Valle & Bravo, 2013).

Given this high prevalence of complex emotional difficulties, there is a need for approaches that integrate trauma understanding into all dimensions of residential care. In response to this challenge, a new evidence-based practice paradigm has emerged internationally in recent years: Trauma-Informed Care (TIC) (Brend & Sprang, 2020). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), as outlined in the Trauma and Justice Strategic Initiative (2014):

A trauma-focused organization "recognizes the widespread impact of trauma and understands potential paths for recovery; identifies signs and symptoms in service users, families, staff, and other system actors; responds by fully integrating knowledge about trauma into its policies, procedures, and practices; and actively seeks to prevent retraumatization (p. 9).

The TIC approach is grounded in decades of clinical research and practice on the treatment of childhood trauma, offering opportunities for healing through specific interventions and environments that facilitate their implementation (Cohen, 2010; Hummer et al., 2010). Thus, TIC represents a holistic approach that guides organizational cultures and professional practices, fostering environments that offer positive interpersonal experiences, therapeutic activities, and opportunities for development (Ames & Loebach, 2023; Brendtro, 2019).

In this context, care practices in residential homes constitute the core of the transformation of models, as they shape the daily lives of children and youth and determine the quality of their care experiences. Recent literature has highlighted that high-quality care is grounded in principles such as kindness, healing, practical wisdom, and autonomy, all of which are aimed at fostering relational practices that interpret behaviors through a comprehensive and non-punitive lens (Gharabaghi, 2024). Recent studies in Spain emphasized that practices related to listening, engagement and involvement in care were well established, although more traditional approaches based on consequences and limited flexibility still persisted (Pulgar et al., 2025). Evidence shows that coercive interventions lose effectiveness over time and may even prove counterproductive (Lieberman et al., 2019; Parhar et al., 2008; Stoll et al., 2024). For this reason, current residential models are oriented toward Trauma-Informed Care, with the aim of supporting youth who have experienced adversity through the strengthening of bonds and meaningful relationships (Holden et al., 2010; Steinkopf et al., 2020).

Trauma-Informed Care also places particular emphasis on the protection and development of staff, recognizing that the prevention of vicarious trauma, high-quality supervision, and the strengthening of professional resilience are indispensable conditions for ensuring stable and effective care (Brend et al., 2024; Molnar & Fraser, 2020). Constant exposure to traumatic situations has been associated with high levels of secondary traumatic stress, compassion fatigue, and professional burnout (Geoffrion et al., 2016; Sprang et al., 2011). Added to this are work-related factors such as excessive workload, insufficient training, low salaries, and the negative perception of residential care, which contribute to many professionals viewing their work as a temporary option and experiencing high turnover (Colton & Roberts, 2007). This instability directly affects the quality of services and the ability to establish supportive bonds with youth, generating greater insecurity in placements (Brend et al., 2025; Tremblay et al., 2016). In this regard, several studies highlight that high-quality residential care

and the implementation of evidence-based approaches will not be possible without paying attention to the stability and training of direct care staff (Aarons et al., 2009). Greater educational and financial support increases caregiver retention and satisfaction, indirectly leading to better outcomes for children and young people (Glisson et al., 2006; James, 2017).

CARE Model

This study focuses specifically on the Children and Residential Experiences (CARE) model, an evidence-based program developed at Cornell University and situated within this TIC paradigm. The model approaches residential care from an ecological perspective, with its central aim being to create the conditions for change and positive development in children and youth through a consistent pattern of positive and reciprocal interactions with caring adults who, over time, foster connection and trust (Bronfenbrenner & Morris, 2007; Li & Julian, 2012; Ryan & Deci, 2000; Schuengel & van IJzendoorn, 2001). The effectiveness of CARE depends not only on staff training or the acquisition of knowledge, but also on meaningful changes in caregivers' attitudes, expectations, and everyday interactions with children and youth. To achieve this, the model is structured around six core principles that guide both daily practices and organizational culture: (a) Relationship-based: Nurturing caregiving experiences, secure emotional bonds, and developmentally supportive relationships are essential for child's growth. (b) Trauma-informed: Sensitive to youth trauma history. All activities, routines, expectations, and interactions are designed with an awareness of the impact of stress and trauma on child development. (c) Developmentally focused: Opportunities for normative developmental experiences are provided, with expectations tailored to meet each child's individual needs. (d) Family involvement: Connection with family, as well as integration with cultural and community contexts, is encouraged through collaboration with families in planning and designing activities. (e) Competency-centered: Opportunities are created for youth to practice problem-solving, coping strategies, and other life skills. (f) Ecologically oriented: The physical and social environment is designed to support youth meaningful participation in relationships, activities, and daily routines (Holden, 2023).

As an organizational model, CARE involves all levels of the agency (management, leadership, and direct care staff) and relies on consultants who support implementation through training, supervision, and technical assistance in the daily application of these core principles (Izzo et al., 2022). Available evidence shows that the implementation of CARE is associated with reductions in behavioral incidents and physical restraints, as well as improvements in the quality of relationships between youth and staff, in perceptions of safety, and in child subjective well-being (Holden et al., 2022; Izzo et al., 2016, 2020; Nunno et al., 2017; Pulgar et al., 2026; Sellers et al., 2020). For this reason, the model has been included as an evidence-based program by the California Evidence-Based Clearinghouse for Child Welfare with a rating of 3 (Promising Research Evidence).

Despite this growing evidence base, existing studies have primarily focused on changes occurring after CARE implementation and have largely been conducted within individual countries. As a result, little is known about the baseline readiness of organizations preparing to implement CARE, including staff characteristics, caregiving beliefs, and knowledge, or about how these factors may vary across different national contexts. Understanding these initial conditions is important because they represent the starting point from which implementation unfolds and may influence subsequent implementation processes and outcomes. At the same time, examining these characteristics across countries provides valuable insight into how residential care staff are positioned within different child welfare context.

Specifically, this study examines staff teams in Australia, Canada, Spain, and the United States, countries where the CARE model is being implemented, and whose child welfare systems differ markedly in their models, policies, and organizational structures. These contextual differences provide a meaningful foundation for understanding how residential care is configured across diverse settings and how such variation may shape staff readiness prior to CARE implementation.

Conceptualization of Residential Care in the Countries of the Study

Residential care services in Australia vary considerably across states and territories (McNamara, 2014), within a system likewise marked by the overrepresentation of Indigenous young people (McNamara & Wall, 2022). Programs typically serve adolescents with mental health diagnoses, persistent school absenteeism, and trajectories of multiple breakdowns in foster care (Monson et al., 2020). In recent years, several states have moved towards homes accommodating between two and four children, following the recommendations of the South Australian Royal Commission into Child Protection Systems (2016). With regard to staff, training requirements remain inconsistent. In most services, it is possible to work as a caregiver with a basic certificate or even without formal qualifications, with internal training and the assessment of personal skills prevailing over formal credentials (Ainsworth, 2017; Benton et al., 2017).

Residential care in Canada is deeply shaped by its colonial history and by the notable diversity across provinces

and territories, often described through the metaphor of the cultural "mosaic" (Gibbon, 1938). The legacy of assimilation policies is reflected in the persistent overrepresentation of Indigenous children and youth in the child welfare system (Sinha et al., 2018). Programs vary widely, with some provinces relying on single-bed homes, others have secure treatment facilities, and many moving toward small-group residential settings (Anglin et al., 2022). Regarding the caregiving workforce, job titles and training requirements differ across provinces and, with the exception of jurisdictions such as Quebec or Alberta, where a diploma or degree in Child and Youth Care (CYC) is required, there are no consistent standards (Brend et al., 2025; Mann-Feder, 2019).

In Spain, residential care is organized in a decentralized manner, with responsibilities assigned to each autonomous community, resulting in significant differences across regions (Bravo & Del Valle, 2009). In 2012, national quality standards were introduced (Del Valle et al., 2012), although each region is allowed to establish its own procedures and accreditation systems. The 2015 child protection reform (Organic Law 8/2015; Law 26/2015) prioritizes family foster care for children under the age of six and establishes specific homes for adolescents with severe behavioral problems and for young people in the process of transitioning to adulthood. The residential population is composed mainly of adolescents, with an overrepresentation of unaccompanied migrant youth (Bravo et al., 2022). Most homes are small, accommodating between six and eight places, and are managed by non-profit organizations (Poole-Quintana et al., 2025). With respect to staffing, the professional reference role is that of the *social educator*, which requires a university degree, although it may be complemented by "assistant educators" as support staff (Bravo et al., 2022).

Residential placements in the United States have progressively declined in recent years (USDHHS, 2020), in favor of family-based alternatives (Daly et al., 2018; Dozier et al., 2014). A higher proportion of boys than girls is observed, along with an overrepresentation of African American youth (USDHHS, 2015). Residential care programs are highly diverse and include child welfare homes, mental health facilities, juvenile justice programs, educational settings, and private residences. Frequently, youth live in smaller residential units, although there are also large campuses that can serve more than 100 young people (Lee & Bellonci, 2022). In terms of staff qualification, there are no national educational standards, training is highly variable, and positions are characterized by low salaries (Gharabaghi, 2024; Smith et al., 2021). Residential homes report high rates of participation in evidence-based programs, although most of these were not specifically designed for residential care (James et al., 2017).

Building on this cross-national contextualization, the main objective of the study is to compare the initial situation of staff members as they face the transformation that CARE model entails,, while also contributing to a broader understanding of the conditions that support high-quality residential care across different child welfare systems beyond CARE itself. The specific research questions are:

1. (1) When we examine organizations that have expressed the intention to implement CARE, what are the sociodemographic characteristics of their staff in Australia, Canada, Spain and the United States?
2. (2) What are their beliefs about caregiving and knowledge of concepts related to caregiving? Do the results differ when comparing staff who provide direct care with those who do not?
3. (3) What differences exist among staff in pre-CARE agencies in Australia, Canada, Spain and the United States regarding their sociodemographic characteristics, caregiving beliefs, and knowledge of the CARE model?

Methodology

Study Design

This study employs a quantitative cross-sectional design to assess the baseline conditions preceding the implementation of the CARE model in Australia, Canada, Spain and the United States. Data were collected between 2017 and 2025, depending on when each participating agency initiated the implementation process. The cross-sectional nature of the study allows for a comparative analysis of the starting point of residential care agencies across countries, providing insight into their initial care contexts.

Participants

The total sample consists of 4,548 staff working in residential care homes that have decided to begin implementing the CARE model. Of the total staff, 1,501 are from Australia, 1,131 from Canada, 110 from Spain, and 1,806 from the United States. Regarding gender, 2,804 (65.4%) members of the staff were women, 1,504 (33.2%) were men, and 60 (1.4%) were non-binary or prefer not to say.

Data were collected from 47 pre-CARE agencies, 9 from Canada, 11 from Australia, 9 from Spain, and 18 from the United States. These agencies varied in size and scope across countries; while in some contexts a single agency covered several residences, in others, agencies were smaller and more localized. It is important to consider this structural

diversity when interpreting the distribution of staff among the residences.

Measures

The measures used in this study were developed by the Residential Child Care Project at Cornell University and have been in use since 2017 (Holden & Sellers, 2019; Holden et al., 2022; Izzo et al., 2022; Pulgar et al., 2025). These measures were originally developed to assess staff's initial alignment with the core principles of the CARE model prior to implementation. Establishing this baseline is essential within the CARE project, as it allows agencies to understand their starting point and to identify areas of strength and areas needing support.

The staff surveys were modified in 2022 and 2023, which limited the comparability of the full measures across the study period from 2017 to 2025. However, a substantial number of survey items remained unchanged, allowing us to compute a Beliefs about Caregiving score and a Knowledge of Caregiving Concepts score. In addition, for the Spanish sample all measures were translated by the authors' research team (authors, 2025).

Beliefs about Caregiving

The Beliefs about Caregiving scale comprises 17 items to assess caregivers' alignment with the principles underlying the CARE program model. The measure spans seven content areas: listening and understanding, being invested and engaged, being inclusive, being flexible, promoting competence, avoiding reliance on consequences, and involving families. Nine items are rated on a 5-point scale ranging from Very Poor to Excellent and 8 items on a 5-point scale ranging from Strongly Disagree to Strongly Agree. Six items are reverse scored so that higher scores reflect beliefs that are more consistent with the CARE principles. A mean score across all 17 items serves as the Overall Beliefs about Caregiving score.

Construction of the Beliefs scale

Parallel analysis (Horn, 1965) suggested retaining up to seven factors; however, inspection of the scree plot indicated that only the first two factors had eigenvalues substantially greater than the simulated data threshold. A two-factor solution was therefore examined based on the convergence of the scree plot and interpretability (Fabrigar et al., 1999). Exploratory factor analysis using principal axis factoring with oblimin rotation was conducted specifying a two-factor extraction. The first factor (eigenvalue = 3.43) accounted for 20.2% of variance, with the second factor (eigenvalue = 1.80) accounting for an additional 10.6%. Inspection of the pattern matrix revealed that the difference in the two factors was the directionality of the items: Factor 1 consisted primarily of reverse-scored items and Factor 2 of positively worded items. Marsh (1996) described these as method effects that emerge from item wording direction rather than substantive content.

These results support treating the Beliefs about Caregiving scale as essentially unidimensional, and the single composite score is used in all subsequent analyses.

Internal consistency of the scale was acceptable (Cronbach's $\alpha = 0.72$; McDonald's $\omega = 0.71$). While the Beliefs about Caregiving scale is treated as a single composite for primary analyses, the seven content areas were examined separately in exploratory models to identify whether country-level differences are concentrated in specific aspects of caregiving beliefs.

Knowledge of Caregiving Concepts

To assess staff knowledge of the CARE curriculum, a multiple-choice test was used across the four participating countries. Because each country employed a different survey version, only five items were common to all of them and therefore available for cross-country comparison. These items covered core content areas, including childhood trauma, children's normative developmental needs, factors that strengthen child–adult relationships, elements influencing children's competence and functioning, and agency-wide approaches to promoting care quality. Scores reflected the number of correct responses, ranging from 1 to 5. The correlations between this 5-item version and the full 13-item versions used in the different countries are high, ranging from 0.74 (Spanish translation of the 2022 survey) to 0.84 (English translation of the 2022 survey), indicating that the shortened version provides a solid and meaningful indicator of staff knowledge.

In addition, the Staff Survey included seven items about sociodemographic and occupational information, comprising primary job role, years in organization, gender, level of education, involvement in daily care, employment type and ethnicity.

Procedure

Instruments were administered either in person by trained members of the research team, who conducted the assessments directly in the residential care homes, or online through the Qualtrics platform. Regardless of the mode of administration, anonymity, confidentiality of responses, and voluntary participation were ensured in all cases.

In Spain, the implementation of the CARE model had the particular feature of being initiated at the request of the regional government, which also managed its funding. Residential care agencies subsequently identified and proposed the residential homes that showed the greatest interest and motivation to participate, and data collection was conducted at the end of 2022. In the remaining countries, implementation was initiated and funded directly by the participating agencies themselves. In Australia, baseline data collection was conducted between 2017 and 2024, depending on when new agencies joined the implementation. In Canada, data collection took place between 2017 and 2022. Finally, in the United States, assessment data have been collected from 2017 to 2025.

Data Analysis

For the data analysis, SPSS (Version 27) was employed. The results section is divided into two parts. The first analyzes the profile of staff working in the four countries included in the study. A chi-square test was conducted to examine differences between countries in the following variables: primary job role, years in the organization, gender, education, daily care, employment type, and ethnicity. To assess the magnitude of these differences, adjusted standardized residuals and Cramer's V were calculated. Adjusted standardized residuals were examined to identify which cells contributed most to the significant chi-square values. Residuals exceeding ± 1.96 indicated categories where the observed frequencies differed substantially from those expected under independence. Cramér's V was computed as a measure of effect size, providing an index of the strength of the association between country and each categorical variable. Cramér's V ranges from 0 to 1, with higher values indicating stronger associations.

The second part of the results addresses the types of beliefs that staff hold regarding care practices, as well as their knowledge. To this end, the beliefs questionnaire was divided into seven categories plus an Overall Beliefs score, and Knowledge was measured using a single total score. Descriptive statistics (mean and standard deviation) were calculated. Before examining country differences, a null model including SITE ID as a random intercept was estimated for each outcome variable to compute the intraclass correlation coefficient (ICC). This quantified the proportion of variance attributable to differences between residential care homes rather than individual staff members, and assessed the need to account for the hierarchical structure of the data. Differences in scores across countries were then examined using linear mixed models, accounting for the nested structure of the data resulting from staff members being clustered within residential care homes. In this regard, the variable SITE ID was again included as a random intercept, and a Sidak post hoc analysis was conducted to identify between which countries these differences occurred. The analysis was repeated by dividing the sample into staff who provide direct care and those who do not. Additionally, the potential contribution of the survey completion date as a fixed effect was also examined; however, it did not significantly improve model fit and was therefore not retained in the final models.

Results

Profile of Staff in the countries of Canada, Australia, Spain and the United States

Table 1 presents the distribution of sociodemographic and occupational characteristics of residential care staff included in the study. Differences between countries in the analyzed variables were assessed using the chi-square test, Cramer's V statistic, and corrected standardized residuals.

Considering the job type, there was variation across countries (V = 0.205), however, most employees worked full-time, a pattern particularly notable in Spain and the United States, where the proportion exceeded 90%. In Australia, a higher proportion of staff were employed on casual or single-day contracts compared with staff in the other countries, accounting for 10.7% of the sample.

With regard to the primary job role, significant differences were observed across countries (V = 0.203). A marked disparity was found in the proportion of staff engaged in direct care: while only 37.6% of staff in the United States reported performing this role, in the other three countries the proportions exceeded half of the sample, with Spain standing out at 73.6%. In addition, 13.8% of respondents in the United States reported working as clinical or medical staff, a role that was much less common in the other countries.

The educational level showed pronounced differences between countries (V = 0.167). Spain shows the highest level of staff qualification, in which 96% of the sample held at least a university degree (Bachelor's or higher), and 78% had completed postgraduate or advanced professional studies. In contrast, Canada and Australia presented the lowest proportions of staff with university-level education. In Australia, 48.2% of participants reported holding a Bachelor's degree or higher, while in Canada the figure was 47.4%. The United States occupied an intermediate position, with 62.2% of the sample having attained a Bachelor's degree or above.

There are notable differences among agencies across the four countries regarding the proportion of workers who provide direct care (V = 0.165). In the United States and

Table 1 Staff profile by country

		AUS		CAN		ESP		USA		Overall	
Variable	Category	%	Res	%	Res	%	Res	%	Res	%	V
Job Type	Full-time	69.1	-16.3	86.0	3.6	90.9	2.4	92.6	12.3	82.4	0.205
	Part-time	20.2	9.9	12.2	-1.0	8.2	-1.5	6.8	-8.5	13.1	
	Casual / Per diem	10.7	13.8	1.9	-4.9	0.9	-1.9	0.6	-8.7	4.5	
	Total N	**1,416**		**1,069**		**110**		**1,374**		**3,969**	
Primary Job Role	Direct Care Staff	57.0	3.7	68.3	11.7	73.6	4.4	37.6	-15.6	52.9	0.203
	Manager / Leadership	19.5	5.3	12.1	-3.4	16.4	0.3	13.8	-2.1	15.3	
	Clinical / Medical	7.3	-2.1	2.9	-7.7	5.5	-1.2	13.8	9.4	8.6	
	School Personnel	2.4	-8.3	5.2	-2.9	0.9	-2.6	12.9	11.4	7.2	
	Caseworkers	9.7	3.3	6.1	-2.4	3.6	-1.6	7.4	-0.6	7.7	
	Other Staff	4.1	-6.9	5.4	-4.0	0.0	-3.2	14.4	11.3	8.3	
	Total N	**1,358**		**1,070**		**110**		**1,599**		**4,137**	
Education	Secondary or below	24.0	-0.1	23.9	-0.1	1.8	-5.5	25.6	1.9	24.0	0.325
	Postsecondary	27.8	7.6	28.7	7.0	1.8	-5.0	12.2	-11.8	21.0	
	Bachelor	31.3	-2.8	39.2	3.9	24.5	-2.2	34.1	-0.1	34.2	
	Graduate / Professional	16.9	-4.3	8.2	-11.6	71.8	13.4	28.1	9.9	20.7	
	Total N	**1,411**		**1,067**		**110**		**1,761**		**4,349**	
Provide Direct Care	Yes	59.5	-3.6	73.1	8.0	94.5	6.9	58.1	-5.8	63.2	0.165
	No	40.5	3.6	26.9	-8.0	5.5	-6.9	41.9	5.8	36.8	
	Total N	**1,501**		**1,131**		**110**		**1,806**		**4,548**	
Years in Organization	<1 year	26.2	2.1	22.8	-1.2	23.6	-0.2	23.6	-0.8	24.3	0.137
	1–2 years	27.8	4.2	20.8	-2.7	16.4	-1.9	23.1	-1.0	23.9	
	3–5 years	27.5	6.3	21.6	-0.2	21.8	0.0	17.5	-5.8	21.9	
	6–10 years	13.4	0.5	15.0	2.2	9.1	-1.2	11.8	-2.0	13.0	
	>10 years	5.1	-14.5	19.7	2.8	29.1	3.4	24.1	10.3	17.0	
	Total N	**1,428**		**1,081**		**110**		**1,775**		**4,394**	
Gender*	Female	65.4	1.2	59.4	-3.7	64.5	0.1	66.1	2.1	64.2	0.050
	Male	33.2	-1.2	39.7	4.2	32.7	-0.4	32.3	-2.4	34.4	
	Non-binary / Rather not say	1.3	-0.2	0.8	-1.7	2.7	1.2	1.6	1.3	1.4	
	Total N	**1,426**		**1,067**		**110**		**1,765**		**4,368**	
Indigenous / Aboriginal	Yes	5.4	-1.1	6.4	1.1					5.9	0.022
	No	94.6	1.1	93.6	-1.1					94.1	
	Total N	**1297**		**1025**							

Note. % = column percentage; N = count of staff; Res = adjusted standardized residual; V = Cramér's V

Total N varies across variables due to missing responses. Adjusted standardized residuals with absolute values exceeding 0.2 indicate cells contributing significantly to the chi-square

* The chi-square test for Gender was significant at $p = .002$; all other variables were significant at $p < .001$. The chi-square test was no significant for Indigenous/Aboriginal

Australia, approximately 40% of staff do not perform direct care tasks. This reflects the presence of diverse roles and organizational levels, with a substantial segment of employees carrying out functions that are not directly related to caregiving. In Spain, by contrast, almost the entire sample (94.5%) consisted of direct care workers, indicating a more limited presence of professional roles operating at other organizational levels. Finally, Canada shows an intermediate pattern, with a higher proportion of professionals providing direct care (73.1%), but also a considerable share of staff engaged in other types of tasks within the agency.

Tenure in the organization also varied significantly across countries (V = 0.137). In Canada, Spain, and the United States, a considerable proportion of staff had been working in residential care for more than ten years, whereas in Australia nearly the entire sample had been employed for less than six years. Similarly, across all countries, approximately one quarter of the workers had been employed for less than one year. Therefore, although there is a proportion of well-established staff in residential care homes, clear trends of high staff turnover can be observed.

Regarding gender, the distribution was more homogeneous across countries, with women consistently outnumbering men, representing approximately or slightly more than 60% of the sample in each of them.

Table 2 Caring Beliefs and Knowledge: Mean Scores by Country and Mixed linear Model

Domain		AUS M (SD)	CAN M (SD)	ESP M (SD)	US M (SD)	F	ICC
Knowledge Total Score	Provide direct-care	3.10 (0.12)	2.95 (0.13)	2.64 (0.15)	2.82 (0.90)	2.27	0.065
	Do not Provide direct-care	3.59 (0.11)	3.34 (0.14)	2.32 (0.50)	3.20 (0.09)	3.96*	0.076
	Total	**3.31 (0.10)^{a}**	**3.05 (0.12)^{ab}**	**2.62 (0.15)^{b}**	**2.94 (0.08)^{b}**	**5.52****	**0.074**
Overall Beliefs Mean	Provide direct-care	3.85 (0.04)^{a}	3.71 (0.05)^{ab}	3.48 (0.05)^{c}	3.56 (0.03)^{bc}	13.11***	0.200
	Do not Provide direct-care	3.97 (0.06)^{a}	3.93(0.70)^{a}	3.48 (0.19)^{ab}	3.66 (0.05)^{b}	7.34***	0.234
	Total	**3.91 (0.04)^{a}**	**3.76 (0.05)^{a}**	**3.48 (0.05)^{b}**	**3.60 (0.03)^{b}**	**17.29*****	**0.208**
Listening & Understanding	Provide direct-care	3.65 (0.04)^{a}	3.59 (0.05)^{ab}	3.40 (0.08)^{b}	3.46 (0.03)^{b}	6.15**	0.028
	Do not Provide direct-care	3.72 (0.06)	3.73 (0.07)	3.24 (0.31)	3.54(0.05)	3.53*	0.045
	Total	**3.69 (0.04)^{a}**	**3.62 (0.04)^{ab}**	**3.40 (0.08)^{b}**	**3.48 (0.03)^{b}**	**8.19*****	**0.031**
Invested & Engaged	Provide direct-care	3.69 (0.09)^{a}	3.37 (0.10)^{ab}	3.08 (0.12)^{b}	3.37 (0.07)^{ab}	5.65**	0.076
	Do not Provide direct-care	3.89 (0.10)^{a}	3.88 (0.13)^{a}	3.49 (0.45)^{ab}	3.39 (0.0.9)^{b}	5.69**	0.120
	Total	**3.79 (0.08)^{a}**	**3.48 (0.09)^{ab}**	**3.10 (0.12)^{bc}**	**3.38 (0.07)^{c}**	**8.72 *** **	**0.084**
Inclusion	Provide direct-care	3.99 (0.07)^{a}	3.80 (0.08)^{ab}	3.62 (0.09)^{b}	3.54 (0.05)^{b}	9.23***	0.142
	Do not Provide direct-care	4.06 (0.07)^{a}	4.02 (0.09)^{a}	3.86 (0.29)^{ab}	3.64 (0.06)^{b}	8.64***	0.148
	Total	**4.03 (0.06)^{a}**	**3.84 (0.07)^{ab}**	**3.63 (0.08)^{b}**	**3.57 (0.05)^{b}**	**12.30*****	**0.144**
Flexibility	Provide direct-care	3.43 (0.08)^{a}	3.18 (0.08)^{ab}	3.13 (0.09)^{ab}	3.10 (0.06)^{b}	4.25 **	0.112
	Do not Provide direct-care	3.55 (0.08)^{a}	3.36 (0.10)^{ab}	3.01 (0.31)^{ab}	3.11 (0.07)^{b}	6.35***	0.151
	Total	**3.48 (0.07)^{a}**	**3.22 (0.08)^{ab}**	**3.13 (0.09)^{b}**	**3.10 (0.06)^{b}**	**6.55*****	**0.118**
Promote Competence	Provide direct-care	4.08 (0.04)	4.11 (0.05)	4.11 (0.06)	4.05 (0.03)	0.35	0.039
	Do not Provide direct-care	4.01 (0.05)	4.14 (0.07)	4.05 (0.24)	4.04 (0.4)	0.89	0.062
	Total	**4.06 (0.04)**	**4.12 (0.04)**	**4.11 (0.06)**	**4.05 (0.03)**	**0.75**	**0.040**
Avoid Reliance on Conseq.	Provide direct-care	3.84 (0.09)^{a}	3.63 (0.09)^{ab}	2.97 (0.10)^{c}	3.33 (0.07)^{b}	16.41***	0.196
	Do not Provide direct-care	4.14 (0.09)^{a}	3.99 (0.11)^{a}	3.28 (0.32)^{ab}	3.58 (0.08)^{b}	9.03***	0.220
	Total	**3.98 (0.08)^{a}**	**3.72 (0.09)^{a}**	**2.99 (0.10)^{c}**	**3.41 (0.06)^{b}**	**23.35*****	**0.225**
Family Involvement	Provide direct-care	4.12 (0.05)^{a}	4.12 (0.06)^{a}	3.78 (0.07)^{b}	3.94 (0.04)^{ab}	7.04***	0.081
	Do not Provide direct-care	4.30 (0.07)	4.29 (0.09)	3.55 (0.29)	4.11 (0.06)	3.33*	0.103
	Total	**4.21 (0.05)^{a}**	**4.16 (0.06)^{ab}**	**3.77 (0.07)^{c}**	**4.00 (0.04)^{b}**	**9.68 *** **	**0.083**

Note. Values represent estimated marginal means from mixed-effects models including country as a fixed effect and site as a random intercept. Groups' means that do not share a subscript are significantly different between each other in Sidak post hoc analysis. $p < .05$*, $p < .01$**, $p < .001$***. ICCs were calculated from null models with SITE ID included as a random intercept to quantify the proportion of variance attributable to residential care homes

Finally, no significant differences were observed between Australia and Canada in the proportion of staff of Indigenous or Aboriginal origin, which in both cases represented a very small share of the residential care workforce.

Beliefs and Knowledge About Caregiving

Table 2 presents the estimated marginal means by country for the subscales assessing knowledge and caregiving beliefs, along with the results of linear mixed models and Sidak-adjusted pairwise comparisons. In each model, country was entered as a fixed factor, and a random intercept was included for site ID to account for clustering within specific residential care homes. The scores are divided between staff who provide direct care and those who do not, as well as the total scores. Superscripts in Table 2 highlight groups of means that do not differ significantly.

Statistically significant differences were observed across most domains. At the global level, the highest scores were observed in the domains of Promoting Competence, where there were no significant differences in any of the countries, and Family Involvement; whereas the lowest scores were found in the Flexibility domain.

Staff in Australia reported the highest scores on most domains (Knowledge Total Score, Overall Beliefs Mean, Listening & Understanding, Invested & Engaged, Inclusion, Flexibility, Avoid Reliance on Consequences and Family Involvement), with the exception of Promoting Competencies, even taking into account the differences that exist due to working in different residential homes. In the case of Canada, the scores also remain elevated, with no statistically significant differences compared to those in Australia.

Spain tended to show the lowest scores, especially in Avoid Reliance on Consequences, although in most domains it did not differ significantly from the case of the United States. There were no significant differences in Knowledge Total Score, Overall Beliefs Mean, Listening & Understanding, Invested & Engaged, Inclusion, Flexibility, Promote Competence.

When comparing staff who provide direct care with those who do not, the data show that direct-care staff tend to score lower than other organizational levels. In contrast, scores among non–direct-care staff appear more homogeneous. An exception emerges in the Knowledge domain, when focusing exclusively on direct-care staff, cross-national differences are no longer significant. While in Australia and Canada higher scores are found among staff who do not provide direct care, the opposite pattern is observed in the United States and Spain.

Discussion

The first objective of the study concerns the profile of the staff working in PRE-CARE agencies within the four countries. One of the main findings was the high level of staff turnover, which emerged as a widespread weakness across the countries included in the study. In this sample, almost 25% of staff had been working in their residential care home for less than one year. Youth in care need to perceive the residential setting as their home: a space that provides stability, security, and enduring relationships (Corrales et al., 2025), an aspect that may be compromised by high staff turnover. Residential care staff face constant exposure to traumatic experiences, compassion fatigue, secondary traumatic stress, and professional burnout, alongside heavy workloads, low salaries, precarious working conditions, and limited social recognition (Colton & Roberts, 2007; Geoffrion et al., 2016; Sprang et al., 2011). Taken together, these factors undermine their job stability and considerably increase the risk of staff turnover (Brend et al., 2025). This phenomenon is particularly concerning, as job instability has been associated with lower service quality and negative consequences for the emotional and behavioral adjustment of children and youth (Brend et al., 2025; Tremblay et al., 2016).

Another staff characteristic common in these agencies across the four countries is the higher representation of women compared to men working in residential care homes. This pattern has been reported in previous research (Pålsson et al., 2023), reflecting the fact that care continues to be socially associated with female roles, which have historically encompassed caregiving functions (European Institute for Gender Equality, 2023). In addition, results indicate a low presence of clinical staff within the workforce, with the agencies of the United States showing a slightly higher representation. Evidence suggests that multidisciplinary approaches integrating educational, social, and clinical profiles are associated with better outcomes in the wellbeing of children and youth in residential care (James, 2011). Although many youth access external mental health services, the ecological principle of the CARE model advocates for comprehensive intervention within the child's normative context (Holden, 2023). In this sense, the presence of clinical staff within the residential home could contribute to the development of more naturalistic interventions, greater cohesion among staff, and stronger alignment between daily care practices and therapeutic goals.

The second objective was to examine cross-country differences in caregiving beliefs and knowledge, first using the full sample and then identifying the differences between staff who provide direct care and those who do not. With regard to the full sample, higher scores tended to appear in the domains of Family Involvement and Promoting Competence, alongside lower scores in Flexibility. Family involvement has been consistently identified as a key element in residential care (McIlwaine et al., 2020). Previous studies have highlighted practices aimed at strengthening this participation, such as fostering communication between children and their families, organizing regular visits, getting to know the family, establishing positive relationships, or involving them in decision-making processes (McPherson et al., 2025; Tang et al., 2024). These practices are fundamental to the experience of children in residential care, as they have been associated with better intervention outcomes (Knorth et al., 2008) as well as with a greater likelihood of family reunification (Maltais et al., 2019). The challenges faced by these families are often intergenerational and chronic and are further complicated by the interactive nature of the psychosocial and socioeconomic factors involved (Tausendfreund et al., 2016). Consequently, it is essential to acknowledge the trauma that families may have experienced and to adopt a holistic approach to understanding their domestic processes, since child well-being is closely linked to family well-being (Geurts et al., 2012; Whittaker et al., 2016). For this reason, the CARE model explicitly advocates in its core principles for family oriented intervention, emphasizing the importance of staff actively promoting children's family, cultural, and community ties (Holden, 2023).

In parallel, high scores in Promote Competence are particularly relevant due to their close connection with child development. The literature highlights the importance of creating empowering and supportive environments in care (Hill, 2000), where residential homes provide normalizing experiences within the child's zone of proximal development (Vygotsky, 1978), thereby fostering the acquisition of basic skills and the progressive transition to adult life (García-Alba et al., 2022; Holden et al., 2014). These processes largely depend on the quality of relationships with caregivers, recognized as a key predictor of adaptive outcomes (Castro et al., 2024; Costa et al., 2020), since care staff play an essential role in helping youth identify emotions, develop coping strategies, and build trusting relationships

(Whittaker et al., 2016). This function becomes even more critical given the heightened vulnerability of these youth compared to their peers and their increased risk of emotional and behavioral difficulties (González-García et al., 2017). Consequently, promoting competencies such as emotional self-regulation, autonomy, and self-sufficiency (Holden, 2023) is indispensable to support both present adaptation and the future transition to independent living, and the high results achieved in this area across countries constitute a particularly encouraging indicator of practice quality.

Conversely, the Flexibility domain consistently received the lowest scores. Resistance to more flexible and individualized approaches is often linked to staff fear of losing authority and control, as well as concerns about an increase in disruptive behaviors, critical incidents, or the need for containment (Lieberman et al., 2019). However, studies have shown that the abolition of rigid and inflexible models did not increase critical incidents or restrictions, and such models have been considered incompatible with trauma-informed approaches (Stoll et al., 2024). Likewise, the literature indicates that a lack of flexibility among staff may lead to maladaptive care practices, whereas a flexible approach allows interventions to be tailored to the unique needs of youth and fosters the development of higher-quality relationships (Bakketeig & Backe-Hansen, 2018; Fonseca et al., 2020). This perspective is also consistent with social pedagogical and therapeutic milieu approaches, which view everyday interactions as the primary context for therapeutic change and emphasize creating a developmental environment through individualized and need-based interventions (Grietens, 2014). Indeed, youth themselves have emphasized the importance of staff achieving a balance between rules and autonomy (Harder et al., 2017; Pérez-García et al., 2019).

Following these results, the sample was divided between staff who provide direct care and those who do not. In this case, the overall pattern of scores remained largely the same: the highest-scoring domains continued to be Promoting Competence (with no statistically significant differences between countries) and Family Involvement. Likewise, the lowest scores were again observed in the Flexibility domain. It was observed that direct-care staff tend to show lower scores than those who do not work in direct care, with the exception of the Knowledge variable, where this pattern appears only in Australia and Canada. These reductions may be associated with the mental load and effort sustained by direct-care staff. These findings further underscore the importance of providing support to staff across the different levels of the agency (Aarons et al., 2014), as they are the ones who have a direct impact on the care provided to children and adolescents (Brend et al., 2025).

Addressing the third research question, the findings reveal clear differences in staff sociodemographic characteristics and in their beliefs and knowledge about care. In Australia, residential care staff obtained the highest scores in beliefs, a striking result considering that less than half of the sample had a university degree and the 24% of the staff had completed only basic education. This invites reflection, as internal training provided by agencies, together with government-led programs, appears sufficiently robust to support effective interventions based on trauma-informed models, suggesting that practical specialization may at times be even more effective than formal accreditation (Ainsworth, 2017; Benton et al., 2017). In this regard, Therapeutic Crisis Intervention (TCI) training becoming increasingly in demand, and in jurisdictions such as Victoria the Certificate IV in Child, Youth and Family Intervention (TAFE) is required for entry into the sector, a full-time one-year course complemented by recognition of prior learning processes (Commission for Children and Young People, Victoria, 2021). The presence of established training structures such as TCI may also provide a foundation for greater alignment with CARE principles, particularly regarding trauma-informed responses, understanding challenging behaviours, and reducing reliance on coercive approaches. Another relevant aspect of the Australian staff profile is the balance between direct care and support, caseworkers or administrative roles, which may facilitate evidence-based practices without placing the entire responsibility solely on frontline workers (Aarons et al., 2014). Finally, it is important to note the low representation of Aboriginal and Torres Strait Islander staff (5.4%) compared to the overrepresentation of Indigenous children in residential care, whose placement rate is ten times higher than that of non-Indigenous children (Australian Human Rights Commission, 2021; Secretariat for National Aboriginal and Islander Childcare [SNAICC], 2021).

In Canada, a trend similar to Australia can be observed, as it is the second country with the highest scores across most domains. Fewer than half of the professionals in the sample held a university degree, and there is a considerable proportion of staff (23.9%) with only basic education. However, the presence of post-secondary studies is increasingly being required, and in some provinces such as Alberta and Quebec certain caregiving roles now involve formal registration processes or regulated professional pathways that demand higher levels of training (Brend et al., 2025; Mann-Feder, 2019). These results highlight the importance of specific and practice-oriented training beyond formal university accreditation for effective interventions in residential care. Likewise, as in Australia, only 6.4% of staff were of Indigenous origin, compared to the marked overrepresentation of Indigenous children and youth in residential care (Gough et

al., 2005; Sinha et al., 2018). This discrepancy underscores the relevance of the CARE principle of cultural humility, which involves recognizing limits in understanding other cultures and maintaining openness to learning while being aware of personal biases (Holden, 2023). In a country historically described as a cultural "mosaic" (Gibbon, 1938), this principle is especially pertinent.

In Spain, lower scores were observed compared to the other countries, even though the differences were not significant compared to the United States. A particular feature is that the implementation of the CARE model was driven by the regional administration, whereas in other contexts it was the agencies themselves that requested it. Although the agencies did not finance the implementation of the model, the residential homes were selected based on those that showed greater interest in using trauma-informed approaches such as CARE. In Spain, since 2012, the welfare system has included national quality standards (Del Valle et al., 2012), which stipulate that care staff must hold at least a university degree, with the social educator as the primary professional reference, complemented by support staff with Postsecondary training. In the sample, 96% of workers held a Bachelor's degree, reflecting this professionalization of the role. However, the results across the different dimensions evaluated show that academic qualifications alone do not guarantee quality practice, underscoring the critical importance of internal training processes within organizations to ensure evidence-based practice. Additionally, low scores were observed in care beliefs regarding "avoiding reliance on consequences" (M = 2.98), substantially below those found in other countries, reflecting the persistence of more traditional care models among Spanish staff.

Finally, in the United States, scores were at an intermediate level in care beliefs and knowledge. In the sample, 62.2% of staff held a university degree, figures higher than those observed in Australia and Canada. There are no national standards requiring a specific qualification (Gharabaghi, 2024; Smith et al., 2021), although the Family First Prevention Services Act (FFPSA) sets accreditation criteria of short duration and therapeutic orientation (Lee & Bellonci, 2022), including Qualified Residential Treatment Programs (QRTPs), which require a higher level of clinical oversight and aim to provide trauma-informed care for youth with serious emotional and behavioral needs. A distinctive feature is the diversity of staff roles beyond direct care, including caseworkers, support staff, leadership, clinical personnel, and school staff. This variety reflects the importance of extending the implementation of evidence-based programs to all levels of the organization (Aarons et al., 2014). The CARE model's theory of change emphasizes the role of leadership, supervision, and the involvement of all personnel, arguing that its application requires structural change (Holden, 2023).

Conclusion and Future Implications

This study provided insight into caregiving beliefs and knowledge in agencies intending to implement the CARE model in Australia, Canada, Spain and the United States, as well as the structural differences across countries. In a global context in which residential care is still conceptualized as a "last resort" (Dozier et al., 2014), and where there is an overrepresentation of youth with emotional and behavioral difficulties and life trajectories marked by trauma (González-García et al., 2017), the high scores observed in Family Involvement and Promote Competence represent a notable strength. For these youth, creating environments that foster connection, family participation, and the development of adaptive skills serves as an important protective factor. In contrast, Flexibility received the lowest scores, underscoring the need to prioritize this dimension during CARE implementation, as youth with histories of adversity require individualized, responsive, and trauma-sensitive interventions (Holden, 2023).

At the organizational level, a high rate of staff turnover was identified, associated with precarious working conditions, excessive workload, limited economic and professional recognition, and continuous exposure to traumatic situations. These conditions have a direct impact on the stability, well-being, and emotional adjustment of children and youth (Brend et al., 2025). Moreover, staff providing direct care consistently reported lower caregiving belief scores than staff in non-direct-care roles, suggesting that those who are most directly involved in children's daily care may also experience greater challenges in their job role. From the CARE perspective, supporting staff and ensuring the involvement of all levels of the agency are essential pillars for effective implementation. In addition, significant cross-national differences in staff training were observed. The cases of Australia and Canada show that internal training and practice-oriented preparation can generate strong alignment with trauma-informed approaches even when the proportion of staff with university degrees is lower. Conversely, the Spanish case shows that formal professionalization alone does not guarantee coherent practice, highlighting the need for ongoing training, supervision, and organizational support (James, 2017).

Overall, the findings provide an international baseline that can inform implementation efforts by identifying shared strengths and areas requiring additional support across residential care contexts. At the same time, the study offers insights that extend beyond CARE itself, contributing to a broader understanding of the conditions that support

high-quality residential care across different child welfare systems. Furthermore, the cross-national nature of the study highlights both commonalities and contextual differences among residential care homes, which may contribute to understanding how CARE can be implemented while maintaining its core principles and allowing for contextual adaptation. Establishing such a baseline is also essential for future evaluations of implementation processes and outcomes, contributing to the growing literature on the implementation of trauma-informed models in residential care homes.

Limitations

Despite the contributions this study offers to the field, several limitations should be considered when interpreting the results. First, it is important to note that the sample comes from specific regions within each country and therefore cannot be considered representative of the national population. Additionally, data collection took place at different time points across agencies, as the initiation of the CARE implementation process varied between organizations. In, Australia, Canada and the United States, the decision to implement the CARE model was made by the agencies themselves. This suggests that their initial level of alignment may already have been more consistent with trauma-informed principles and practices, which may partially explain the high scores obtained. In the case of Spain, a particular feature is that the implementation of the model was driven by the government, although the agencies selected were those that showed motivation and intention to implement CARE. Finally, it was also necessary to adapt the different versions of the instrument, with some items being omitted from the scale. This may have led to a partial loss of information in cross-country comparisons. Nevertheless, despite these limitations, the study provides a valuable description of the types of attitudes and beliefs being implemented in residential care across the four countries, as well as the profile of the professionals working within the child welfare system.

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Declarations

Competing interests The authors declare no competing interests.

References

Aarons, G. A., Fettes, D. L., Flores, L. E., & Sommerfeld, D. H. (2009). Evidence-based practice implementation and staff emotional exhaustion in children's services. *Behaviour Research and Therapy*, *47*(11), 954–960. https://doi.org/10.1016/j.brat.2009.07.006

Aarons, G. A., Fettes, D. L., Hurlburt, M. S., Palinkas, L. A., Gunderson, L., Willging, C. E., & Chaffin, M. J. (2014). Collaboration, Negotiation, and Coalescence for Interagency-Collaborative Teams to Scale-Up Evidence-Based Practice. *Journal of Clinical Child & Adolescent Psychology*, *43*(6), 915–928. https://doi.org/10.1080/15374416.2013.876642

Ainsworth, F. (2017). For the Few Not the Many: An Australian Perspective on the Use of Therapeutic Residential Care for Children and Young People. *Residential Treatment for Children & Youth*, *34*(3–4), 325–338. https://doi.org/10.1080/0886571X.2017.1383868

Ames, R. L., & Loebach, J. E. (2023). Applying Trauma-Informed Design Principles to Therapeutic Residential Care Facilities to Reduce Retraumatization and Promote Resiliency Among Youth in Care. *Journal of Child & Adolescent Trauma*, *16*(4), 805–817. https://doi.org/10.1007/s40653-023-00528-y

Anglin, J. P., Saint-Girons, M., & Trocmé, N. (2022). Residential Care for Children and Youth in Canada. In J. K. Whittaker, L. Holmes, J. C. Fernández del Valle, & S. James (Eds.), *Revitalizing Residential Care for Children and Youth: Cross-National Trends and Challenges* (pp. 75–90). https://doi.org/10.1093/oso/9780197644300.003.0006

Australian Human Rights Commission (2021). Closing the gap. https://humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-socialjustice/publications/close-gap-2021

Bakketeig, E., & Backe-Hansen, E. (2018). Agency and flexible support in transition from care: Learning from the experiences of a Norwegian sample of care leavers doing well. *Nordic Social Work Research*, *8*(sup1), 30–42. https://doi.org/10.1080/2156857X.2018.1518815

Benton, M., Pigott, R., Price, M., Shepherdson, P., & Winkworth, G. (2017). *A national comparison of carer screening, assessment,*

selection, training and support in foster, kinship and residential care. Royal Commission into Institutional Responses to Child Sexual Abuse.

Bravo, A., & Del Valle, J. F. (2009). Crisis y revisión del acogimiento residencial: su papel en la protección infantil. *Papeles del Psicólogo*, *30*(1), 42–52.

Bravo, A., Martín, E., & Del Valle, J. F. (2022). The Changing Character of Residential Care for Children and Youth in Spain. In J. K. Whittaker, L. Holmes, J. C. Fernandez Del Valle, & S. James (Eds.), *Revitalizing Residential Care for Children and Youth* (1st ed., pp. 179–192). Oxford University Press. https://doi.org/10.1093/oso/9780197644300.003.0013

Brend, D. M., & Sprang, G. (2020). Trauma-Informed Care in Child Welfare: An Imperative for Residential Childcare Workers. *International Journal of Child and Adolescent Resilience*, *7*(1), 154–165. https://doi.org/10.7202/1072595ar

Brend, D. M., Olaniyan, O. S., & Collin-Vézina, D. (2024). Residential childcare worker perceptions of work-related achievement and pride. *Frontiers in Child and Adolescent Psychiatry*, *3*, 1360365. https://doi.org/10.3389/frcha.2024.1360365

Brend, D. M., Collin-Vézina, D., & Daignault, I. V. (2025). Claiming the edge as central: What residential childcare workers need to better serve children and families. *Residential Treatment For Children & Youth*, *42*(3), 459–484. https://doi.org/10.1080/0886571X.2025.2467106

Brendtro, L. K. (2019). Creating Powerful Environments. *Residential Treatment for Children & Youth*, *36*(1), 10–17. https://doi.org/10.1080/0886571X.2018.1515601

Bronfenbrenner, U., & Morris, P. A. (2007). The bioecological model of human development. In W. Damon, & R. M. Lerner (Eds.), *Handbook of child psychology: Theoretical models of human development* (pp. 793–828). John Wiley & Sons, Inc. https://doi.org/10.1002/9780470147658.chpsy0114

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: a national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*(8), 960–970. https://doi.org/10.1097/01.chi.0000127590.95585.65

Castro, E., Magalhães, E., & Del Valle, J. F. (2024). A Systematic Review of Quality Indicators in Therapeutic Residential Care Drawn from Young People´s Beliefs and Experiences. *Child Indicators Research*, *17*(3), 1195–1216. https://doi.org/10.1007/s12187-024-10118-5

Cohen, J. (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(4), 414–430. https://doi.org/10.1016/j.jaac.2009.12.020

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

Commission for Children and Young People, Victoria (2021). Out of sight: Systemic inquiry into children and young people who are absent or missing from residential care. https://ccyp.vic.gov.au/assets/Publications-inquiries/out-of-sight-inquiry-report-summaryWeb.pdf

Corrales, T., McNamara, P., Smith, B., Bath, H., Clark, E., Goodchild, K. L., Grabda, S., Harrison, M., & McGrady, B. (2025). They just want people in their lives that will be there forever: A conceptual model of permanency for children and young people in therapeutic residential care. *Children and Youth Services Review*, *172*, 108211. https://doi.org/10.1016/j.childyouth.2025.108211

Costa, M., Melim, B., Tagliabue, S., Mota, C. P., & Matos, P. M. (2020). Predictors of the quality of the relationship with caregivers in residential care. *Children and Youth Services Review*, *108*, 104579. https://doi.org/10.1016/j.childyouth.2019.104579

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

Del Valle, J. F., & Bravo, A. (2013). Current trends, figures and challenges in out of home child care: An international comparative analysis. *Psychosocial Intervention*, *22*(3), 251–257. https://doi.org/10.5093/in2013a28

Del Valle, J. F., Bravo, A., Martínez, M., & Santos, I. (2012). Estándares de calidad en acogimiento residencial EQUAR [Quality standards in residential care: EQUAR]. Ministerio de Sanidad, Servicios Sociales e Igualdad. https://www.observatoriodelainfancia.es/ficherosoia/documentos/4071_d_Estandares-calidadacogimiento.residencial-EQUAR.pdf

U.S. Department of Health and Human Services (USDHHS) Administration on Children, Youth and Families, Children's Bureau (2015). A national look at the use of congregate care in child welfare. https://www.acf.hhs.gov/sites/default/files/documents/cb/cbcongregatecare_brief.pdf

U.S. Department of Health and Human Services (USDHHS) Administration on Children, Youth and Families, Children's Bureau (2020). The AFCARS report: Preliminary estimates for FY 2019 as of June 23, 2020. https://www.acf.hhs.gov/cb

Dozier, M., Kaufman, J., Kobak, R., O'Connor, T. G., Sagi-Schwartz, A., Scott, S., Shauffer, C., Smetana, J., van IJzendoorn, M. H., & Zeanah, C. H. (2014). Consensus statement on group care for children and adolescents: A statement of policy of the American Orthopsychiatric Association. *American Journal of Orthopsychiatry*, *84*(3), 219–225. https://doi.org/10.1037/ort0000005

European Institute for Gender Equality. (2023). *A better work–life balance: bridging the gender care gap*. Publications Office of the European Union. https://data.europa.eu/doi/10.2839/741565

Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E. J. (1999). Evaluating the use of exploratory factor analysis in psychological research. *Psychological Methods*, *4*(3), 272–299. https://doi.org/10.1037/1082-989X.4.3.272. (1999-03908-004).

Fonseca, A., Moreira, H., & Canavarro, M. C. (2020). Uncovering the links between parenting stress and parenting styles: The role of psychological flexibility within parenting and global psychological flexibility. *Journal of Contextual Behavioral Science*, *18*, 59–67. https://doi.org/10.1016/j.jcbs.2020.08.004

García-Alba, L., Gullo, F., & Del Valle, J. F. (2022). Readiness for independent living of youth in residential childcare: A comparative study. *Child & Family Social Work*, *28*(1), 171–183. https://doi.org/10.1111/cfs.12951

Geoffrion, S., Morselli, C., & Guay, S. (2016). Rethinking compassion fatigue through the lens of professional identity: The case of child-protection workers. *Trauma Violence & Abuse*, *17*(3), 270–283. https://doi.org/10.1177/1524838015584362

Geurts, E. M. W., Boddy, J., Noom, M. J., & Knorth, E. J. (2012). Family-centred residential care: The new reality? *Child & Family Social Work*, *17*, 170–179. https://doi.org/10.1111/j.1365-2206.2012.00838.x

Gharabaghi, K. (2024). Quality Care in Residential Care and Treatment Settings in North America: From Complex Research to Four Everyday Principles for Practice. *Youth*, *4*(1), 244–259. https://doi.org/10.3390/youth4010017

Gibbon, J. (1938). *Canadian mosaic: The making of a northern nation*. J. M. Dent and Sons.

Glisson, C., Dukes, D., & Green, P. (2006). The effects of the ARC organizational intervention on caseworker turnover, climate and culture in children's service systems. *Child Abuse and Neglect*, *30*, 849–854. https://doi.org/10.1016/j.chiabu.2005.12.010

González-García, C., Bravo, A., Arruabarrena, I., Martín, E., Santos, I., & Del Valle, J. F. (2017). Emotional and behavioral problems of children in residential care: Screening detection and referrals to mental health services. *Children and Youth Services Review*, *73*, 100–106. https://doi.org/10.1016/j.childyouth.2016.12.011

Gough, P., Trocmé, N., Brown, I., Knoke, D., & Blackstock, C. (2005). *Pathways to the overrepresentation of Aboriginal children in care*. CECW Information Sheet #23E. University of Toronto, Faculty of Social Work.

Grietens, H. (2014). Is the group under threat as a therapeutic milieu? An analysis of the views of group workers in residential youth care. *International Journal of Child & Family Welfare, 15*(1–2). https://ugp.rug.nl/IJCFW/article/view/37858

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

Hill, M. (2000). The residential child care context. In M. Chakrabarti, & M. Hill (Eds.), *Residential child care: International perspectives on links with families and peers* (pp. 9–29). Jessica Kingsley.

Holden, M. J. (2023). *CARE: Crear condiciones para el cambio* (3rd ed.). CWLA. http://rccp.cornell.edu

Holden, M., & Sellers, E. (2019). An evidence-based program model for facilitating therapeutic responses to pain-based behavior in residential care. *International Journal of Child Youth and Family Studies*, *19*, 63–80. https://journals.uvic.ca/index.php/ijcyfs/article/view/18853

Holden, M., Izzo, C., Nunno, M., Smith, E., Endres, T., Holden, J., & Kuhn, F. (2010). Children and residential experiences: a comprehensive strategy for implementing a research-informed program model for residential care. *Child Welfare*, *89*, 131–149.

Holden, M. J., Anglin, J. P., Nunno, M. A., & Izzo, C. V. (2014). Engaging the total therapeutic residential care program in a process of quality improvement: Learning from the CARE model. In J. K. Whittaker, & L. Holmes (Eds.), *Therapeutic residential care for children and youth: Developing Evidence-Based International Practice*. Jessica Kingsley. J. F. del Valle.

Holden, M. J., Sellers, D. E., & Smith, E. G. (2022). The CARE Program Model. In J. K. Whittaker, L. Holmes, J. C. Fernandez Del Valle, & S. James (Eds.), *Revitalizing Residential Care for Children and Youth* (pp. 139–153). Oxford University Press. https://doi.org/10.1093/oso/9780197644300.003.0010

Horn, J. L. (1965). A Rationale and Test for the Number of Factors in Factor Analysis. *Psychometrika*, *30*(2), 179–185. https://doi.org/10.1007/BF02289447

Hummer, V., Dollard, N., Robst, J., & Armstrong, M. (2010). Innovations in implementation of trauma-informed care practices in youth residential treatment: A curriculum for organizational change. *Child Welfare*, *89*(2), 79–95.

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

Izzo, C. V., Smith, E. G., Sellers, D. E., Holden, M. J., & Nunno, M. A. (2020). Improving relationship quality in group care settings: The impact of implementing the CARE model. *Children and Youth Services Review*, *109*, 104623. https://doi.org/10.1016/j.childyouth.2019.104623

Izzo, C. V., Smith, E. G., Sellers, D. E., Holden, M. J., & Nunno, M. A. (2022). Promoting a relational approach to residential child care through an organizational program model: Impacts of CARE implementation on staff outcomes. *Children and Youth Services Review*, *132*, 106330. https://doi.org/10.1016/j.childyouth.2021.106330

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. (2017). Implementing Evidence-Based Practice in Residential Care: How Far Have We Come? *Residential Treatment for Children & Youth*, *34*(2), 155–175. https://doi.org/10.1080/0886571X.2017.1332330

James, S., Thompson, R. W., & Ringle, J. L. (2017). The implementation of evidence-based practices in residential care: Outcomes, processes, and barriers. *Journal of Emotional and Behavioral Disorders*, *25*(1), 4–18. https://doi.org/10.1177/1063426616687083

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*, 123–140. https://doi.org/10.1016/j.childyouth.2007.09.001

Lee, B. R., & Bellonci, C. (2022). *Residential care for children and youth in the United States*. En J. K. Whittaker, L. Holmes, J. C. Fernández del Valle, & S. James (Eds.), *Revitalizing Residential Care for Children and Youth: Cross-National Trends and Challenges* (Chap. 7). Oxford University Press. https://doi.org/10.1093/oso/9780197644300.003.0007

Ley Orgánica 8 (2015). / de 22 de julio, de modificación del sistema de protección a la infancia y a la adolescencia. (BOE, núm. 175, 23 de julio de 2015). https://www.boe.es/buscar/doc.php?id=BOE-A-2015-8222

Ley 26/ (2015). de 28 de julio, de modificación del sistema de protección a la infancia y a la adolescencia. (BOE, núm. 180, 29 de julio de 2015). https://www.boe.es/buscar/doc.php?id=BOE-A-2015-8470

Li, J., & Julian, M. M. (2012). Developmental relationships as the active ingredient: a unifying working hypothesis of what works across intervention settings. *The American journal of orthopsychiatry*, *82*(2), 157–166. https://doi.org/10.1111/j.1939-0025.2012.01151.x

Lieberman, R. E., Sackley, W., Polan, K., Rieger, P., Dicharry, L. K. B., Heine, S., & Sisson, K. (2019). Trauma informed practice: Moving away from point and level systems. https://togetherthevoice.org/best-practices/position-papers/

Maltais, C., Cyr, C., Parent, G., & Pascuzzo, K. (2019). Identifying effective interventions for promoting parent engagement and family reunification for children in out-of-home care: A series of meta-analyses. *Child Abuse & Neglect*, *88*, 362–375. https://doi.org/10.1016/j.chiabu.201812.009.

Mann-Feder, V. R. (2019). Child and youth care in Quebec. In K. Gharabaghi, & G. Charles (Eds.), *Child and youth care across sectors: Canadian perspectives* (pp. 209–226). Canadian Scholars.

Marsh, H. W. (1996). Positive and negative global self-esteem: A substantively meaningful distinction or artifactors? *Journal of Personality and Social Psychology*, *70*(4), 810–819. https://doi.org/10.1037/0022-3514.70.4.810

McIlwaine, F., Proctor, K., O'Sullivan, K., & Manley, L. (2020). Practitioners' Perspectives: Partnering with families in Out-of-Home Care (OOHC) – from 'on the outer' to shared caring. *Residential Treatment for Children & Youth*, *37*(4), 327–341. https://doi.org/10.1080/0886571X.2020.1800550

McNamara, P. (2014). A new era in the development of therapeutic residential care in the State of Victoria. In J. K. Whittaker, del J. F. Valle, & L. Holmes (Eds.), *Therapeutic residential care with children and youth: Developing Evidence-Based International Practice* (pp. 126–139). Jessica Kingsley.

McNamara, P., & Wall, S. (2022). *Australian residential care: Creating opportunities for hope and healing*. In J. K. Whittaker, L. Holmes, J. F. del Valle, & S. James (Eds.), *Revitalizing residential care for children and youth: Cross-national trends and challenges*

(Cap. 23). Oxford University Press. https://doi.org/10.1093/oso/9780197644300.003.0023

McPherson, L., Canosa, A., Gilligan, R., Moore, T., Gatwiri, K., Day, K., Mitchell, J., Graham, A., & Anderson, D. (2025). Young people's lived experience of relational practices in therapeutic residential care in Australia. *Children and Youth Services Review*, *170*, 108129. https://doi.org/10.1016/j.childyouth.2025.108129

Molnar, B., & Fraser, J. (2020). Child abuse workforce health: Research to promote a healthy and resilient child abuse & neglect workforce. *Child Abuse & Neglect*, *110*, 104704. https://doi.org/10.1016/j.chiabu.2020.104704

Monson, C., Moeller-Saxone, K., Humphreys, K., Harvey, C., & Herrman, C. (2020). Promoting mental health in out-of-home care in Australia. *Health Promotion International*, *35*(5), 1026–1036. https://doi.org/10.1093/heapro/daz090

Nunno, M. A., Smith, E. G., Martin, W. R., & Butcher, S. (2017). Benefits of embedding research into practice: An agency-university collaboration. *Child Welfare*, *94*(3), 113–133.

Pålsson, D., Andersson, P., Shanks, E., & Wiklund, S. (2023). A professional field? Educational attainments, gender and age among staff in Swedish residential care. *Residential Treatment For Children & Youth*, *40*(4), 497–516. https://doi.org/10.1080/0886571X.2023.2241361

Parhar, K. K., Wormith, J. S., Derkzen, D. M., & Beauregard, A. M. (2008). Offender Coercion in Treatment: A Meta-Analysis of Effectiveness: A Meta-Analysis of Effectiveness. *Criminal Justice and Behavior*, *35*(9), 1109–1135. https://doi.org/10.1177/0093854808320169

Pérez-García, S., Águila-otero, A., González-García, C., Santos, I., &, J. F. V. (2019). No one ever asked us. Young people's evaluation of their residential child care facilities in three different programs. *Psicothema*, *31*(3), 319–326. https://doi.org/10.7334/psicothema2019.129

Poole Quintana, M., Álvarez Vélez, M. I., & Ruiz de Huidobro de Carlos, J. M. (2025). *II Estudio de los centros de acogimiento residencial en el ámbito de la protección a la infancia en España: Avances en la estrategia de desinstitucionalización*. Dykinson. https://doi.org/10.14679/3971

Pulgar, A., Ordiales, R., González-García, C., & Bravo, A. (2025). Care practices in residential child homes: Caregiver and youth voices. *Child & Family Social Work*, 1–14. https://doi.org/10.1111/cfs.70082

Pulgar, A., Ordiales, R., Burón, J., González-García, C., & Bravo, A. (2026). Implementing the CARE model in Spain: Effects on relationship quality and child subjective well-being. *Children and Youth Services Review*, *188*, 109160. https://doi.org/10.1016/j.childyouth.2026.109160

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68–78. https://doi.org/10.1037/0003-066X.55.1.68

SA Child Protection Systems Royal Commission. (2016). *The life they deserve. Summary and report*. Government of South Australia.

Schuengel, C., & van IJzendoorn, M. H. (2001). Attachment in mental health institutions: A critical review of assumptions, clinical implications, and research strategies. *Attachment & Human Development*, *3*(3), 304–323. https://doi.org/10.1080/14616730110096906

Secretariat for National Aboriginal and Islander Childcare (SNAICC) (2021). Our approach in 2020. https://www.familymatters.org.au/our-approach-in-2020/

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. https://doi.org/10.1080/0886571X.2020.1712576

Sinha, V., Delaye, A., & Orav-Lakaski, B. (2018). Reimagining overrepresentation research: Critical reflections on researching the overrepresentation of First Nations children in the child welfare system. *Journal of Law and Social Policy*, *28*, 10–38.

Smith, Y., Colletta, L., & Bender, A. E. (2021). 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.

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare*, *90*(6), 149–168.

Steinkopf, H., Nordanger, D., Stige, B., & Milde, A. M. (2020). How do staff in residential care transform Trauma-Informed principles into practice? A qualitative study from a Norwegian child welfare context. *Nordic Social Work Research*, *12*(5), 625–639. https://doi.org/10.1080/2156857X.2020.1857821

Stoll, S. J., Hartman, J. D., Paxton, D., Wang, L., Ablon, J. S., Perry, B. D., & Pollastri, A. R. (2024). De-Implementing a Point and Level System in Youth Residential Care without Increased Safety Risk: A Case Study. *Residential Treatment For Children & Youth*, *41*(2), 233–253. https://doi.org/10.1080/0886571X.2023.2233408

Substance Abuse and Mental Health Services Administration (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. *HHS Publication No (SMA)*, 144884. https://library.samhsa.gov/product/samhsas-concept-trauma-and-guidance-traumainformed-approach/sma14-4884

Tang, E., De Haan, A. D., Kuiper, C. H. Z., & Harder, A. T. (2024). Family-centred practice and family outcomes in residential youth care: A systematic review. *Child & Family Social Work*, cfs13120. https://doi.org/10.1111/cfs.13120

Tausendfreund, T., Knot-Dickscheit, J., Schulze, G. C., Knorth, E. J., & Grietens, H. (2016). Families in multi-problem situations: Backgrounds, characteristics, and care services. *Child & Youth Services*, *37*(1), 4–22. https://doi.org/10.1080/0145935X.2015.1052133

Tremblay, C., Haines, V., & Joly, J. (2016). Staff Turnover and Service Quality within Residential Settings. *Human Service Organizations Management Leadership & Governance*, *40*(1), 22–36. https://doi.org/10.1080/23303131.2015.1085479

Turner, H. A., Vanderminden, J., Finkelhor, D., & Hamby, S. (2019). Child Neglect and the Broader Context of Child Victimization. *Child Maltreatment*, *24*(3), 265–274. https://doi.org/10.1177/1077559518825312

Vygotsky, L. (1978). *Mind and Society: The Development of Higher Mental Processes*. Harvard University Press.

Whittaker, J. K., Valle, D., J. F., & Holmes, L. (Eds.). (2015). *Therapeutic residential care with children and youth: Developing evidence based international practice*. Jessica Kingsley.

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

Whittaker, J. K., Holmes, L., del Fernández, J., & James, S. (2022). Residential care for children and youth in a cross-national perspective. In J. K. Whittaker, L. Holmes, J. C. Fernández del Valle, & S. James (Eds.), *Revitalizing Residential Care for Children and Youth: Cross-National Trends and Challenges* (pp. 3–15). Oxford University Press. https://doi.org/10.1093/oso/9780197644300.003.0001